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Paying for Nursing Home Care: Medicaid and Planned Poverty

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PAYING FOR NURSING HOME CARE: MEDICAID AND PLANNED POVERTY

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I. INTRODUCTION

Thirty million Americans are sixty-five or over.[1] More than 1.3 million of them live in nursing homes.[2] Of those who live to age eighty-five, nearly one in four will require nursing home care at some time during their lives.[3] They will spend an average of two and one-half years in nursing homes.[4] While the rest will never become residents of a nursing home, virtually all of them, and all of us, will be affected by the emotional and financial trauma of a family member entering a nursing home.[5] Unfortunately, discussing the potential need for nursing home care with elderly or disabled family members is difficult. Too often, families do not consider the need for or plan for nursing home care until it is imminent. They then learn that their procrastination has exacted a heavy price.

Medicaid is the largest third party payer of nursing home care in the United States, and the only third party payer potentially available to most individuals.[6] Medicaid is a complex amalgam of federal and state law. Its relationship to estate and financial planning is often overlooked. This article offers an overview of the Medicaid program, in general, and the Wyoming Medicaid program, in particular. Three pro-

1. LONG-TERM CARE FOR THE ELDERLY: ISSUES OF NEED, ACCESS, AND COST, GAO REPORT No. HRD-89-4, Nov. 28, 1988, *reprinted in* Medicare and Medicaid Guide (CCH), ¶ 37,652, at 19,506. That number is expected to increase to 51.4 million by the year 2020. *Id.* at 19,506.

2. *Id.* Nursing home care should be of greater concern to women since three out of every four nursing home residents are female. *Id.* at 19,509.

3. *Id.* at 19,506. Persons over age 85 are the fastest growing segment of the population. By the year 2020, nearly fifteen percent of the population will be over age 85. *Id.* Not surprisingly, the probability of needing nursing home care increases with age. Only 1.3 percent of persons aged 65 to 74 require nursing home care. That increases to 5.8 percent of persons aged 75 to 84. *Id.*

4. *Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the State and the Elderly,* GAO REP. No. IPE-84-1, October 21, 1983, *reprinted in* Medicare & Medicaid Guide (CCH), ¶ 33,469 at 9363.

5. Many of those who do not require nursing home care will require some sort of long-term care. Long Term Care For The Elderly, *supra* note 1 at 19,508. Most will be cared for in their homes by family member or home health providers. *Id.* The cost and ramifications of long-term care other than nursing home care are beyond the scope of this article.

6. In 1985, the most recent year for which figures are available, Medicaid paid for 40.1 percent of nursing home residents' care. Fifty percent of nursing home residents paid their own way. Medicare covered only seven percent of nursing home residents' care. *Id.* at 19,516.

visions of the program which are likely to affect planning for extended nursing home care are identified and analyzed. What type of planning is appropriate for specific clients is discussed. The article closes with some suggestions for changing the current structure of paying for nursing home care.

II. BACKGROUND

For reasons which are unclear, or at least never fully articulated, our society has traditionally distinguished between financing nursing home care and all other types of medical care.[7] Private health insurance, with few exceptions, has never provided coverage for long term nursing care.[8] While there has been an increase in the availability of private nursing home insurance policies in the last several years, only one percent of persons over age sixty-five carry such insurance.[9]

Contrary to popular opinion, Medicare, the government health insurance program for the elderly and disabled, does not cover long term nursing home stays.[10] Only Medicaid provides long term coverage.[11] Since Medicaid is a welfare program, however, the majority of Americans are not eligible for the program without appropriate planning. They are, consequently, vulnerable to the potential economic devestation of extended nursing home care.

Americans spent over $45 billion on nursing home care in 1985.[12] The average annual cost of nursing home care is $22,000.00.[13] The average annual cost of nursing home care in Wyoming is $22,600.80.[14] The high cost of nursing home care puts many persons in a Catch 22. Their income and assets are insufficient to pay for more than a brief nursing home stay, but in excess of the eligibility standards for Medicaid. Accordingly, how to finance extended nursing home care ought to be of paramount concern to older Americans, their families and their attorneys, before such care is imminent.

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7. The reason may be that nursing home care is a relatively recent phenomenon. Historically, families provided care for elderly or disabled relatives. As life expectancy has increased, however, the number of elderly persons has increased substantially and is projected to continue that increase as the baby boom generation moves into middle age. With that increase, and the increase of elderly persons who live far from their families, the demand for nursing home care has increased. *See infra* note 217.

8. A. RIVLIN AND J. WIENER, CARING FOR THE DISABLED ELDERLY p. 59 (1989).

9. *Id.* at 81.

10. Medicare coverage of nursing home care is limited to 100 days of post-hospital care per spell of illness. 42 U.S.C. § 1395d(a)(2)(A) (1982).

