

## V. CONCLUSION

At some point or another, all of us will be patients in the delivery system, and thus patient safety affects us all. Key systems approaches outside medicine and within it have shown the effectiveness of these methods. However, these methods require open, honest, and frank communications, discussions, and corrective actions. Currently, providers and patients rely on precisely the wrong methods to "improve" safety—shame and blame of individuals and a legal system that thwarts effective communication of safety data and issues. As well, federal-state issue analysis indicate PR/QA privilege may not be applicable to safety and error discussions, and mediation communications may be used for other, inappropriate activities that were never intended by the parties.

To improve safety, safe, confidential communications must be allowed, promoted, and rewarded. To obtain this goal, and to clarify the need for protected communications, federal legislation should be passed to protect PR/QA and mediation communications as they relate to safety. This piece proposes such a statute.

Overall, the conflicts between federal and state laws regarding PR/QA and mediation communications must be addressed. The vagaries of conflict of laws, privilege, jurisdiction, and choice of laws may be of great interest to the attorney; however, to an injured patient or provider caught in a system which discourages open discussion of safety, they represent only a source of angst that limits what can and will be discussed—and corrected. We must do better; for our lives, and the lives of our families and future generations, depend upon it.

## AN ASSESSMENT OF MEDICAID PLANNING

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### INTRODUCTION

Access to long-term care in the United States, like health care, is allocated primarily on the basis of ability to pay. For a substantial segment of the population, health care costs are covered by insurance; however, long-term care insurance is far less common and may cover an unpredictably low portion of actual costs.<sup>1</sup> Therefore, premiums are high due to actuarial unpredictability and prevailing price strategies that determine premiums based on the insured's age at the time of purchase or that increase premiums with the advancing age of the insured.<sup>2</sup> Thus, older people who have such insurance must be quite affluent in order to afford the premiums.<sup>3</sup>

Long-term care policy and finance is intertwined with health care policy, in that long-term care in the second half of the twentieth century is defined as physical care that is *not* health care.<sup>4</sup> Long-term care policy is also closely aligned with government benefits for the poor.<sup>5</sup> In the past, one who could be self-supporting presumably could pay for long-term care, including non-medical physical assistance to offset incapacities due largely to the natural process of aging. As a result, social policy has yet to determine with certainty whether long-term care assistance is a legitimate need for those who are not clearly determined to be poor. Thus, policy makers in the United States are uncertain how and by what type of benefit long-term care should be available to elders. A persistent theme is that many elders can and should provide for their own long-term care.

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<sup>1</sup> See ALISON BARNES ET AL., COUNSELING OLDER CLIENTS 16-1 (1997).

<sup>2</sup> See *id.* at 16-4.

<sup>3</sup> See *id.* (citing LONG-TERM CARE POLICIES AVAILABLE IN WISCONSIN, Office of the Commissioner of Insurance (Jan. 1994)).

<sup>4</sup> See *id.* at V-3.

<sup>5</sup> See *id.* at V-4.

costs out of their life saving. If that is not possible, the right model to meet these needs is a poverty program.<sup>6</sup>

Medicaid is the national U.S. program of health care payments for the poor.<sup>7</sup> Only those who are poor, according to various federal and state guidelines, are eligible to receive Medicaid assistance.<sup>8</sup> The basic federal rules of the program require the states to cover institutional care, such as long-term care nursing home services for a restricted group of eligible people.<sup>9</sup> However, states can cover certain other populations and can provide some other long-term care services with the approval of the federal agency.<sup>10</sup>

Demands for Medicaid nursing home benefits are affected by changes in the coverage and delivery of health care services. Beginning in the late 1980s, policymakers sought to restrict coverage for nursing home stays to Medicare beneficiaries by enforcing rigorous interpretations of eligibility standards that allowed payment only for relatively short-term, intensive rehabilitative care.<sup>11</sup> As a result, the average cost of a day in a nursing home rose sharply, and admissions were curtailed.<sup>12</sup> Nursing homes became medical care facilities, rather than "rest homes," with the attendant increase in cost associated with an institution.<sup>13</sup>

As a result, nursing home care costs are high, more like medical care than assistance at home. Costs cannot be covered by typical combinations of Social Security and pension income, and can quickly exhaust retiree savings.<sup>14</sup> Yet, the general policy of the United States continues to be: Government funds will not be expended for long-term care costs for those who do not meet poverty eligibility limits.

<sup>6</sup> See *id.*

<sup>7</sup> 42 U.S.C. § 1396a(a)(10)(A) (West Supp. 2002).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*; § 1396d(a)(1)-(5), (17), (21).

<sup>10</sup> § 1396a(a)(10)(C).

<sup>11</sup> See §§ 1395y(a)(1)(C), 1395y(a)(9).

<sup>12</sup> See Susan C. Eaton, Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs 15, KEYSTONE RESEARCH CENTER HIGH ROAD INDUSTRY SERIES, #1 (Apr. 1997), available at <http://www.keystoneresearch.org/pdf/eaton.pdf> (last visited Apr. 25, 2003).

<sup>13</sup> See LAWRENCE A. FROLIK & ALISON McCHRYSTAL BARNES, ELDERLAW: CASES AND MATERIALS 328 (2nd ed., LEXIS Law Publ'g 1999). As a result of these policy changes, nursing homes are required to provide increasingly in-depth medical care, which results in increased health care costs for nursing home residents. *Id.*

<sup>14</sup> See *id.*

This article asserts that Medicaid income and asset eligibility limits that apply to the elderly in need of nursing home care are very complex in their application because Congress intended them to apply to people who were not always poor. The rules are subject to reinterpretation on a case-by-case periodic basis by legislatures, and differ from state to state. Eligibility is denied temporarily or permanently to persons with financial assets or arrangements that are incompatible with the complex state and federal Medicaid rules.<sup>15</sup> In some states, people who cannot pay the monthly bill for any nursing home are denied Medicaid coverage, because their retirement incomes are "too high."<sup>16</sup>

On the other hand, more recent provisions of Medicaid law explicitly leave an older person (provided they have a spouse who resides in a nursing home) with assets well above the average for retired individuals.<sup>17</sup> The Medicaid benefits are extended to cover nursing home care of a married elder person, protecting substantial resources for the at-home spouse.<sup>18</sup> Thus, certain middle-class retirees, those who are nursing home residents and have a spouse living in the community, are eligible for Medicaid nursing home payments.

The process of "Medicaid planning," or arranging assets and income for an individual or couple in order to achieve earlier Medicaid eligibility for nursing home benefits and protect assets for other uses than nursing home payments, is an important legal service that is identified with the broader field of elder law.<sup>19</sup> However, specific techniques for obtaining Medicaid eligibility are seldom openly discussed in the literature.<sup>20</sup> Two reasons seem readily apparent. First, practitioners may reasonably view their techniques as trade secrets, and may tailor information shared with colleagues to assure incom-

<sup>15</sup> 42 U.S.C. 1396d (West Supp. 2002).

<sup>16</sup> FROLIK & BARNES, *supra* note 13, at 328.

<sup>17</sup> 42 U.S.C. § 1396r-5 (West Supp. 2002); see also L. RUSH HUNT ET AL., UNDERSTANDING ELDER LAW: ISSUES IN ESTATE PLANNING, MEDICAID, AND LONG-TERM CARE BENEFITS, 186-87 (American Bar Association, 2002). Under the Medicare Catastrophic Coverage Act of 1988 (MCCA), states are required to set a minimum income level, which can be retained by the community spouse. This income, referred to as the monthly maintenance needs allowance, can be set by the state at an amount between \$1451.25 and \$2232.00 in 2002. *Id.*

<sup>18</sup> See FROLIK & BARNES, *supra* note 13, at 365.

<sup>19</sup> *Id.* at 360-61.

<sup>20</sup> See, e.g., HUNT ET AL., *supra* note 17, at 220. While this book includes what is probably the most extensive discussion of elder law issues and some planning techniques including the use of annuities and trusts (Chapter 9), it devotes only half a page to "gift giving" (§ 9.06), a fundamental and hotly debated technique for Medicaid planning. *Id.*

pleteness as an economic protection for their individual practices. Secondly, some commentators have aggressively criticized Medicaid planning as a misuse of Medicaid funds. In each case, the assertions must be scrutinized to determine the extent to which these views are based in self (or employer) interest or misperception.

Individuals and the states struggle to determine the extent to which older people are responsible for impoverishing themselves in order to pay for long-term care.

In February 2002, the United States Supreme Court issued a decision in *Wisconsin Department of Health & Family Services v. Blumer*<sup>21</sup> that reveals a recognition and endorsement of a change in attitude toward Medicaid long-term care, one that recognizes the program as distinct in its structure and purposes from welfare programs. This article contends that Medicaid long-term care is a program for middle class elders of at least modest means.

This article explores the techniques of Medicaid eligibility planning, with attention to the question of whether current Medicaid eligibility policies identify appropriate eligible persons and exclude those who should not be eligible. However, a caveat is necessary: This article does not provide information that enables the reader to engage in Medicaid planning in any specific state. Each state has its own rules and interpretations of acceptable practice. Further, the rules are sufficiently complex that the resolution of a specific issue may vary according to the specific worker reviewing financial information, and the process of review within the agency at the local and state levels. This article instead seeks to identify the policies and their implementing practices that represent the meaning of Medicaid eligibility planning for older people and policy makers, as a basis for understanding our present stance on government long-term care benefits and clarifying policy for the future.

This article first describes Medicaid eligibility for unmarried seniors in need of nursing home care, considering the costs and average assets of retirees in order to determine when and how these individuals might become eligible. Next, this article discusses the division of opinion about the acceptability of Medicaid planning, and its bases in ideology and corporate self-interest. Third, the article traces the evolution of Medicaid planning over two decades, reviewing the various techniques and the response of the states. The article then reviews the "spousal impoverishment" provisions of the Medicare Catastrophic Coverage Act of 1988, and how recent Medi-

<sup>21</sup> 534 U.S. 473 (2002).

caid planning enhances coverage for spouses who are separated because one spouse enters a nursing home. Finally, the discussion turns to the views expressed by the various Justices of the United States Supreme Court in the *Blumer* case, finding some recognition that Medicaid long-term care is no longer a welfare benefit, but rather an entitlement for the prudent middle class.