11. *Id.* § 1396d(a)(4)(A), (d) (Supp. V 1987).

12. LONG-TERM CARE FOR THE ELDERLY, *supra* note 1 at 19,516.

13. J. CRICHTON, THE AGE CARE SOURCE BOOK p. 211 (1987).

14. The average daily charge to private pay patients in nursing homes in Wyoming as of July 1, 1989, was $61.92. DRAFT ANALYSIS OF 7/01/89 MEDICAID COSTS AND RATES, MEDICAL ASSISTANCE SERVICES, DIVISION OF HEALTH AND MEDICAL SERVICES, WYOMING DEPARTMENT OF HEALTH AND SOCIAL SERVICES. That results in an annual charge of $22,600.80, or $1,883.40 per month.

A. Medicaid

Medicaid is a joint federal state program established pursuant to Title XIX of the Social Security Act to pay the cost of necessary medical services provided to certain persons who are unable to pay for such services.[15] While simple in concept, Medicaid has been unflatteringly, but accurately, described as "a morass of bureaucratic complexity."[16] Despite its deserved reputation, an understanding of the general operation of Medicaid is fundamental to any consideration of planning for nursing home care.

States need not participate in Medicaid, but those which elect to do so must administer the program in conformance with the Social Security Act and applicable federal regulations.[17] In exchange for complying with federal directives, participating states receive federal funds to pay part of the cost of providing certain medical services.[18] All states other than Arizona participate in Medicaid.[19]

Congress has delegated the responsibility for administering Medicaid to the United States Department of Health and Social Services (HHS).[20] Within HHS, administration of Medicaid is the responsibility of the Health Care Financing Administration (HCFA).[21]

A participating state must appoint a "single state agency" to administer the state's Medicaid program.[22] That agency must administer the program in conformance with a "state plan" submitted to and approved by HCFA.[23] The state plan is a "comprehensive statement" of the state's Medicaid program, which includes "assurances that it will be administered in conformity with the specific requirements" of the Social Security Act and federal regulations.[24]

Within the broad framework established by the Social Security Act and HCFA regulations, states have considerable discretion in the administration of their Medicaid programs. That discretion extends to determining whether to offer services beyond the minimal services man-

15. 42 U.S.C. §§ 1396-1396s (1982 & Supp. V 1987).
16. Herweg v. Ray, 455 U.S. 265, 279 (1982)(Burger, C.J., dissenting).
17. Harris v. McCrae, 448 U.S. 297, 301 (1980).
18. The federal medical assistance percentage (FMAP) varies from fifty percent to eighty percent of states' expenditures for covered medical services, depending on the states' average per capita income. 42 U.S.C. § 1396b(a)(1) (Supp. V. 1987). For fiscal year 1989, the FMAP for Wyoming was 62.61 percent. Medicare & Medicaid Guide (CCH) ¶ 14,905. The FMAP for administrative costs varies from fifty percent to ninety percent, depending on the nature of the costs. 42 U.S.C. § 1396b(a)(2)-(7) (1982 & Supp. V 1987).
19. Arizona operates a limited demonstration program pursuant to a waiver from HCFA. Medicare & Medicaid Guide (CCH) ¶ 15,504. The District of Columbia and the territories of Guam, North Mariana Islands, Puerto Rico and the Virgin Islands also participate in Medicaid. *Id.*
20. 42 U.S.C. § 1396 (Supp. V 1987).
21. Medicare & Medicaid Guide (CCH) ¶ 13,170 at 5,341 (1988).
22. 42 U.S.C. § 1396a(a)(5) (1982).
23. *Id.* § 1396a(5) (Supp. V 1987); 45 C.F.R. § 201.3 (1988).
24. 45 C.F.R. § 201.2 (1988).

dated by Congress,[25] whether to cover persons other than those groups specified by Congress,[26] the amount of Medicaid reimbursement that providers of medical services will receive,[27] and many eligibility criteria.[28] Because of that discretion, it is meaningless to speak of Medicaid as a national program. It is, instead, fifty-four very different programs.

Unlike Medicare, with which it is often confused, Medicaid is a welfare program.[29] Eligibility is restricted to persons who meet stringent income and asset limitations and who have certain characteristics. Medicaid is potentially available to two groups: the "categorically needy" and the "medically needy." Coverage of the former group is mandatory.[30] Coverage of the latter group is optional.[31]

Categorically needy persons are those who are both within a defined category and meet certain income and asset guidelines. There are two such categories: minor children of single parents (and the parent with whom they reside); and persons who are over age sixty-five, blind or disabled. Persons in the first category are eligible for Aid to Families with Dependent Children (AFDC).[32] Persons in the second category are eligible for Supplemental Security Income (SSI).[33] AFDC and SSI are "income maintainance" programs which provide cash subsidies for

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25. 42 U.S.C. § 1396a(a)(10)(A) (Supp. V 1987).

26. *Id.* § 1396a(a)(10(A)(ii).

27. *See, e.g.*, 42 U.S.C. § 1396a(a)(13) (Supp. V 1987) (reimbursement for hospital and nursing home services must be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws . . . ").

28. For example, although Medicaid coverage is automatic for recipients of Aid to Families with Dependent Children, states are able to control eligibility for AFDC though controlling the AFDC eligibility criteria. 42 U.S.C. § 602(a)(7)(Supp. V 1987).

29. Medicare is a social insurance program enacted pursuant to Title XVIII of the Social Security Act. 42 U.S.C. §§ 1395-1395ccc (1982 & Supp. V 1987). It has two distinct parts: Part A and Part B. Medicare Part A provides hospital insurance for all persons age sixty-five or over. 42 U.S.C. § 1395c (Supp. V 1987). Part A also covers persons eligible for social security disability, railroad retirement and persons suffering from end-stage renal disease. *Id.* Part B provides supplementary medical insurance to cover other medical expenses incurred by persons age sixty-five or over that elect such coverage. 42 U.S.C. § 1395j (1982). Part A and Part B are available regardless of an individual's income and assets.

Part A is funded primarily by the Federal Hospital Insurance Trust Fund through payroll deduction taxes and taxes on employers and the self-employed. 42 U.S.C § 1395i (1982 & Supp. V 1987). Part B is funded through enrollees' premiums and federal funds. *Id.* § 1395j (1982).

30. 42 U.S.C. § 1396a(a)(10)(A)(i) (Supp. V 1987).

31. *Id.* § 1396a(a)(10)(A)(ii) (Supp. V 1987).

32. AFDC was enacted as Title IV of the Social Security Act, ch. 531, 49 Stat. 627 (1935) (codified as amended at 42 U.S.C. § 601 (1982 & Supp. V 1987).

33. SSI was enacted by Title XVI of the Social Security Act. Pub. L. No. 92-603, Title III, § 301, 86 Stat. 1465 (codified as amended at 42 U.S.C. §§ 1381-1383c (1982 & Supp. V. 1987). SSI is a federal program which provides income assistance to persons that are age sixty-five or over, blind or disabled. 42 U.S.C. § 1381 (1982). It is funded exclusively by the federal government and administered by the Social Security Administration. *Id.* § 1381a (1982).

living expenses. Medicaid coverage for AFDC and SSI recipients is automatic.[34]

Medicaid is also potentially available to persons who fall within the so-called categorically optional groups.[35] One of those groups is persons in need of long term nursing home care whose income falls within the "special income standards"; that is, their income does not exceed 300 percent of the SSI benefit level.[36]

The medically needy are those persons who meet the categorical requirements for AFDC or SSI, but are ineligible for cash assistance because their assets or income exceed the eligibility limits.[37] They are eligible for Medicaid to cover their medical expenses if the state in which they reside has elected to cover the medically needy and their income and assets are insufficient to pay for necessary medical care.[38] A state which elects to cover the medically needy establishes "reasonable" income and resource limitations for the program.[39] A medically needy person becomes eligible for Medicaid by incurring medical expenses in an amount which reduces available income and resources to the state's standards.[40] This process is know as "spending down."

B. Medicaid in Wyoming

The State of Wyoming elected to participate in Medicaid through the enactment of the Wyoming Medical Assistance and Services Act.[41] The Wyoming Department of Health and Social Service is the single state agency appointed to administer the Wyoming Medicaid program.[42] Responsibility for administering the program has been further delegated to the Division of Health and Medical Services.[43]

Medicaid eligibility is restricted, with one significant exception, to the categorically needy, i.e. AFDC and SSI recipients.[44] The exception is that the State has elected to include persons in need of long term

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34. 42 U.S.C. § 1396a(a)(10)(A)(i)(I) & (II) (1982).
35. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1982 & Supp. V 1987).
36. 42 U.S.C. § 1396a(a)(10)A)(ii)(v) (Supp. V 1987); 42 C.F.R. § 435.231 (1988).
37. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1982); 42 C.F.R. § 435.301(a) (1988)
38. 42 C.F.R. § 435.301(ii) (1988).
39. 42 C.F.R. §§ 435.812, 435.841(a) (1988).
40. 42 C.F.R. § 435.301(a)(ii) (1988).
41. 1967 Wyo. Sess. Laws, ch. 238, § 1 (codified as amended at WYO. STAT. §§ 42-4-101 to 42-4-112 (1977)).
42. WYO. STAT. §§ 42-1-101(a)(ii), 42-4-104(a) (1977).
43. Exec. Order of Wyoming Governor Herschler 1977-4 (June 21, 1977).
44. STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM, p. 12, Attachment 2.2A. Medicaid is available to the following groups: Qualified Medicare beneficiaries, RULES PERTAINING TO MEDICAID ELIGIBILITY, STATE OF WYOMING DEPARTMENT OF HEALTH AND SOCIAL SERVICES, ch. II.I (Proposed); Persons residing in medical institutions whose income does not exceed 300 percent of the SSI standard, *id.*, ch. II.II (Proposed); Persons eligible for AFDC benefits or AFDC extended Medicaid benefits, *id.*, ch. II.III-IV (Proposed); persons eligible for SSI, *id.*, ch. II.V (Proposed); and persons eligible for Refugee benefits, *id.*, ch. II.VI (Proposed).