## I. MEDICAID LONG-TERM CARE ELIGIBILITY

Medicaid was created in July 1965 in the same congressional session as Medicare, a program of health care services for elderly and long-term disabled people.<sup>22</sup> The era was one of great political unrest, due to the aftermath of President Kennedy's assassination and the subsequent presidency of Lyndon Johnson.<sup>23</sup> Civil rights had moved from demonstrations in the streets to legislation, including the landmark Civil Rights Act of 1964, that prohibited discrimination on the basis of race in jobs, housing, government programs and public accommodation.<sup>24</sup>

The passage of the Medicaid legislation is curious, however, in that it generated little debate.<sup>25</sup> Congress was concerned with the scope and implications of Medicare, a program traditionally opposed by physicians and private insurers as opening the door to a nationalized health system.<sup>26</sup> The decision to enact the first nationwide government health care benefits program apparently turned on revised views of Medicare among a few policy makers.<sup>27</sup> Medicaid was institutionalized incidentally as a continuation of annual federal grants to the states provided since 1950 for health care for the indigent.<sup>28</sup> No new structure or guidance was provided. Thus, the federal legislation to provide health care to the poor left each state to define its full scope of services and eligibility.

<sup>22</sup> In 1965, Congress passed the Health Insurance for the Aged Act (Medicare Act), Pub.L. 89-97, 79 Stat. 290, 343; see also FROLIK & BARNES, *supra* note 13, at 213-14.

<sup>23</sup> *Biography of John F. Kennedy*, at <http://www.whitehouse.gov/history/presidents/jk35.html> (last visited Apr. 25, 2003); *Biography of Lyndon B. Johnson*, at <http://www.whitehouse.gov/history/presidents/lj36.html> (last visited Apr. 25, 2003).

<sup>24</sup> In 1964, Congress passed the Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241.

<sup>25</sup> See FROLIK & BARNES, *supra* note 13, at 213.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.* at 212.

The Medicaid program is first and foremost a program for the poor.<sup>29</sup> It is defined by federal guidelines, which establish eligibility of "categorically needy" persons, defined as those with incomes low enough to qualify them for government income assistance.<sup>30</sup> For the aged, categorical eligibility most often includes persons who have not worked the number of quarters necessary to qualify for Social Security income,<sup>31</sup> and who therefore receive Supplemental Security Income (SSI), a minimal income for those who are poor, aged, blind, or disabled.<sup>32</sup> In order to draw down federal Medicaid funds, states are required to provide at minimum certain mandatory benefits including nursing facility care<sup>33</sup> to this group.<sup>34</sup>

#### A. Medically Needy Eligibility

The majority of older people in need of nursing home care are not "categorically needy."<sup>35</sup> They have not been poor, though their earnings might have been modest and, particularly for women, sporadic. Nevertheless, they are the recipients of at least the minimum Social Security payment on their own record or their spouse's, which gives them an income above the poverty line. States may extend eligibility for nursing home benefits to such non-poor people by including the category of "medically needy" in their Medicaid plans.<sup>36</sup> Medically needy people would be eligible for Medicaid but for the fact that their income or property exceeds financial guide-

<sup>29</sup> *Id.* at 337.

<sup>30</sup> 42 U.S.C. § 1396a(a)(10)(A) (West Supp. 2002).

<sup>31</sup> 20 C.F.R. § 404.101(a) (2002).

<sup>32</sup> 42 U.S.C. § 1381-83 (West Supp. 2002); 20 C.F.R. Pt 416 (2002).

<sup>33</sup> 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21) (West Supp. 2002).

<sup>34</sup> § 1396a(a)(10)(C). States may choose to provide several optional services, including home health care, and home and community care for functionally disabled elder people. *Id.* In addition to those captured in this general description, more than a dozen special categories of Medicaid eligibles have been specially carved out by Congress over the years. *Id.*

<sup>35</sup> See FROLIK & BARNES, *supra* note 13, at 353. Optionally categorically needy eligibility applies in some states. *Id.* Under this category, states may provide particular services to distinct groups defined by the federal rules, without triggering an obligation to serve all who are financially eligible. *Id.* See also *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources*, available at [www.cms.gov](http://www.cms.gov). A special income level can be set under 42 U.S.C. § 1396a(a)(10)(A)(ii)(V) (West Supp. 2002) for applicants in a medical institution for at least thirty consecutive days with gross income that does not exceed 300% of the SSI income standard. *Id.*

<sup>36</sup> § 1396a(a)(10)(C).

lines.<sup>37</sup> States need not include medically needy eligibility in their Medicaid plans, and many do not do so.<sup>38</sup>

Medically needy people become eligible for Medicaid benefits by incurring health and long-term care costs that are calculated to reduce their excess income and assets.<sup>39</sup> As the language suggests, the bills need not be paid to be credited against excess resources.<sup>40</sup> The great majority of medically needy elders incur nursing home costs.<sup>41</sup>

Qualification for medically needy eligibility begins with accounting for an applicant's income and assets in order to determine what must be "spent down" in order to qualify.<sup>42</sup> For simplicity, one might envision consuming assets as distinct from income, though in this pre-eligibility phase the source of the funds to meet incurred medical debt is not specified. While it is in the interest of the applicant to reduce total assets, actual excess income will be allocated to nursing home cost each month so long as it is received, unless the Medicaid rules allow some other treatment, such as diverting income to the support of a spouse.<sup>43</sup>

#### B. The Gap Group and the 300% Rule: Planning by the States

A number of states have authority to refuse to allow applicants to spend down income. Instead, in so-called "income cap" states, people are ineligible if their incomes exceed three times the SSI income in the area,<sup>44</sup> \$1635 in 2002.<sup>45</sup> The provision is the "300% rule."<sup>46</sup> The method of eligibility determination leaves a "gap group" of individuals who are not poor enough for Medicaid nursing home coverage, but who cannot pay nursing home bills themselves.<sup>47</sup>

<sup>37</sup> *Id.*

<sup>38</sup> See FROLIK & BARNES, *supra* note 13, at 352.

<sup>39</sup> See *id.*, at 353.

<sup>40</sup> See 42 U.S.C. § 1396a(a)(10)(C) (West Supp. 2002).

<sup>41</sup> FROLIK & BARNES, *supra* note 13, at 353. Less than ten percent of medically needy elderly people live in the community and incur high health care costs. *Id.*

<sup>42</sup> See BARNES ET AL., *supra* note 1, at 17-5 - 17-9.

<sup>43</sup> See HUNT ET AL., *supra* note 17, at 194-95.

<sup>44</sup> 42 U.S.C. § 1396b(f)(4)(C) (West Supp. 2002).

<sup>45</sup> HUNT ET AL., *supra* note 17, at 195.

<sup>46</sup> FROLIK & BARNES, *supra* note 13, at 355.

<sup>47</sup> BARNES ET AL., *supra* note 1, at 17-9. See *infra* note 53-58 and accompanying text (states' response to the Medicaid gap group is the relatively recent provision for Miller trusts).

In most states, assets of a Medicaid eligible person are limited to \$2000 for an individual.<sup>48</sup> Assets include everything the applicant legally owns that is *reasonably available* to be converted to cash so that it can be expended for incurred costs.<sup>49</sup> Certain assets are exempt from the calculation, including a homestead, an automobile necessary for employment or medical treatment, a life insurance policy usually limited to \$1500, and a burial fund generally limited to \$1500.<sup>50</sup>

For many years, elders in the "gap group" were permanently ineligible for Medicare, though their incomes fell hundreds of dollars short of covering typical nursing home costs.<sup>51</sup> States declined to extend benefits to avoid the cost.<sup>52</sup> Individuals in need of nursing home care were forced to rely on less intensive services, including a non-medical residential care facility if one could be located that agreed to take a resident requiring relatively heavy care, and home care put together from a combination of family, friends and "home-maker" workers who were willing to provide some personal care.

### C. Miller Trusts: The Federal Response to the States

In response to this unhappy impasse, in the Omnibus Budget Reconciliation Act 1993 (OBRA 1993) Congress created an exemption that allows "gap group" people to create irrevocable trusts to reorganize their income.<sup>53</sup> So-called Miller trusts receive all of the individual's income in excess of the amount allowed by the cap, i.e., the \$1635 mentioned above.<sup>54</sup> If the individual receives \$2000 in income, the excess of \$365 goes to the trust. Once received by the trust, the funds are no longer considered income to the applicant/grantor; rather, they are assets that are unavailable because of the trust's irrevocability and restrictive purposes.<sup>55</sup> Under federal

<sup>48</sup> Assets are limited to \$3000 for a couple under basic Medicaid rules, but other rules apply to married persons when one spouse needs nursing home care. FROLIK & BARNES, *supra* note 13, at 352-53.

<sup>49</sup> See BARNES ET AL., *supra* note 1, at 17-9.

<sup>50</sup> 20 C.F.R. §§ 416.1212, .1218, .1230, .1231. If the auto is not used for any of the reasons allowed by the regulation, it will be excluded from the resource calculation as long as its current market value is less than \$4500. § 416.1218(b)(2).

<sup>51</sup> See *supra* notes 44-50 and accompanying text.

<sup>52</sup> See *supra* notes 53-58 and accompanying text.

<sup>53</sup> See 42 U.S.C. § 1396p(d)(4)(B) (West Supp. 2002); see also HUNT ET AL., *supra* note 17, at 191.

<sup>54</sup> HUNT ET AL., *supra* note 17, at 194-95.

<sup>55</sup> See *id.*

guidelines, the trust can make payments only for specified purposes, including maintenance for spouse and dependents, maintenance of a homestead, the personal needs allowance for the grantor, and medical and remedial expenses not covered by a third party.<sup>56</sup> Thus, by establishing a Miller trust, an individual decreases his or her income to qualify for Medicaid.<sup>57</sup> These few exceptions aside, all income will be paid to the nursing home. On the grantor's death, the trust must pay the state up to the amount it has extended for Medicaid benefits.<sup>58</sup>

Because the Miller trust is a recent innovation, drafting is technically difficult because the provisions are in conflict with certain basic Medicaid provisions.<sup>59</sup> The provisions are a microcosm of the Medicaid rules because the questions and confusion begin whenever one seeks to understand eligibility for an applicant who is not almost destitute. More fundamentally, it shows that the Medicaid long-term care benefit for the aged is at the outset, in the design by the state, already a study in eligibility strategies for the purpose of controlling state health and welfare spending. That is, the eligibility criteria are drafted with attention to the total cost, and individuals in need must work within that budget constraint.

States have a mixed view of asset transfers. Though many complained about the use of the types of trusts that would be cut off by federal law in OBRA 1993,<sup>60</sup> many states decline to save or recover all possible funds.<sup>61</sup> For example, Idaho and North Dakota declined to try to recover their costs from the estates of former Medicaid recipients<sup>62</sup> until compelled by federal law. Maryland, Washington and New Jersey limited the amounts they would seek

<sup>56</sup> *Id.* at 194.

<sup>57</sup> See *id.* Miller trusts can also be used to good effect by couples when one is institutionalized. *Id.* However, it is discussed here in reference to a single person because it is one of relatively few plans that have a definitive effect on an older individual's eligibility, because it was essentially withheld from many by the states, and because it is a clear need for Medicaid planning that is intended under the Medicaid rules. *Id.*

<sup>58</sup> *Id.* at 195.

<sup>59</sup> See HCFA Transmittal No. 64, amending State Medicaid Manual § 3259.7(B) (Nov. 1994) cited in JOHN REGAN, REBECCA MORGAN AND DAVID ENGLISH, TAX, ESTATE AND FINANCIAL PLANNING FOR THE ELDERLY 10-107-10-110 (2001 update).

<sup>60</sup> ALISON P. BARNES, CHRONIC CARE 1992 at 24-25, Intergovernmental Health Policy Project, George Washington University.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

to recover.<sup>63</sup> Clearly, fiscal pressures cause the states to consider more active programs to retrieve their expenditures, but many seem reluctant despite the OBRA 1993 requirement to place a lien on property as a means of collection.<sup>64</sup>

#### D. The Social and Psychological Costs of Non-Planning

To understand the widespread ambivalence toward Medicaid planning one must first understand the impact of "spend down" on aged applicants. Facing a long nursing home stay, by definition, represents a difficult time in recognition of restricted activity and choice, and an end to living at home among family. Perhaps most distressing to applicants, Medicaid medically needy eligibility calls for this radical change in the financial status of an elderly individual who has not lived a life in poverty. This author has argued that resources are more important for elders than for others because the time of earning is over and spending can compensate for physical and social losses.<sup>65</sup>

Miller trust arrangements, and annuities discussed below, are structured with the recognition that forty dollars a month does not begin to cover the needs of an institutionalized person, particularly one who is able to interact with family and can sometimes leave the nursing home with assistance.

The social and psychological cost of this impoverishment can be very great to the individual, who knows that after a lifetime of earning and activity, he or she is virtually foreclosed from activities such as buying Christmas presents, a restaurant meal, or replacement clothing. Spending on the nursing home also is a harsh shock for the aged, who may have engaged in thrifty habits typical of those who experienced the Depression and been unaware of the current costs of nursing home care. Further, many are distressed that they will leave little or nothing to their children, a goal of many who are now aged. If Medicaid planning is to continue, society must

<sup>63</sup> *Id.*

<sup>64</sup> See HUNT ET AL., *supra* note 17, at 197-200. While the state is required to seek recovery of expenditures made on behalf of Medicaid recipients, and is allowed to place a lien on property, many exceptions exist. *Id.* In most cases, a lien can not be imposed until the death of the Medicaid recipient, and recovery can not be made until after the death of the recipient's spouse. The state is also prohibited from making recovery if such action would create an undue hardship. *Id.*

<sup>65</sup> See Alison P. Barnes, *Beyond Guardianship Reform: Toward Principled Decision Making in Long Term Care*, 41 EMORY L. REV. 633, 733 (1992).

decide to what extent these needs and wishes on the part of the aged are worthy of support.

In any case, medically needy eligibility standards offer the possibility of assistance with long-term care costs.<sup>66</sup> Yet, the rules suggest that if individuals simply present their financial information and ask for a determination from the state, the result is likely to be more in favor of the state's budget than the elder's well-being.

## II. THE MEDICAID PLANNING DIVIDE

Clearly, the costs to society must also be weighed. Commentary on Medicaid planning reveals differences so polarized that they sometimes seem to be rooted in ideology untempered by reason.<sup>67</sup> On the one hand, advocates for strong individual and family independence suggest that Medicaid planning, though clearly allowed by program rules, is dishonest.<sup>68</sup> On the other hand, those who believe that long-term care should be a benefit provided by all, to those in need, sometimes endorse qualifying by any means. Neither view will be carried out in reality. It is useful to attempt to understand the payment policies we have.

### A. The Critics and Costs

A 2003 essay published in Newsweek is particularly sharp in tone, questioning why so many otherwise honest citizens take Medicaid money they don't deserve.<sup>69</sup> The author, a middle aged daughter, discusses the impact of her mother's costs of care.<sup>70</sup> She reviews her mother's reluctance to pay the current cost of assisted living, her desire to leave something for her grandchildren, and her frugal habits based in the Depression.<sup>71</sup> The author was offended that social workers and nursing home personnel quickly asked about Medicaid eligibility.<sup>72</sup> One would refer her to a lawyer for

<sup>66</sup> See FROLIK & BARNES, *supra* note 13, at 353.

<sup>67</sup> See, e.g., Diana Conway, *Cheating Uncle Sam for Mom and Dad*, NEWSWEEK, Jan. 27, 2003, at 14.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* "My 85-year-old mother looked at the column of numbers the housing manager of her new assisted living home showed her and burst into tears." *Id.*

<sup>71</sup> *Id.* "My mother always delighted in finding a penny on the street." *Id.*

<sup>72</sup> Conway, *supra* note 67, at 14 (noting that the first question asked was "is your wife Medicaid eligible?").

assistance; the author was appalled, and perceived the worker's laugh as "nervous."<sup>73</sup>

In sum, she says, "when we steal from the federal government, or the state . . . , we steal from our fellow citizens."<sup>74</sup> Her father says: "I never cheated one penny on my taxes, and I'm not going to start hiding money now."<sup>75</sup> The author looks to this as an example of ethical behavior "when most people are out to grab everything they can for themselves."<sup>76</sup>

Clearly, she and her elderly parents strongly believe that Medicaid planning is a way to avoid paying one's own way in the same way they have throughout their lives. They do not recognize long-term nursing home care as different from the expense of living in the community. They find declining to seek Medicaid eligibility laudable, while acknowledging that the rules of the program allow some transactions that have been recognized as acceptable by state and federal government.<sup>77</sup> Her mother (who "was lucky" to die quickly and avoid substantial long-term care costs)<sup>78</sup> might well disagree.

Critical commentary is renewed periodically with some remarkably judgmental stances. A student who has researched the law speaks of the "amorality of certain transactions" analogizing to the Bank Secrecy Act which calls for reporting cash transactions exceeding \$10,000 and prohibits structuring the transfer into smaller transactions to avoid the need to report.<sup>79</sup> According to the author, the analogy is appropriate, because the purpose of Medicaid is to provide "medical assistance to low income persons" and Medicaid planners should be screened out of benefits.<sup>80</sup>

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> Conway, *supra* note 67, at 14. "Lawyers . . . can show the upper middle class how to become poor on paper . . . These arrangements are all perfectly legal, but are they ethical?" *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> John M. Broderick, Note, *To Transfer or Not to Transfer: Congress Failed to Stiffen Penalties for Medicaid Estate Planning, but Should the Practice Continue?*, 6 ELDER L.J. 257, 286 (1998) (citing *Ratzlaf v. United States*, 510 U.S. 135 (1994)).

<sup>80</sup> *Id.* at 287 (citing 42 C.F.R. § 430.0 (1998)); but see Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J.L. & POL. 195, 258-66 (1996) (finding a lack of clear Congressional intent to support the position that Medicaid was only meant for the poor . . . but, noting, however, that Congress declined to increase penalties for transferring assets for Medicaid eligibility).

## B. Filial Responsibility

An undeniable source of dissonance in views of Medicaid planning is an individual's view of the appropriate relationship between parents and their grown children. Should the younger generation, by virtue of the care provided by parents, or perhaps merely because the parents provided life itself, be responsible for supporting their parents in disabled old age?

There is renewed interest in filial responsibility laws.<sup>81</sup> Provisions vary widely. However, the laws generally require adult children who have the means to provide necessary support to needy parents.<sup>82</sup> In some states, the child may counter the parent's demand for support by showing that the parent provided inadequate care to the child, or otherwise failed in the parental role.<sup>83</sup> In general, states do not enforce the obligations imposed by these statutes.<sup>84</sup> One article counted only seventeen cases in four states.<sup>85</sup>

The states most often decline to enforce their filial responsibility laws, preferring to meet the needs of the elderly in other ways, including welfare.<sup>86</sup> The reason most often cited is the possibility of elder abuse, if the arrangements include physical proximity rather than just financial support.<sup>87</sup> The question posed by long-term nursing home care costs is: Is filial responsibility more important, and more to be sought, because the costs greatly exceed the cost of living in the community? The question implies it is unfair to society to require contribution from public funds.<sup>88</sup> Or is filial responsibility less important because institutional long-term care is an extraordi-

<sup>81</sup> See, e.g., Seymour Moskowitz, *Filial Responsibility Statutes: Legal and Policy Considerations*, 9 J.L. & POL'Y 709, 714 (2001) (noting that although some states have laws that were enacted over a century ago, many more have been enacted or re-enacted recently).

<sup>82</sup> *Id.* at 713-14.

<sup>83</sup> *Id.* at 716. See also RICHARD L. KAPLAN, *Financing Long-term Care in the United States: Who Should Pay for Mom and Dad?* reprinted in *AGING: CARING FOR OUR ELDERS*, (David N. Weisstub et al., eds., 2001).

<sup>84</sup> Ann Britton, *America's Best Kept Secret: An Adult Child's Duty to Support Aged Parents*, 26 CAL. W. L. REV. 351 (1989-1990) (stating that filial responsibility statutes are rarely enforced).

<sup>85</sup> See Moskowitz, *supra* note 81, at 716 (citing Art Lee, *Singapore's Maintenance of Parents Act and U.S. Filial Responsibility Laws*, 17 LOY. L.A. INT'L & COMP. L. REV. 671, 678 (1995)).

<sup>86</sup> Britton, *supra* note 84, at 353.

<sup>87</sup> *Id.* at 369-70.

<sup>88</sup> See FROLIK & BARNES, *supra* note 13, at 392 (noting that payment due to the nursing home resident from income and assets varies, generally in accord with the financial well-being of the resident at admission to the facility).

nary cost, such that compelling a minority of adult children to pay nursing home bills is for many a great unfairness?<sup>89</sup>

### III. THE LONG-TERM CARE INSURANCE INDUSTRY

Beginning in the late 1980s, as the economy softened and the impact on state Medicaid budgets were projected, a number of voices were raised against the idea of arranging assets in order to assure or speed Medicaid eligibility. Two well-known critics were Stephen A. Moses<sup>90</sup> and Brian Burwell<sup>91</sup> each of whom was known to have support from the long-term care insurance industry. Clearly the insurance industry has an interest in preventing Medicaid planning because if Medicaid is reliable and successful the motivation to buy long-term care insurance is reduced.<sup>92</sup> Burwell's section titles give a flavor of the commentary: Beating the System: How Medicaid Estate Planning Works Around Transfer of Asset Rules; The Elderly are Not the Problem (Their Adult Children Are); Divesting Assets: Other Tricks of the Trade; Manipulating the Medicaid Spousal Impoverishment Rules. Medicaid planning is depicted as shameful, associated with being a deadbeat.