nursing home care who meet the SSI categorical requirements and the "special income standards."[45]

Since Medicaid is automatically available for persons who qualify for AFDC and SSI, eligibility determinations for those categorical groups are done by the agencies responsible for the administration of those programs. The Division of Public Assistance and Social Services (DPASS) determines eligibility for AFDC.[46] The Social Security Administration determines eligibility for SSI.[47] Medicaid eligibility determinations for persons seeking eligibility under the special income standards are performed by DPASS.[48]

C. Nursing Home Care

Nursing home care is a mandatory Medicaid service.[49] Traditionally, nursing home care has been divided into two levels of care: intermediate care and skilled nursing care, provided by intermediate care facilities (ICFs) and skilled nursing facilities (SNFs), respectively.[50] Effective October 1, 1990, the distinction will be eliminated, leaving one level of care, known as "nursing facility services."[51]

Persons in need of nursing facility services are invariably over sixty-five, disabled, or both. They are, therefore, within the category of potential SSI recipients. Accordingly, the only question is whether they meet the state's income[52] and resource[53] standards as categorically or medically needy. In Wyoming, the only question is whether they meet the SSI income and asset limitations or the special income level standards. If they meet the applicable standards, Medicaid will cover the difference between the cost of care and what the individuals are able to pay.

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45. STATE PLAN, *supra* note 44, Attachment 2.6A, Supplement C; RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 8(b) (Proposed).

46. WYO. STAT. § 42-2-106(a) (1977).

47. Agreement between the Secretary of Health, Education and Welfare and the State of Wyoming (January 17, 1977).

48. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 4. (Proposed).

49. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A), (d) (Supp. V 1987). States must also cover inpatient hospital services, outpatient hospital services, nurse midwife services, laboratory and X-ray services, home health services for individuals age twenty-one and over, early and periodic screening, diagnosis and treatment for individuals under age twenty-one, and family planning services. 42 U.S.C. §§ 1396a(10)(A), 1396d(a)(1)-(5), (17) (1982 & Supp. V 1987). States may elect to cover any or all of thirty-two other categories of medical services. *Id.*

50. The primary difference was the level of nursing services. Intermediate care provided nursing services only during the day. Skilled care provided 24 hour nursing care. 42 U.S.C. §§ 1396d(d), 1396d(f).

51. Pub. L. No. 100-230, § 4211(a), 101 Stat. 1330-183 (1988).

52. "Income" includes anything received in cash or in kind that can be used to meet a person's need for food, clothing or shelter. 20 C.F.R. § 416.1102 (1988); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 3(lll) (Proposed).

53. "Resources" include "cash or other liquid assets or any real or personal property that an individual owns and could convert to cash." 20 C.F.R. § 416.1201(a) (1988). "Liquid resources" include any resources which can be converted into cash in twenty days. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 3(aaaaa)(i) (Proposed). "Non-liquid resources" are those assets which cannot be converted to cash within twenty days. *Id.* ch. II, § 3(aaaaa)(ii).

If they are not eligible for Medicaid, they must use their own income and assets to pay for nursing home care.

Persons who meet the categorical requirements or the SSI special income level standards may not qualify for Medicaid because of excess resources. Such resources are often insufficient, however, to pay for extended nursing home care. The result is that the resources must be sold and the proceeds used to pay for nursing home care. After the sale proceeds are exhausted, the newly impoverished person qualifies for Medicaid.

Nursing home residents, persons concerned about becoming nursing home residents, and their families, are or quickly become aware that Medicaid is the primary source of funding for nursing home care other than personal assets or income.[54] Since the high cost of nursing home care often quickly exhausts the savings of a lifetime, Medicaid becomes an attractive alternative. It will, potentially, pay for nursing home care while preserving at least part of the estate of a nursing home resident.[55]

There are three aspects of Medicaid with which an individual considering the possibility of extended nursing home care should be concerned: (1) the transfer of assets preclusion; (2) the relative responsibility provisions; and (3) the provisions which permit states to recover Medicaid benefits paid on behalf of a recipient through the filing of liens against the recipient's property or estate. The transfer of assets preclusion and relative responsibility provisions apply at the time of application and during the receipt of Medicaid benefits. The lien provisions apply primarily after benefits have been paid.

III. THE TRANSFER OF ASSETS PRECLUSION

A. *Background*

Until 1980, an individual faced with nursing home care or other significant medical expenses could become eligible for Medicaid, assuming the categorical requirement were met and the individual's income was less than the applicable limit, by transferring his or her assets in excess of the Medicaid limits to a friend or family member. Such transferred assets were considered unavailable and could not be considered in determining Medicaid eligibility.[56] Medicaid would then pay

54. In 1985, the last year for which accurate figures are available, Americans spent $45 billion dollars on nursing home care. LONG TERM CARE FOR THE ELDERLY, *supra* note 1 at 19,516. Public programs paid for 48 percent, and private sources paid for 52 percent. Medicaid accounted for ninety percent ($17.2 billion) of the public expenditures for nursing home care. *Id.* Expenditures for nursing home care are expected to increase between fifty to two-hundred percent by the year 2000. *Id.*

55. The preservation of the assets of the elderly to pass on to their children is a primary objective of many elderly persons (and their children). Dobris, *Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance,* 24 REAL PROPERTY, PROBATE & TRUST J. 1 (1989).

56. Several states attempted to deny Medicaid because of the transfer of assets for less than fair market value. Those attempts were unsuccessful. *See, e.g.,* Caldwell

the difference between the cost of care and the person's income. Accordingly, there was little need to plan for the cost of nursing home care. The result was that Medicaid became a social insurance program, rather than a welfare program, available to all who became voluntarily impoverished prior to applying for coverage.

Since then, Congress has struggled with whether to permit voluntary impoverishment as a means of obtaining Medicaid eligibility. The issue raises the fundamendal question of whether nursing home care should be available to all as a social insurance entitlement or restricted to the poor and the wealthy. That question has not been satisfactorily answered or even addressed directly. Instead, Congress has attempted to have it both ways by repeatedly tinkering with the transfer of assets issue. Despite the tinkering, Medicaid remains, ostensibly, a welfare program. In reality, it is a social insurance program open to all who plan properly. Only the ill-informed need not apply.

Medicaid eligibility criteria, including resource standards, are largely left to the states.[57] The primary federal restriction is that states must establish "reasonable standards for determining eligibility . . . taking into account only such income and resources as are . . . available to the applicant or recipient."[58] The key word is available. Except as otherwise decreed by Congress, assets which have been transferred are not available and may not be considered in determining Medicaid eligibility. The history of the transfer of assets issue is how Congress has gone from prohibiting states from considering transferred assets to requiring the consideration of such assets. It is a paradigm of how not to establish social policy.

In the last ten years, Congress has passed three provisions restricting the transfer of assets to qualify for Medicaid, the last two of which are still applicable, at least in part.[59] The frequency of change indicates the need for long-term, informed planning with regular reviews to determine if changes have rendered existing planning obsolete. Since the amendments have all adopted substantially the same approach to the transfers of assets issue, a review of the transfer of assets provisions illustrates how Congress is attempting to respond to the issue, and provides guidance in advising a client about financing long term care.

B. The Boren-Long Amendment

In 1980, Congress passed the Boren-Long amendment, which included the first attempt to prevent individuals from giving away their

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v. Blum, 621 F.2d 491, 498, (2d Cir. 1980), *cert. denied,* 452 U.S. 909 (1981); Dokos v. Miller, 517 F.Supp. 1039, 1044 (N.D. Ill. 1981); Buckner v. Maher, 424 F.Supp. 366, 374 (D. Conn. 1976); and Owens v. Roberts, 377 F. Supp. 45, 54-5, (M.D. Fla. 1974).

57. 42 U.S.C. § 1396a(a)(17)(Supp. V 1987).

58. *Id.*

59. The Boren-Long Amendment, Pub. L. No. 96-611, § 5(b), 94 Stat. 3568 (1980); The Tax, Equity and Fiscal Responsibility Act, Pub. L. No. 97-248, § 132, 96 Stat. 370 (1982); and The Medicare Catastrophic Coverage Act, Pub. L. No. 100-360, § 303(b), 107 Stat. 760 (1988).

assets in order to qualify for Medicaid.[60] The amendment authorized states to deny Medicaid to a person who transferred assets for less than fair market value within twenty-four months before applying for Medicaid.[61] States were permitted to consider the difference between the fair market value of the transferred asset and the value received in exchange as an available asset for purposes of Medicaid eligibility.[62] Eligibility could be denied if the value so computed plus the applicant's remaining assets exceeded the Medicaid resource limit, regardless of whether the transferred assets were actually available after the transfer.[63]

Simultaneously, Congress enacted a transfer of assets restriction for the SSI program.[64] The SSI transfer of assets language was incorporated by reference in the Medicaid transfer of assets provision.[65]

The Boren-Long amendment contained an important exception. The procedure used by states to deny Medicaid because of the transfer of assets could not be more restrictive than the newly enacted SSI transfer of assets procedure.[66]

Under SSI, certain assets were, and are, exempt for purposes of determining eligibility.[67] Most importantly, an applicant's home and the adjacent property are exempt.[68] Furthermore, exempt assets could be transferred for less than fair market value without affecting SSI eligibility.[69] The question arose, however, of whether the transfer of assets exempt under SSI, particularly the home, affected Medicaid eligibility.