Long-term care coverage was a new product seeking consumer acceptance. Its purpose is to avoid asset depletion and the need for Medicaid eligibility by providing an alternative payer.<sup>93</sup> Long-term care costs, including premiums for insurance that meets federal requirements for coverage, are treated as medical expenses for tax purposes.<sup>94</sup> Nevertheless, a number of difficulties with the coverage and cost have limited sales of long-term care insurance. First, pre-

<sup>89</sup> *Id.* at 392-94 (noting that nursing homes do require some adult children and other relatives to pay for their elders' nursing home care, in spite of federal law, by seeking a guarantee at admission that a third-party will be responsible for payment, or that families will pay at the private pay rate for a period of time before the resident applies for Medicaid coverage). See *SWA, Inc. v. Straka* (Ohio Ct. App., No. 82103, June 19, 2003).

<sup>90</sup> See, e.g., *The Fallacy of Impoverishment*, *THE GERONTOLOGIST*, Vol. 30, No. 1 (1990) at 21.

<sup>91</sup> See, e.g., *MIDDLE CLASS WELFARE: MEDICAID ESTATE PLANNING FOR LONG-TERM CARE COVERAGE*, (Sept. 1991) (describing a study conducted for the Health Insurance Association of America).

<sup>92</sup> See Alison P. Barnes, *The Policy and Politics of Community-Based Long-term Care*, 19 *NOVA L. REV.* 487, 524-26 (1995) (explaining an assessment of the viability of long-term care insurance).

<sup>93</sup> See Robert D. Hayes et al., *What Attorneys Should Know About Long-Term Care Insurance*, 7 *ELDER L. J.* 1, 4 (1999).

<sup>94</sup> Joshua M. Wiener et al., *Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance*, 8 *ELDER L. J.* 57, 63-67 (2000).

miums are high because actuarial projections for so few policies must be conservative, and nearly all long-term care policies are sold on an individual rather than a group basis.<sup>95</sup> Recent efforts are under way to improve the product<sup>96</sup> and cultivate group sales.<sup>97</sup> Nevertheless, long-term care insurance pays for less than one percent of nursing home care.<sup>98</sup> Clearly, the availability of Medicaid benefits is at odds with the sales of long-term care policies.<sup>99</sup> Thus, assertions of disapproval for Medicaid planning must be examined for influence by the financial interests of the industry.

### IV. THE NURSING HOME INDUSTRY: FINANCIAL INTERESTS AND QUALITY

The most straightforward interest in the Medicaid long-term care mix is the nursing home industry's interest in receiving adequate payments to support an appropriate standard of care. The mix is threatened as states cut or fail to raise Medicaid rates to meet staffing and operating costs, resulting in nursing homes raising private pay rates to maintain their financial viability. In some states, Medicaid payments have fallen far below the cost of private pay.<sup>100</sup>

Between 1990 and 1997, the portion of nursing home payments made by Medicaid rose from fifty-six to sixty-one percent.<sup>101</sup> This does not, however, reflect growth in the institutionalized poor elderly because the number declined in that time frame; the overall

<sup>95</sup> *Id.* at 71-101 (comparing the prices of premiums sold to forty and seventy-nine year-olds).

<sup>96</sup> *Id.* at 93-94.

<sup>97</sup> See JASON G. GOETZE, *LONG TERM CARE* 150 (3rd ed. 1999) (noting that over 1500 employers offer group coverage).

<sup>98</sup> KAPLAN, *supra* note 83, at 73.

<sup>99</sup> See Barnes, *supra* note 92, at 526-27 (noting that federal government and long-term care insurers devised a plan to link insurance coverage and Medicaid benefits, called the public-private partnership, which would assure Medicaid eligibility for an individual who purchased a policy meeting government coverage requirements). See also Weiner et al., *supra* note 94, at 83-100 (noting that the states declined to participate for several years due to the fear the costs would be excessive, and only recently have revived their projects).

<sup>100</sup> See, e.g., Peter Neurath, *Doctors Shun Medicaid Patients: Plan for Poor Pays Poorly, They Say*, *PUGET SOUND BUS.J.* (Apr. 6, 2001), available at <http://seattle.bizjournals.com/seattle/stories/2001/04/09/story1.html> (last visited Apr. 25, 2003).

<sup>101</sup> CITIZENS FOR LONG-TERM CARE, *DEFINING COMMON GROUND: LONG-TERM CARE FINANCING REFORM IN 2001*, 18 (2001). Citizens for Long-term Care is a nonprofit coalition of long-term care providers, including consumer and patient advocates, insurers, workers and advocates for people with disabilities, chaired by former Senator David Durenberger of Minnesota. *Id.*

population increase is due to survival of disabled younger people.<sup>102</sup> Nevertheless, the prospect of the numbers of the aging baby boomers in the next twenty years causes concern about an absolute increase in the numbers of nursing home residents.<sup>103</sup> Projections twenty and forty years into the future lack critical information. In the shorter term, however, the adequacy of Medicaid nursing homes rates is a sensitive matter, particularly in light of constrained state budgets.

Most important is the effect of funding and financial structure on nursing home care, combined with quality care regulation.<sup>104</sup> There is ample evidence that Medicaid payments fail to provide the necessary income for good care.<sup>105</sup> A February 2002 report by the Department of Health and Human Services indicates that it is not feasible to require nursing homes to meet minimum staffing ratios.<sup>106</sup> The report, which reviews data first considered by the government in the 1980s, states that a nursing home resident requires 4.1 hours of care in order to fulfill tasks such as turning, changing linens, assistance with bathing and toileting.<sup>107</sup> This calls for one nurse aide for every five or six residents. Over ninety percent of nursing homes had staffing ratios too low to provide that intensity of services.<sup>108</sup> Further, more than forty percent would have to increase staffing by at least fifty percent in order to provide minimally necessary care.<sup>109</sup>

The impact of regulation on the quality of care is complex, in that – at the least – it takes workers away from direct care and re-

<sup>102</sup> *Id.* at 19.

<sup>103</sup> *Id.* at 19-20. The threatening prospect of more than doubling the need for long-term care expenditures for the elderly between 2000 and 2040, must of course be treated with care in light of changes of the fitness of the aged population and the effectiveness of medical treatment to maintain capability among the old. *Id.*

<sup>104</sup> See generally Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, ELDER L.J. 267 (1999) (examining the effect of OBRA 1987 on compliance in nursing homes over its first decade).

<sup>105</sup> *Id.* at 280.

<sup>106</sup> CENTER FOR MEDICARE AND MEDICAID SERVICES, APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES, reported in Robert Pear, 9 in 10 Nursing Homes Lack Adequate Staff, *Study Finds*, N.Y. TIMES, Feb. 18, 2002, at A1. See also UNTIE THE ELDERLY: QUALITY CARE WITHOUT RESTRAINTS, CONG. HEARING REPORT, Serial No. 101-H 1990.

<sup>107</sup> Pear, *supra* note 106, at A1.

<sup>108</sup> See *id.*

<sup>109</sup> *Id.*

quires time for recordkeeping.<sup>110</sup> Nursing homes with the greatest need for residents are most likely to accept marginally appropriate patients such as mentally ill, or developmentally disabled patients with violent or aggressive behavior, and Medicaid eligible residents.<sup>111</sup> According to Marshall Kapp's interviewees, "the most dependent and most vulnerable individuals sometimes are placed as a last resort in nursing facilities of dubious quality."<sup>112</sup> Such facilities require only that a source of payment has been identified, with Medicaid being the least desirable source. Kapp terms these the "hungriest" facilities, those which initiate Medicaid applications themselves.<sup>113</sup>

The quality of nursing home care is a source of recurring concern throughout society, and a solution has yet to be found. A significant correlation exists between under funded and understaffed facilities and neglect of residents. Anyone with significant assets is truly misguided in attempting to divest assets to go directly to Medicaid eligibility.

The most useful scenario, which may for some applicants bridge the gap between entering a nursing home as a Medicaid beneficiary and paying the full costs, is to assure payment for a certain period of time that, statistically, satisfies the facility's need for a proportion of private pay patients.<sup>114</sup> Payment for a period of time, typically one to three years, may depend on the nature of Medicaid planning, or may rely on the promise of another, typically an adult child, to assure the funds will be paid. Several states have adopted programs that assure elderly people who buy qualified long-term care insurance policies with specific time limited benefits will be eligible for Medicaid without loss of assets if their stay exceeds the term of coverage.<sup>115</sup>

<sup>110</sup> See Marshall B. Kapp, *Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got to Do with It?* 31 McGEORGE L. REV. 707, 719-720 (2000) (noting that workers with the most experience are often preoccupied with administrative work).

<sup>111</sup> See MARSHALL B. KAPP, THE "VOLUNTARY" STATUS OF NURSING FACILITY ADMISSIONS: LEGAL, PRACTICE, AND PUBLIC POLICY IMPLICATIONS 6, Scripps Gerontology Ctr. (1997).

<sup>112</sup> *Id.* at 7-8.

<sup>113</sup> *Id.*

<sup>114</sup> See FROLIK & BARNES, *supra* note 13, at 393-94. When demanded in a nursing home admission contract, contrary to federal law, such requirements are termed "duration of stay" clauses.

<sup>115</sup> See Barnes, *supra* note 92, at 526-27.

## V. INDIVIDUAL AND GOVERNMENT INTERACTION

The confusion of values regarding Medicaid long-term care eligibility runs very deep, and it seems to turn on the question of whether long-term nursing home care for the aged really is a program for the poor, despite its administration by a single agency in every state.<sup>116</sup> The values of administrators reflect not only state budget shortfalls (surely there is more discussion of restrictive standards when funds are inadequate) but also the different structure and nature of social insurance as opposed to poverty eligibility processes and programs.

This author suggests a significant difference between welfare programs and government agencies dealing with the non-poor, such as state and national tax agencies, is in the exchange of information. In a program for use by the homeowner/worker/citizens of the community, applicants read the rules, present and verify their information in accord with their best presentation of assets. For example, a would-be homeowner who seeks a subsidy for a government insured mortgage presents the best aggregation of the information, knowing that the mortgagor will ask good questions and treat the application positively if there is reason to expect the mortgagee will pay faithfully.

Analogies to other interactions with government are apt. Planning to avoid excess tax is, for example, a recognized and honest choice for a prudent citizen. This does not imply that there are no tax scams, and we expect the expertise of the Internal Revenue Service (I.R.S.) to identify them to avoid higher taxes for the rest of us. The expertise of the I.R.S. extends to the tax code and regulations and their many creative uses.