Several states attempted to deny Medicaid to persons who had transferred homes for less than fair market value. The states argued that the reason for exempting the home (to permit the applicant or family members to reside there) evaporated at the instant of transfer. The states' attempts were uniformly rebuffed.[70] As a result, the Boren-Long transfer of assets preclusion was generally ineffective. The most valuable asset of most applicants, their home, was exempt, even when transferred for less than fair market value within twenty-four months of applying for Medicaid. For most persons, qualifying for Medicaid became a simple matter of transferring their home immediately before applying for Medicaid.

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60. Pub. L. No. 96-611, § 5(b), 94 Stat. 3567 (1980).
61. *Id.*
62. *Id.*
63. *Id.*
64. Pub. L. No. 96-611, § 5(a), 94 Stat. 3567 (1980) (codified at 42 U.S.C. § 1382b(c) (1982 & Supp. V 1987)).
65. Pub. L. No. 96-611 § 5(b), 94 Stat. 3568 (1980).
66. *Id.*
67. 42 U.S.C. § 1382b(a) (1982 & Supp V 1987).
68. 42 U.S.C. § 1382b(a)(1) (1982).
69. *Id.*
70. *See, e.g.,* Beltran v. Myers, Medicare & Medicaid Guide (CCH), ¶ 31,465 (C.D.Cal. 1981), *aff'd.* 677 F.2d 1317 (9th Cir. 1982).

C. TEFRA

Two years after Boren-Long, Congress tried to close the door on the transfer of homes to qualify for Medicaid. The Tax, Equity and Fiscal Responsibility Act of 1982 (TEFRA) included detailed transfer of assets provisions: one for Medicaid applicants or recipients in general; and one for residents of nursing homes.[71] The TEFRA transfer of assets provisions remain in effect for transfers made before July 1, 1988, with respect to persons who apply for Medicaid after July 1, 1988.[72]

First, TEFRA contained a general transfer of assets provision which permitted states to deny Medicaid to a person who disposed of assets for less than fair market value in order to meet the applicable resource limitation.[73] The requirement that the procedure for denying Medicaid not be more restrictive than the procedure for denying SSI was retained.[74] Since the SSI procedure for evaluating the transfer of assets still permitted the transfer of otherwise exempt assets, including the home, that provision was incorporated by reference.[75] States were also authorized to waive Medicaid ineligibility caused by the transfer of assets if the denial of Medicaid would "work an undue hardship."[76]

Second, TEFRA permitted states, for the first time, to deny Medicaid to a resident of a nursing home who transferred a home for less than fair market value within twenty-four months before applying for Medicaid, subject to certain exceptions.[77] States were prohibited from denying Medicaid because of the transfer of a home for less than fair market value if the individual:

(1) Made a "satisfactory showing" that he or she could "reasonably be expected to be discharged . . . and return to that home;"[78]

(2) Transferred the home to the individual's spouse, a minor child or a disabled child;[79]

(3) Made a "satisfactory showing" that he or she "intended to dispose of the home either at fair market value or for other valuable consideration";[80] or

(4) The state determined that the denial of Medicaid would "work an undue hardship."[81]

Under either the general provision or the nursing home resident provision, states were allowed to deny eligibility for all Medicaid ser-

71. Pub. L. No. 97-248, § 132, 96 Stat. 324, 371 (1982) (codified at 42 U.S.C. § 1396p(c)(1982)).
72. Pub. L. No. 100-360, § 303(g)(2)(B), 102 Stat. 764 (1988).
73. 42 U.S.C. § 1396p(c)(1) (1982).
74. *Id.*
75. *Id.*
76. *Id.*
77. 42 U.S.C. § 1396p(c)(B)(i)(1982).
78. *Id.* § 1396p(c)(2)(C).
79. *Id.* § 1396p(c)(2)(A)(ii).
80. *Id.* § 1396p(c)(2)(C)(i).
81. *Id.* § 1396p(c)(2)(D).

vices for a time determined as follows: the uncompensated value of the transfered home would be divided by the average amount payable under the state's plan for skilled nursing home care.[82] The quotient was the number of months of ineligibility.