The Medicaid agency, in contrast, spends most of its efforts in a different type of interaction with the poor. In typical welfare benefits case work, the applicant's economic information is fairly simple. Possibly, the agency must collect more details about other people in the household, or others who should or do contribute to the support of an applicant family. However, the income and assets are likely to be relatively simple; the calculation of how much the benefit will be and when the applicant must apply for recertification are more likely to be important issues. Thus, being confronted with applicants who have not been living from hand to mouth is potentially shocking.

<sup>116</sup> By federal rule, one agency must be designated in every state to administer Medicaid funds and services. 42 U.S.C. § 1396a(a)(5) (West Supp. 2002).

The United States Congress fully intends that Medicaid long-term care benefits exist, and the states are encouraged by the Medicaid funding formula to draw down funds that at least match the state funds expended for this purpose.<sup>117</sup> The nature of the criticism leveled at Medicaid planning and Medicaid planners (both applicants and their lawyers) seems to have a subtext of misunderstanding about the amount of money typically sheltered,<sup>118</sup> the use of money in the alternative to paying the nursing home,<sup>119</sup> and the impact on care that is likely to attend one's choice of facility and the staffing levels and amenities in a facility that has a substantial proportion of Medicaid residents.

## VI. THE EVOLUTION OF MEDICAID PLANNING

The development of Medicaid long-term care assistance may be viewed either as a promise abandoned by government or as a strategic retreat by government from exposure to institutional long-term care costs. Prior to 1980, individuals were free to transfer away assets in order to meet Medicaid eligibility requirements.<sup>120</sup> The federal courts enforced applicants' ability to divest themselves of their property by prohibiting the states from denying eligibility on account of transfers for less than fair market value.<sup>121</sup>

### A. Asset Transfers

The states complained to Congress, which included an amendment to the Parental Kidnapping Prevention Act of 1980 that prohibited such transfers for the purpose of qualifying for Medicaid benefits.<sup>122</sup> Under this provision, an applicant could offer evidence

<sup>117</sup> 42 U.S.C. § 1396d(b) (West Supp. 2002) (requiring that federal assistance will equal ten percent minus whatever percentage the State pays).

<sup>118</sup> See Barnes, *supra* note 92, at 498-500 (in 1988 the median assets in an elderly household totaled over \$70,000, higher than any age group except age 55-64. However, only approximately ten percent of people age 85 and older have assets over \$100,000.).

<sup>119</sup> See *infra* notes 122-133 and accompanying text (spending assets prior to Medicaid eligibility).

<sup>120</sup> Shawn Patrick Regan, *Medicaid Estate Planning: Congress' Ersatz Solution for Long-Term Health Care*, 44 CATH. U. L. REV. 1217, 1227 (1995).

<sup>121</sup> See Broderick, *supra* note 79, at 264 (citing *Blum v. Caldwell*, 446 U.S. 1311 (1980); *Fabula v. Buck*, 598 F.2d 869 (2d Cir. 1979); *Dokos v. Miller*, 517 F. Supp. 1039 (N.D. Ill. 1981); *Robinson v. Pratt*, 497 F. Supp. 830 (D. Mass. 1980); *Udina v. Walsh*, 440 F. Supp. 1151 (D. Mo. 1977); *Buckner v. Maher*, 424 F. Supp. 366 (D. Conn. 1976)).

<sup>122</sup> See Regan, *supra* note 120, at 1227 (citing Social Security Amendments of 1980, Pub.L. No. 96-611, § 6-10, 94 Stat. 3568-73; 42 U.S.C. § 1396a(j)(1)).

that the transfer was for a reason other than meeting Medicaid standards, and might be found eligible.<sup>123</sup> The standard remains in effect today. Transfers of exempt assets, including the home and personal property, are still freely permitted.

In 1982, the Tax Equity and Fiscal Responsibility Act (commonly called TEFRA) imposed further conditions on eligibility for elders.<sup>124</sup> States could place liens on exempt property, such as a home or a temporarily unavailable asset, in order to recover for their Medicaid expenditures.<sup>125</sup> An elderly person's home could no longer be transferred to another and its value, therefore, was likely to be subject to state recovery claims.<sup>126</sup>

Perhaps most important to Medicaid planning, a period of ineligibility was imposed for transfers for less than fair market value.<sup>127</sup> The resources lost to an elderly applicant through any transfer of property for less than fair market value were taken into account in calculating the period of ineligibility for state support.<sup>128</sup> The formula calls for the state to set an average monthly rate for nursing home care, for example, \$4000.<sup>129</sup> The shortfall from fair market value (say, a gift of \$24,000 to a child, which has a value of \$24,000) would be divided by the average cost of care to calculate the term of ineligibility for the giver.<sup>130</sup> That is to say, the state could deny payment to the nursing home for the period of time that the "lost" assets would have paid the bill, in this case six months.<sup>131</sup>

States could "look back" in an applicant's financial records initially for a period of twenty-four months. That period of "look back" for such transfers has been increased twice, first to thirty months and subsequently to thirty-six months.<sup>132</sup> If an elderly indi-

<sup>123</sup> *Id.* at 1237.

<sup>124</sup> *Id.* at 1229 (citing Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 132(d), 96 Stat. 324, 373 (1982) (codified as amended at 42 U.S.C. § 1396p (1994)).

<sup>125</sup> *Id.* at 1228.

<sup>126</sup> See *id.* at 1238 (citing 42 U.S.C. § 1396p(c)).

<sup>127</sup> *Id.* at 1228.

<sup>128</sup> See *id.* (citing 42 U.S.C. § 1396p(c)(2)(B)(i) (1983)).

<sup>129</sup> See 42 U.S.C. § 1396p (West Supp. 2002).

<sup>130</sup> 42 U.S.C. § 1396p(c).

<sup>131</sup> *Id.*

<sup>132</sup> § 1396p(c)(1)(B)(i).

vidual applies for Medicaid within the "look back" period and a transfer is discovered, a period of ineligibility is imposed.<sup>133</sup>

## B. "Medicaid Qualifying" Trusts

Until 1985, an elderly applicant for Medicaid could transfer his or her assets to a trust without effect on his or her eligibility.<sup>134</sup> Applicants, as grantors, could create so-called "Medicaid Qualifying Trusts," transferring legal title to a trustee.<sup>135</sup> The trust might be revocable and the applicant might be the beneficiary.<sup>136</sup> Nevertheless, trust creation had no effect on eligibility.<sup>137</sup>

In the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85), however, Congress curtailed the use of trusts in Medicaid planning<sup>138</sup> by stating that an inter vivos trust established with the applicant's funds that enables the applicant/grantor to retain discretion over the use of the assets, effectively leaves those trust assets available to pay nursing home bills.<sup>139</sup> Thus, if the trust is revocable or the grantor can change the use of the funds without revocation, the link of ownership has not been broken for the purposes of Medicaid eligibility.

The law on Medicaid trust issues was modified again in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93),<sup>140</sup> due to some confusion about the implications for eligibility of COBRA '85 trust creation. Distinctions were created between trusts depending on the scope of the discretion the grantor retains.<sup>141</sup> All revocable trust assets are treated as though their assets are available to the

<sup>133</sup> *Id.* The period of ineligibility begins on the first day of the first month after the transfer is made. *Id.*

<sup>134</sup> Broderick, *supra* note 79, at 265 (citing Pub. L. No. 99-272, 100 Stat. 82 (1986); § 9506(a), 100 Stat. at 210 (codified as amended at 42 U.S.C. § 1396a(k) (1994)).

<sup>135</sup> See William H. Overman, *Treatment of Trusts Under OBRA '93 and FICA '99* (2001), available at [http://www.specialneedtrustees.com/Trusts\\_Under\\_OBRA\\_93\\_and\\_FICA\\_99.PDF](http://www.specialneedtrustees.com/Trusts_Under_OBRA_93_and_FICA_99.PDF); see also, Paul Premack, *Medicaid Planning to Maintain Exempt Assets* (2003), available at <http://www.premack.com/barsem.htm>.

<sup>136</sup> See Overman, *supra* note 135, at 2.

<sup>137</sup> See *id.*

<sup>138</sup> See Broderick, *supra* note 79, at 265.

<sup>139</sup> *Id.* (citing 42 U.S.C. § 1396a(k) (1994)).

<sup>140</sup> See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1994) (relevant provisions codified as amended at 42 U.S.C. § 1396p(d) (1994)).

<sup>141</sup> See 42 U.S.C. §§ 1396p(d)(3)(A)—(B) (West Supp. 2002) (differentiating between revocable and irrevocable trusts).

grantor, regardless of the identity of the beneficiary.<sup>142</sup> An irrevocable trust with the grantor as beneficiary also is treated as a non-transfer for an indefinite period of ineligibility.<sup>143</sup>

The only type of trust that can be established with an applicant's assets after OBRA '93 without creating an indefinite period of ineligibility, is an irrevocable trust from which the applicant cannot benefit.<sup>144</sup> Such a trust is subject to a sixty-month "look back" term.<sup>145</sup> Under the rule on "look back" for trusts, if the trust was created more than five years before the Medicaid application, the state must disregard the transaction.<sup>146</sup> If not, the assets of the trusts are subject to the calculation of average monthly cost of nursing home care to create a term of ineligibility.<sup>147</sup> There is no limit on the period of ineligibility.<sup>148</sup>

### C. Half-a-Loaf and Other Divestments by Formula

Variations on "half-a-loaf" or the "rule of halves" is perhaps the most common plan for protecting assets while speeding Medicaid eligibility. The concept is quite obvious for one planning to speed Medicaid eligibility. A simplified formula (omitting calculations of profits on assets and other changes over time) is that an elderly person in need of nursing home care can give away at least half of his or her assets, incurring a period of ineligibility, and spend the remaining assets on nursing home care.<sup>149</sup> Thus, if Mrs. Smith has \$120,000 in non-exempt assets, she gives away roughly \$60,000 and retains roughly \$60,000 (plus, of course, the \$2000 in assets she retains after Medicaid eligibility). The transfer for \$0 instead of actual value of \$120,000 is subject to the calculation to identify the applicable period of ineligibility. If the average cost of nursing home care in her state is \$4000, Mrs. Smith may be subject to a period of ineligibility of only fifteen months, rather than the thirty months she would have incurred for giving away \$120,000 or might have been required to use for nursing home care because it is char-

<sup>142</sup> See 42 U.S.C. § 1396p(d)(3)(A)(i) (noting that assets will be considered available to the individual).

<sup>143</sup> § 1396p(d)(3)(B) (2002).

<sup>144</sup> 42 U.S.C. 1396p(d)(3)(A)-(B).

<sup>145</sup> 42 U.S.C. § 1396p(c)(1)(B)(i).

<sup>146</sup> *Id.*

<sup>147</sup> § 1396p(c)(1)(E)(i).

<sup>148</sup> See *id.* Former limits on period of ineligibility were 24 and 30 months. *Id.*

<sup>149</sup> FROLIK & BARNES, *supra* note 13, at 362.

acterized as an exempt asset upon review by the state agency.<sup>150</sup> Therefore, Mrs. Smith has resources to pay for her care at the average rate for the period of ineligibility, after which the state will begin to pay.<sup>151</sup>

As with trusts, "half" formulas have been curtailed at the behest of the states.<sup>152</sup> One plan objectionable to the states was the so-called "stacked half-a-loaf" that could be used when periods of ineligibility run concurrently.<sup>153</sup> If Mrs. Smith undertook this plan, she would protect more funds and would be eligible for Medicaid sooner. Simplifying the calculation to avoid obscuring the principle to be illustrated, Mrs. Smith might give away \$24,000 of her \$120,000, only six months before she becomes a Medicaid applicant. She incurs a six month period of ineligibility, and begins to spend her funds for care. The next month, she gives away \$20,000, incurring a five month period of ineligibility. The process is repeated to create concurrent periods of ineligibility that result in Medicaid eligibility after six months, rather thirty months, or fifteen months. Mrs. Smith could give away around \$85,000, spend only about \$24,000 on nursing home care, and have a few thousand to spend for to meet other needs before eligibility.

Recognizing so-called "stacked half-a-loaf" as a strategy unacceptably burdensome to the states, HCFA (now CMS) declared that periods of ineligibility are consecutive rather than concurrent.<sup>154</sup> Thus, since she incurred a penalty period that continued at the time of her next transfer, Mrs. Smith would again have her original half-a-loaf period of ineligibility of fifteen months, rather than eight.<sup>155</sup>

Perhaps the simplest version of "loaf" formulas could be called "no loaf at all." "No loaf" takes into account the federal rule that rounds down a transfer of assets that exceeds the cost of months of care.<sup>156</sup> Thus, an applicant can give away an amount each month that is just short of the state-determined cost of care. In rounding down, the state counts the transfer as zero.

<sup>150</sup> *Id.* (noting that certain types of transfers cause the period of ineligibility).

<sup>151</sup> *Id.* (noting that an added benefit of this strategy is that nursing homes are more likely to accept residents who are able to pay for their care).

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> FROLIK & BARNES, *supra* note 13, at 362.

<sup>155</sup> *Id.* at 368. See also Natalie J. Kaplan, *Maximum Medicaid Transfers: A 21st Century "Half-A-Loaf Recipe" from Classic Elder Law Cuisine*, NAELA NEWS, Vol. 14, No. 5 at 1 (Sept. 2002) (discussing the calculation of Medicaid eligibility using "half-a-loaf").

<sup>156</sup> 42 U.S.C. § 1382b(a) (West Supp. 2002).

#### D. Transfers in Exempt Assets

Exempt assets include a short list of items originally found in the oldest Medicaid provisions that contemplated poor non-elderly adults.<sup>157</sup> They involve devoting money to "exempt" assets, those disregarded in the eligibility calculation.<sup>158</sup>

Two distinct types of these traditional exempt asset transfers are available to elderly individuals contemplating eligibility for nursing home care. First, any prospective applicant can spend his or her money in order to acquire or improve an exempt asset. For older people, the most likely use of savings is repairing and improving an old house and lot that have deteriorated because of age and lack of rigorous maintenance. The typical causes of deterioration are that the individual has reached an age when he or she can no longer do the work and is unfamiliar with paying another to do it. In addition, retirees almost universally have or at least perceive that they have fewer resources, so it is easy to simply live with the deterioration that is familiar to the owner/occupant of a dwelling. The possibilities of fixing the roof or the driveway, the sewer or septic, or the power and telephone resources are varied and ultimately contribute to the value of the asset.

Other exempt assets may also bear investment. For example, a 92-year-old woman's 1962 Ford Falcon with 38,000 miles on it in 1998 might be replaced by a reliable new vehicle. Though the owner is in a nursing home and no longer drives, the car she owns can be used and justified by the adult child who, by means of this purchase, has reliable transportation that is actually used to take the parent on drives, to family holiday celebrations, or medical appointments.

OBRA '93 includes specific provisions authorizing transfer of the elder nursing home resident's house.<sup>159</sup> First, the elderly person can transfer the house to an adult "caretaker child" provided the child lived and presumably cared for the parent in the house for two years prior to the move to the nursing home.<sup>160</sup> Further, the elderly person is authorized to transfer the house to a spouse for his or her

<sup>157</sup> See *id.* (listing burial space, Social Security, and other types of statutory "assistance," among other things).

<sup>158</sup> See *id.*

<sup>159</sup> § 1396p(c)(2)(A).

<sup>160</sup> See § 1396p(c)(2)(A)(iv).

sole benefit,<sup>161</sup> to a disabled child, or a trust for that disabled child.<sup>162</sup>

The elder is also free to transfer the total value of the house to a sibling who has an equity interest in the house, provided the sibling has lived in the house in the year prior to the elder's move to a nursing home.<sup>163</sup>

Medicaid planning for individuals relies upon quite simple measures to protect assets of limited value. Such measures are allowed for younger disabled people, in that their family members can place assets in trust to provide more than the necessities of food, shelter, and care under Medicaid.<sup>164</sup> To restrict an elder to only \$40 a month seems, in context, a form of ageism.

#### VII. MEDICAID AND THE MIDDLE CLASS: "SPOUSAL IMPOVERISHMENT" IN THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Quite possibly, the very nature of the Medicaid poverty program underwent a significant change with the enactment of the so-called Spousal Impoverishment provisions of 1988.<sup>165</sup> Notably, other portions of the same legislation dealt with the expansion of Medicare into nursing home care and pharmacy benefits, billed as the first long-term care provisions of that program.<sup>166</sup> The Medicare portions of the bill were repealed because they pleased few and angered some relatively affluent, conservative seniors.<sup>167</sup> The Medi-

<sup>161</sup> See § 1396p(c)(2)(B)(i); see also *infra* notes 227-229 and accompanying text (on rules of transfer in the context of "spousal impoverishment").

<sup>162</sup> 42 U.S.C. § 1396p(c)(2)(A)(ii) (West Supp. 2002).

<sup>163</sup> § 1396p(c)(2)(A)(iii) (noting that OBRA 1993 further requires states to implement plans to reclaim expended benefits after the death of Medicaid recipient in the amount of Medicaid benefits (to be determined at death), provided the state determines the individual is unable to return home). See *W.Va. Loses Appeal in Fight Against Estate Recovery Provision*, THE ELDERLAW REPORT, Vol. 14, No. 1 (July/Aug. 2002) at 6.

<sup>164</sup> 42 U.S.C. § 1396p(d)(4) (West Supp. 2002).

<sup>165</sup> § 1396r(5).

<sup>166</sup> See P.L. 100-360, Medicare Catastrophic Coverage Act Of 1988 (MCCA).

<sup>167</sup> See MCCA § 303(a) amending Title XIX of the Social Security Act by adding new § 1924(c) and (d), codified at 42 U.S.C. § 1396r-5. The MCCA was enacted in order to please elder voters with long-term care assistance, but suffered from the meager benefit that could be justified and the nature of the premiums needed to finance any benefit at all. *Id.* More affluent seniors for the first time paid more for a Medicare benefit than poorer beneficiaries. *Id.* The so-called surcharge for MCCA Medicare benefits actually was collected for one year on income tax returns. *Id.* Certain constituents particularly objected to making such a payment to support other Medicare beneficiaries, who include long-term disabled

caid provisions remain and apply to all persons institutionalized after September 30, 1989.<sup>168</sup>

Prior to the passage of the Medicare Catastrophic Coverage Act of 1988 (MCCA), couples contemplating the need of one spouse to go to a nursing home faced a true Hobson's choice.<sup>169</sup> The healthier spouse could continue to provide care at home, however, the care might fail to meet the needs of the impaired spouse and could lead to breakdown in the physical and mental health of the care giving spouse. Alternatively, the couple who sought nursing home care had to devote income and resources to pay nursing home bills.

After the MCCA, the treatment of spouses' income and assets are as follows:

A determination of actual or potential eligibility is made at the time one spouse begins a continuous period of institutionalization, defined as more than thirty days.<sup>170</sup> The assessment is called a "snapshot" and is important because the couple's total resources will decrease by paying for the imminent nursing home care.<sup>171</sup> The division of assets is made according to the state's marital property laws.<sup>172</sup> The "snapshot" can be made by reconstructing the financial situation that existed at the beginning of the elderly person's institutionalization.<sup>173</sup>

After the institutionalized spouse becomes eligible, income is subject to the "name on the instrument (or check)" rule.<sup>174</sup> Unlike

adults. *Id.* Somewhat irrationally in 1988-89, this group of constituents identified their payment as providing care to persons with AIDS, which they deemed objectionable. This author was a senior policy analyst for the U.S. Senate Special Committee on Aging in the months before and after the repeal of these provisions, and so reports the discussion of that time.

<sup>168</sup> 42 U.S.C. § 1396r(5)(c).

<sup>169</sup> Choice without an alternative (e.g. any color, so long as it is black).

<sup>170</sup> See 42 U.S.C. § 1396r(5)(h)(1)(B) (West Supp. 2002).

<sup>171</sup> See *Wis. Dept. of Health and Fam. Serv. v. Blumer*, 534 U.S. 473 (2002). The *Blumer* case, discussed below, concerns this pre-eligibility hearing, as which federal law states that in the division of the assets, if the community spouse lacks state designated income amounts, assets will be transferred sufficient to earn the additional income. "Income-first" states anticipate the point of eligibility, when the institutionalized spouse's income, if any, can be "reverse-deemed" to the community spouse. Reverse deeming is unnecessary while the couple has assets that can be consumed. By the time of eligibility, the institutionalized spouse by definition lacks assets that could be transferred to make up the income deficit. The only remaining option (absent a refund of private pay by the nursing home, and acceptance of the state Medicaid rate) is to transfer income.

<sup>172</sup> 42 U.S.C. § 1396r(5)(c)(1)(B) (West Supp. 2002).