TEFRA raised as many questions as it answered. HCFA did not promulgate regulations. It was left for the states to decide what was a "satisfactory showing," what was "other valuable consideration," and what was "undue hardship." There are no reported cases involving the meaning of the exceptions, perhaps because the exceptions largely eliminated the prohibition on transferring homes and the issue of whether exempt assets could be transferred without endangering Medicaid eligibility had already been resolved.

The result was unsatisfactory. Only those persons who failed to seek competent advice were caught by the transfer of assets preclusion. As part of the Medicare Catastrophic Coverage Act (MCCA), Congress once again attempted to resolve the dilemma of whether Medicaid is a welfare program or an entitlement program for those in need of extended nursing home care.

D. Current Law—The Medicare Catastrophic Coverage Act

Although MCCA was primarily an expansion and revision of the Medicare program, it also contained important Medicaid amendments.[83] The subsequent repeal of MCCA did not affect the MCCA Medicaid provisions.[84]

MCCA was intended to broaden Medicare to provide medical coverage in the event of "catastrophic" medical expenses. Ironically, even with the expanded coverage under MCCA, Medicare provided very limited coverage for nursing home care, generally the most catastrophic of medical occurrences.[85] MCCA is important for our purposes because Congress addressed the issues of transfers of assets and spousal liability for the costs of nursing home care.[86]

MCCA attempts to balance the needs and obligations of the spouse that is in a nursing home, the "institutionalized spouse,"[87] and the

82. *Id.* § 1396p(c)(1)(B)(i), (ii).

83. Pub. L. No. 100-360, Title III, § 303, 102 Stat. 754 (1988).

84. MCCA was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 (H.R. 3607), *reprinted in* Medicare & Medicaid Guide (CCH), No. 603 (December 8, 1989). For the most part, the Act simply reinstated the previously existing Medicare laws. *Id.*

85. Before the enactment of MCCA, Medicare coverage of skilled nursing facility care was limited to one-hundred days of post-hospital care per spell of illness. 42 U.S.C. § 1395d(a)(2)(A)(1982). MCCA expanded coverage to 150 days of skilled nursing care per year with no prior hospitalization required. Pub. L. No. 100-360, Title I, § 101, 102 Stat. 685 (1988). The MCCA Repeal Act reduced coverage to the pre-MCCA levels. Medicare Catastrophic Coverage Repeal Act (H.R. 3607), § 101, *reprinted in* Medicare & Medicaid Guide (CCH), No. 603 (December 8, 1989).

86. Pub. L. No. 100-360, § 303, 102 Stat. 754 (1988) (to be codified at 42 U.S.C. § 1396r-5).

87. 42 U.S.C.A. § 1396r-5(h)(1)(Supp. 1989); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(i) (Proposed).

spouse that remains at home, the "community spouse."[88] First, MCCA added provisions to protect a substantial portion of the couple's income and assets for the benefit of the "community spouse."[89] Second, Congress substantially revised the Medicaid transfer of assets preclusion.[90] Both provisions need to be considered when planning for nursing home care.

1. Treatment of Income.

MCCA contains Congress's first attempt to resolve the issue of how much of a married couple's income and assets should be reserved for the community spouse and considered unavailable to the institutionalized spouse. The MCCA income and resource attribution and protection standards significantly changed existing Medicaid law. As a result, planning for persons concerned about the possibility of nursing home care must also change significantly.

Under pre-MCCA law, the income and assets of a couple were considered to be available to the spouse in need of Medicaid regardless of whether they were actually contributed.[91] If one spouse entered a nursing home, the income of the community spouse was not considered available to the institutionalized spouse after the month of institutionalization.[92] Resources were considered available for six months after the month of institutionalization.[93] Accordingly, after institutionalization, Medicaid eligibility for the institutionalized spouse was determined using the "name on the instrument rule." That is, income received in the name of one spouse was considered to be income of that spouse, and was not available to the other, regardless of the type or source of income.

The "name on the instrument" rule frequently resulted in the impoverishment of the community spouse. The reason is that income is often received in the name of the husband since the husband worked outside the home. If the husband entered a nursing home, all the income received in his name was available to him for purposes of Medicaid eligibility. As a result, the wife, who remained in the community, was reduced to poverty since she received little income in her name.[94] MCCA reduced the possibility of impoverishment of the community spouse by protecting a substantial portion of the couple's income for the community spouse.

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88. 42 U.S.C.A. § 1396r-5(h)(2)(Supp. 1989); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(e) (Proposed).

89. Pub. L. No. 100-360, § 303(a), 102 Stat. 754 (1988).

90. *Id.* § 303(b), 102 Stat. 760 (1988).

91. 42 C.F.R. § 435.723(b) (1988).

92. *Id.* § 435.723(c)(1)(i).

93. *Id.* § 435.723(c)(1)(ii).