<sup>173</sup> *Id.*

<sup>174</sup> § 1396r(5)(b)(2)(A)(i).

the treatment of income for spouses living in the community, the income of the healthier "community" spouse is not "deemed" to be available to the spouse in the nursing home.<sup>175</sup> The community spouse keeps all of her<sup>176</sup> income once the nursing home stay begins. The rules provide that that income must meet a certain minimum, however, called the "minimum monthly maintenance needs allowance" (MMMNA).<sup>177</sup> The amount is chosen by each state within parameters set by federal guidelines.<sup>178</sup> If the community spouse's income falls short, the institutionalized spouse's income is "reverse deemed" to be available to her.<sup>179</sup> That income amount to be protected by the states according to the state plan, redetermined annually, is at least \$1493 in 2003,<sup>180</sup> but in no instance can exceed \$2267.<sup>181</sup> Some state calculations allow for a range of results depending on the total income of the couple, while others work with a single figure that will be protected for the community spouse provided the combined income of both spouses will produce it.<sup>182</sup>

The couple's assets also are divided between them, in principle with half to be spent by the nursing home spouse for care, and half to be allocated to the spouse at home. As with income, however, the federal law sets annual amounts that the states must or may protect for the community spouse.<sup>183</sup> The amount of assets to be protected by the states in 2003 (termed the community spouse resource allowance or CSRA) must be at least \$18,132.<sup>184</sup> States may protect up to

<sup>175</sup> See *id.*

<sup>176</sup> See *Blumer*, 534 U.S. 473. Statistically, it is more likely that the community spouse is female because of the prevalence of marriages between older men and younger women, and the likelihood that the wife and others will expect her to care for the husband as long as is reasonably possible. *Id.* The *Blumer* case clearly shows that the generality is no more than just that. *Id.* This is not to imply that husbands are not excellent and willing caregivers for seriously disabled wives, in this author's experience. *Id.*

<sup>177</sup> 42 U.S.C. § 1396r(5)(d)(3) (West Supp. 2003).

<sup>178</sup> § 1396r(5)(d)(3)(A).

<sup>179</sup> § 1396r(5)(d)(2).

<sup>180</sup> 42 U.S.C. 1396r(5)(d)(3). Sometimes new figures issue late, for example the minimum community spouse MMMNA for 2002 was announced and declared effective on July 1, 2002. *Id.*

<sup>181</sup> See 42 U.S.C. §§ 1396r(5)(d)(4), 1396r(5)(e). In a fair hearing, the community spouse who finds the MMMNA insufficient can present evidence of housing costs to obtain an order to protect an additional sum of income called the Excess Shelter Allowance (ESA) which, if granted, usually amounts to \$450. *Id.*

<sup>182</sup> FROLIK & BARNES, *supra* note 13, at 362-65.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.*

\$90,660.<sup>185</sup> As with other Medicaid eligibility calculations, \$2000 is protected for the nursing home spouse.

With the use of the MCCA rules, the United States Congress clearly took the Medicaid program beyond the borders of welfare. Though only \$2000 is protected for the institutionalized spouse, the resources of the community spouse (over \$90,000) are available to support them both. With a hearing to show additional costs in the community still more can be sheltered. With widely recognized planning still more, provided the couple has these assets at the time one of them enters the nursing home.

### VIII. ANNUITIES: A CASE STUDY IN DISCOVERY AND DISAPPROVAL BY THE STATES

The treatment of annuities in Medicaid planning illustrates the process of extending eligibility, perceiving abuse or excessive spending, and limiting the acceptance of a planning tool. Some states have disregarded the use of certain annuities, despite the fact that rules regarding "available resources" seem to require that annuities be cashed in so the principal becomes immediately available to pay for nursing home care.<sup>186</sup> This is true regardless of the fact that the annuity may be recently purchased in what might easily be inferred as an attempt to protect assets from immediate and direct diminishment to meet the cost of nursing home care.<sup>187</sup> Discussion and sale of annuities has increased since the implementation of the OBRA '93 prohibition on trusts, which could have been structured to accomplish similar purposes: To slow the expenditure of the resident's funds by securing the Medicaid rate of payment, and making less available to meet that payment.<sup>188</sup>

An annuity is established by a contract in which the buyer pays a sum of money in exchange for a promise that payments will be made to the buyer on an agreed upon schedule and rate.<sup>189</sup> The purchase of an annuity from a public seller or by agreement with any person including a family member, makes the savings unavaila-

<sup>185</sup> *Id.* at 369 (noting that nine states protect the maximum amount, from which it is politically difficult to retreat).

<sup>186</sup> See 42 U.S.C. § 1832b(c) (West Supp. 2002).

<sup>187</sup> *Id.*

<sup>188</sup> See *supra* notes 160-161 and accompanying text (on restriction of use of trusts).

<sup>189</sup> See BLACK'S LAW DICTIONARY 88 (7th ed. 1999).

ble, and converts those savings into a stream of income.<sup>190</sup> The income may be paid either to the buyer or to others.<sup>191</sup> In general, annuities may be established upon any terms agreeable to the buyer and seller. At the agreed conclusion of the contract, which might be an uncertain date such as the death of the buyer, a remainder of unpaid principal may be paid to anyone designated by the buyer.

For the purposes of being disregarded for Medicaid eligibility, the annuity must be irrevocable, unassignable, and have no cash surrender value.<sup>192</sup> The term of the payout must begin immediately, be limited to the life expectancy of the buyer, and provide a federally designated "reasonable rate of return."<sup>193</sup> The rate of return must be sufficient to justify the conversion of this asset into a stream of income, and thus is prohibited from being too low.<sup>194</sup> For example, a recent rate of return was 6.42% for a three to nine year annuity and 6.9% for a period over nine years. Bob, age 91, has a life expectancy of 83 months, or 6.91 years. If he purchases an annuity for \$80,000 of his entire savings (\$78,000 of investment after his deduction for allowed assets under Medicaid), he can receive \$1166.27 per month for 83 months. This income is used to offset the cost of care for the state for that time period, after which any remaining assets must be spent for care.<sup>195</sup>

The alternative for Bob to become eligible for Medicaid is to pay for his nursing home care for nineteen months (at \$4000 a month). The advantage of the annuity is that Bob spends his savings at a greatly reduced rate because the assets used to establish the annuity are considered unavailable to pay for nursing home bills. Only the income produced from the annuity is devoted to nursing care expenses each month.

If Bob has a spouse, he may avoid paying any personal funds to the nursing home. In many states, a couple may "convert countable" resources into an income stream for the community spouse only.<sup>196</sup> The income becomes part of the community spouse's

<sup>190</sup> *Id.*

<sup>191</sup> *Id.*

<sup>192</sup> See Thomas D. Begley, Jr., & Jo-Anne Herina Jeffreys, *The Use of Annuities in Medicaid Planning: An Update*, XII THE ELDERLAW REPORT, No. 1 at 2 (2000).

<sup>193</sup> *Id.* at 3 (citing HCFA Transmittal No. 64).

<sup>194</sup> *Id.*

<sup>195</sup> See Dale Krause, *Medicaid - The Basics: A Wisconsin Approach*, prepared by Krause Financial Services (year 2000 materials on Medicaid planning and the use of annuities) (on file with the author).

<sup>196</sup> FROLIK & BARNES, *supra* note 13, at 372.

MMMNA, and therefore the nursing home spouse may spend more income on the bills for care. However, the purchase of annuity can in some instances completely shelter the assets.<sup>197</sup> Because Bob is Medicaid eligible, Bob's nursing home is paid at the Medicaid rate, which by law never exceeds the private pay rate and is sometimes much less.<sup>198</sup> Whose ox is gored? The nursing home, because of the lesser rate, or the state, which begins to pay a portion of costs immediately.

#### A. The *Blumer* Case and a Message from the U.S. Supreme Court

In February 2002, the United States Supreme Court announced its decision in *Wisconsin Department of Health & Family Services v. Blumer*, a case involving Irene Blumer, the institutionalized spouse of Burnett Blumer.<sup>199</sup> The case turned on technical points of law that bear some explanation, particularly to reveal the impact of *Blumer* on elder couples with different circumstances.<sup>200</sup> Regardless of the facts, the difference for the individuals is rarely great. Perhaps the most important point is the philosophy revealed by the writings of the majority and dissent.

Irene and Burnett Blumer married in 1941 and lived in a small town in Wisconsin after fifteen years spent on the family farm.<sup>201</sup> Burnett Blumer worked in a barber chair factory, did carpentry, and moved on to the repair of railroad tracks.<sup>202</sup> Irene drafted forms for a business in Madison, Wisconsin.<sup>203</sup> In 1994, Irene suffered a stroke that rendered her unable to walk or speak.<sup>204</sup> She began to live in a nursing home twenty-five miles from the Blumers' home.<sup>205</sup> Burnett

<sup>197</sup> See, e.g., *Mertz v. Houstoun*, 155 F. Supp.2d 415, 426 (E.D. Pa. 2001) (*Federal Court Grudgingly Approves Use of Annuities In Accelerating Medicaid Eligibility*, in *The Elder Law Advocate*, Vol. X, No. 2 (Fall 2001) at 10 (pointing out that the Department of Public Welfare found the annuities to be a transfer that could not be penalized).

<sup>198</sup> Of course, the nursing home industry objects to this and other Medicaid planning to hasten eligibility because of the drop in payments.

<sup>199</sup> 534 U.S. 473 (2002).

<sup>200</sup> See *id.*

<sup>201</sup> Meg Kissinger & Joe Manning, *Golden Years Robbed of Glow: Couple who sued state over Medicaid lost life's savings after woman's stroke*, MILWAUKEE J. SENTINEL, Dec. 11, 2001, at A1.

<sup>202</sup> *Id.*

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

would drive to the home and spend time with her almost every day.<sup>206</sup>

The *Blumer* case reached the United States Supreme Court by 2001.<sup>207</sup> The legal point was quite technical. The federal statute on the CSRA states that

If either . . . spouse establishes that the [CSRA] (in relation to the amount of income generated by such allowance) is inadequate to raise the community spouse's income to the [MMMNA] there shall be substituted for the [CSRA]. . . an amount adequate to provide such a [MMMNA].<sup>208</sup>

Two interpretations of the provision were offered by the states.<sup>209</sup> First, the provision directs the transfer of resources to the community spouse in order to generate income to make up the MMMNA.<sup>210</sup> Alternatively, some states (including Wisconsin) interpret the provision to allow the use of "income first."<sup>211</sup> Under this alternative, the state might choose to transfer to the community spouse an amount from the nursing home spouse's income, if available, rather than transferring resources intended to generate that income.<sup>212</sup>

The Blumers had non-exempt assets of \$145,644 when Irene moved into the nursing home.<sup>213</sup> Burnett's CSRA was \$72,822, and the balance (minus Irene's allowed \$2000) was intended for care.<sup>214</sup> At the time of the snapshot, \$14,513 remained in the savings to be spent on care.<sup>215</sup> The application for immediate eligibility was rejected.<sup>216</sup>

<sup>206</sup> Kissinger, *supra* note 201.

<sup>207</sup> *Blumer*, 534 U.S. 473.

<sup>208</sup> See Medicaid Act, § 1924(d)(1)(B), (e)(2)(C), as amended, 42 U.S.C. § 1396r-5(d)(1)(B), (e)(2)(C); Medicare Catastrophic Coverage Act of 1988 (MCCA or Act), 102 Stat. 754, 42 U.S.C. § 1396r-5 (1994 ed. and Supp. V).

<sup>209</sup> *Blumer*, 534 U.S. 473, 484; see generally *Robbins v. DeBuono*, (2d Cir. Ct. App.) No. 99-7663 (June 30, 2000); *Cleary v. Waldman*, (3d Cir. Ct. App.) No. 97-5145, 1999 WL 53046 (Feb. 8, 1999); *Chambers v. Ohio Dept. of Human Services*, (6th Cir. Ct. App.) No. 96-3046 (May 27, 1998); *Golf v. N.Y. State Dept. of Social Serv.* (N.Y. Ct. App. No. 7) 1998 WL 151293 (Apr. 2, 1998); *Thomas v. Comm'r of the Div. of Medical Asst.* (Mass. Supr. Jud. Ct.) SJC-07344 (Aug. 14, 1997).

<sup>210</sup> *Blumer*, 534 U.S. 473, 484.

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

<sup>213</sup> *Id.* at 486. The "snapshot" was actually reconstructed from their records in 1996, when Burnett applied for Medicaid assistance for Irene. *Id.*

<sup>214</sup> *Id.*

<sup>215</sup> *Blumer*, 534 U.S. 473, 486.

<sup>216</sup> *Id.* at 478.

Therein lies the issue. Burnett's MMMNA was \$1727 per month, but his own income was \$1702.45 per month, a shortfall of \$24.55.<sup>217</sup> The legal question was whether Burnett should receive the difference from Irene's income, or take assets that would generate the amount in interest income.<sup>218</sup> The state argued that a transfer of income was a permissible interpretation of the federal statute.<sup>219</sup>

The amounts seem small, but it is instructive to understand that even if Burnett received all of Irene's remaining assets (\$14,513) he would fall short of his MMMNA and need a transfer of her income as well. Thus, it is easy to understand how much property must be transferred if the community spouse has little or no income. Equally important to the spouses is that a stream of income might end with the death of the nursing home spouse or the expiration of a contractual income agreement.<sup>220</sup> At that time, there may be no assets left to transfer to the spouse, who might suffer a huge and permanent decrease in income.

*Blumer* is termed the United States Supreme Court's first elder law case.<sup>221</sup> The holding represents a loss for aged Medicaid applicants, who might have had the benefit of asset transfers to enhance the security of the community spouse, and indirectly, the institutionalized spouse. However, a divided Supreme Court presents interesting messages regarding the nature of Medicaid coverage.

The opinion shows a clear grasp of the technical interpretation problem that poses the legal question, while recognizing the action of Medicaid planning. Written by Justice Ginsberg, the majority opinion represents the views of an unusual coalition: Justices Kennedy, Souter, Breyer, Thomas, and Chief Justice Rehnquist.<sup>222</sup> The issues cut across the lines of liberal and conservative values, or perhaps represent different concerns in a complex analysis. Policy arguments regarding spousal support might persuade some,<sup>223</sup> while the precision of statutory interpretation might persuade others.<sup>224</sup>

<sup>217</sup> *Id.* at 486.

<sup>218</sup> *Id.*

<sup>219</sup> *Id.*

<sup>220</sup> Such as an annuity, or pension.

<sup>221</sup> Harry S. Margolis, *Supreme Court Considers Income-First Rule*, THE ELDERLAW REPORT, Vol. XIII, No. 6, Jan. 2002, at 1.

<sup>222</sup> *Blumer*, 534 U.S. 473, 478.

<sup>223</sup> *Id.*

<sup>224</sup> *Id.*

The priority of states' rights might move more conservative justices to endorse the conclusions of more liberal justices.

The dissent, which rejects the "income first" interpretation with very plausible reasoning based on the statutory provisions, was written by Justice Stevens, joined by Justices O'Connor and Scalia.<sup>225</sup> The more "applicant friendly" interpretation endorsed by the dissent seems at odds with the conservative values of two of the Justices, particularly if Medicaid is viewed as a welfare benefit.

Yet, it appears that Justice Ginsberg's writing includes counter-intuitive reasons to leave the states a choice in a close question of interpretation. In the last paragraph of the opinion, she writes: "Eliminating the discretion to choose income-first would hinder a State's efforts to 'strike its own balance' in the implementation of the [Medicaid] Act."<sup>226</sup> The Court observes that individuals with significant resources might receive a scarce benefit that would not be available to those of lesser means.<sup>227</sup>

While concerned with low income applicants, the Court recognizes the fact that many elders who plan and apply for Medicaid are not destitute. Justice Breyer even voiced his confusion over whether it was better for the government to make people spend down their assets or pay them to a doctor.<sup>228</sup>

The United States Supreme Court, in grappling with the Medicaid rules for aged nursing home residents, acknowledged that people who are not poor are the intended beneficiaries.<sup>229</sup>

## IX. DISSONANCE AND RESOLUTION IN THE MEDICAID LONG-TERM CARE CONTROVERSY

The cost of Medicaid long-term care is again in the spotlight as state revenues are reduced by a weak economy.<sup>230</sup> The proportion of nursing home beds paid for by Medicaid has increased from the

<sup>225</sup> *Id.* at 497 (Stevens J. dissenting).

<sup>226</sup> *Id.*

<sup>227</sup> *Blumer*, 534 U.S. 473, 497.

<sup>228</sup> Wis. Dept. of Health and Fam. Serv. v. *Blumer*: Transcript, 42:6 – 43:12, available at [http://www.supremecourtus.gov/oral\\_arguments/argument\\_transcripts.html](http://www.supremecourtus.gov/oral_arguments/argument_transcripts.html) (last visited Aug. 23, 2003) (giving an example of a woman with \$800,000 in assets either going to an institution or going to a doctor to "fix the root").

<sup>229</sup> See generally *Blumer*, 534 U.S. 473.

<sup>230</sup> See Robert Pear and Robin Toner, *Grim Choices Face States in Making Cuts in Medicaid*, N.Y. TIMES, Jan. 14, 2002; Robert Pear, *Governors Say Medicaid Needs More Federal Help to Control Rising Costs*, N.Y. TIMES, Feb. 25, 2002, at A14.

last crisis in costs in the early 1990s to the present.<sup>231</sup> However, only a limited portion of the increase is attributable to the elderly.<sup>232</sup> While the proportion that might be saved by cutting off any remaining Medicaid planning has yet to be determined, it is notable that in research undertaken to justify the passage of the trust disqualifying provisions of OBRA '93, indicates that the savings to state Medicaid budgets ranged from a high of four percent to less than two percent.<sup>233</sup>

Most individuals who engage in Medicaid planning retain significant assets (and so might be engaged in gift-giving unrelated to anticipation of need for nursing home assistance).<sup>234</sup> The motivation to do so is strong. Many want choices in lifestyle and activities, or want to give future gifts to family and friends. Few would knowingly consent to entering a nursing home subject to the limited options available to one who cannot initially offer private payment. Thus, many of these individuals are not excluded should they need extended care because the "look back" period has expired.

Most others never need long-term nursing home care so their planning has no impact on Medicaid expenditures.

States engage in strategies to control their Medicaid expenditures.<sup>235</sup> An inordinate amount of energy is spent on issues of elderly nursing home eligibility. Sources for that dissonance may be commentators whose interests are in accord with business in long-term care insurance or corporate nursing homes.

Disagreement also may arise from different fundamental values. Opponents of Medicaid planning of any kind invoke a mindset that asserts that even to consider terms other than self-sustained independence from the community is an error. With such a view, using legal arguments is in itself wrong.<sup>236</sup> Proponents of honest

<sup>231</sup> ALISON P. BARNES, MEDICAID, Intergovernmental Health Policy Project (1992).

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> *Id.*

<sup>235</sup> *Id.*

<sup>236</sup> See Randy Cohen, *The Ethicist*, N.Y. TIMES, July 28, 2002, (Magazine), at 12. No doubt, many would be distressed at this advice. *Id.* In a recent column, Cohen writes in response to a letter from a 50-year-old woman who has been married for seven years to a husband who has a diagnosis of early-onset Alzheimer's disease. *Id.* She states that in their state all their assets except for \$90,000 and the house and car would have to be spent before her husband is eligible. *Id.* She doesn't "want to cheat Medicaid, but she doesn't want to be driven to poverty." *Id.* She wants a "Medicaid divorce," which would divide the couple's assets and, presumably, protect more of them. *Id.* The *Ethicist* responds that in such a "late in life" marriage, she can better honor her spousal vow by obtaining the divorce in order

planning see the Medicaid rules as a process that is intended to provide access to nursing home benefits and can provide that access without impoverishment for all.<sup>237</sup>

Medicaid eligibility rules are an accretion of requirements and prohibitions, influenced over time by changing economic and social circumstances. States adjust their potential exposure to costs without reference to the individual who might be excluded. So long as we lack the political will to include long-term care in some program in the nature of social insurance, the almost-eligibles and others will work with the law we have.<sup>238</sup>

Many Medicaid planners choose the strategies they believe are sound and ethically acceptable. Sound Medicaid planning calls for a combination of social courage in the face of possible public opprobrium, discernment regarding the choice for means of achieving Medicaid eligibility and protecting client assets, and conviction that individual elders and society benefit overall by implementing the actual rules of Medicaid nursing home benefits for the aged.

to preserve their "small savings" for both of them by becoming "loving but unmarried companions." *Id.* On the other hand, a spouse is advised to become single in order to protect the couple from "impoverishment" with assets under \$90,000. *Id.*

<sup>237</sup> Cf. Kapp, *supra* note 110, at 707 (making a contrasting observation about the beliefs of nursing home regulators). Kapp says:

Religion is mainly an issue of faith. *Id.* Sound public policy, by contrast, ought to be based on evidence regarding the likely impact of particular governmental actions on the actual lives and well being of the intended beneficiaries. . . the environment of pervasive, comprehensive regulation, within which the nursing facility industry presently operates, has evolved steadily over the past quarter century as a matter of a political, almost quasi-religious, belief. . . prodded on and abetted by the popular media. *Id.*

Kapp calls for a healthy skepticism about the value of direct command and control regulation in maintaining quality in nursing home care.

<sup>238</sup> See, e.g., Reed Abelson, *Drug Sales Bring Huge Profits, and Scrutiny, to Cancer Doctors*, N.Y. TIMES, Jan. 26, 2003, at § 1, at 1 (noting oncologists sell drugs to their patients, a unique practice among specialists.) (Health care coverage suffers from similar problems with determinations of eligible costs and ethical practices).