94. The "name on the instrument rule" was declared illegal in community property states, which had the effect of protecting half of the couple's income for the community spouse. *See, e.g.,* Department of Health Services of the State of California v. Secretary of Health and Human Services, 823 F.2d 323, 327 (9th Cir. 1987); Washington v. Bowen, 815 F.2d 549, 555 (9th Cir. 1987).

MCCA established formulae for apportioning income and resources between the institutionalized and community spouses.[95] The income and resources allocated to the community spouse are considered unavailable to the institutionalized spouse for purposes of Medicaid eligibility.[96] The objective is to end the "pauperization" of the community spouse and permit the community spouse to remain financially self-sufficient.[97]

The MCCA standards for the treatment of income and resources when one spouse is institutionalized supersede all other eligibility standards, whether state or federal.[98] MCCA also overrides the mandate that states treat all applicants for or recipients of Medicaid uniformly.[99]

a. Attribution of Income. MCCA separates a couple's income into two categories: institutionalized spouse income and community spouse income.[100] The division applies regardless of state laws relating to community or marital property.[101] MCCA further divides income into trust and non-trust income, although the categories are treated substantially the same.[102] The income attribution rules apply "during any month" in which one spouse is in an institution.[103]

Income attribution begins with the "name on the instrument" rule. The income received by each spouse in his or her name is considered income of that spouse.[104] One half of income received jointly is considered to be available to each spouse.[105] At a minimum, therefore, income received solely by the community spouse and one-half of income received jointly is unavailable to the institutionalized spouse in most instances.[106]

The big change is that the community spouse is also entitled to a living allowance, which may far exceed the income he or she receives under the name of the instrument rule.[107]

b. Protection of Community Spouse's Income. After applying the income attribution rules, the state must determine what portion of the

95. 42 U.S.C.A §§ 1396r-5(b), (c) (West Supp. 1989).
96. *Id.* § 1396r-5(c)(4).
97. H.R. REP. No. 100-105, 100th Cong., 2d. Sess (1988), *reprinted in* 1988 U.S. CODE CONG. & AD. NEWS 888.
98. 42 U.S.C.A. § 1396r-5(a)(1)(Supp. 1989).
99. It was necessary for MCCA to override all other eligibility criteria since individuals in need of nursing home care are now subject to substantially different income and resource standards than other applicants or recipients, contrary to the general rule that states must treat all persons the same. *See* 42 U.S.C. § 1396a(a)(17)(Supp. V 1987).
100. 42 U.S.C.A. § 1396r-5(b)(Supp. 1989).
101. *Id.* § 1396r-5(b)(2).
102. *Id.* § 1396r-5(b)(2)(A) & (B).
103. *Id.* § 1396r-5(b)(1).
104. *Id.* §§ 1396r-5(b)(2)(A)(i)-(ii), 1396r-5(b)(2)(B)(ii).
105. *Id.* §§ 1396r-5(b)(2)(A)(iii), 1396r-5(b)(2)(B)(ii)-(iii).
106. The institutionalized spouse may challenge the income attribution. *Id.* § 1396r-5(b)(2)(d). The burden is on that spouse to prove by a preponderence of the evidence that the ownership interests are different than presumed by the MCCA attribution rules. *Id.*
107. *See supra* notes 93, 94 and accompanying text.

institutionalized spouse's income, if any, must be applied to the cost of care, and what portion is to be protected for the benefit of the community spouse.[108] That, in turn, determines what amount Medicaid will pay because Medicaid pays the difference between the income deemed available to the institutionalized spouse and the cost of care. MCCA has significantly decreased the portion of the institutionalized spouse's income that must be applied to the cost of care by increasing the amount of income preserved for the community spouse.

To determine the portion of the income attributed to the institutionalized spouse, which must be applied to the cost of care, the state must deduct:

(1) A personal need allowance for the use of the institutionalized spouse (at least $30.00 per month);[109]

(2) A "community spouse monthly income allowance;"[110]

(3) A "family allowance;"[111] and

(4) Certain medical expenses, such as Medicare and health insurance premiums and other unreimbursed costs of care.[112]

For planning purposes, the community spouse monthly income allowance and the family allowance, also collectively known as the "maintenance allowance,"[113] are the most important. The difference between the maintenance allowance and the community spouse's monthly income, if any, is considered unavailable to the institutionalized spouse.[114] That amount may then be contributed to the community spouse.

The community spouse monthly income allowance is the amount by which the "minimum monthly maintenance needs allowance" exceeds the income otherwise available to the community spouse.[115] The minimum monthly needs allowance is 122 percent of the official poverty line for a family of two plus an "excess shelter allowance," provided the total does not exceed $1500.00 per month.[116] The excess

108. 42 U.S.C.A. § 1396r-5(d)(1) (Supp. 1989).
109. *Id.* § 1396r-5(d)(1)(A) (Supp. 1989).
110. *Id.* § 1396r-5(d)(1)(B).
111. *Id.*
112. *Id.* § 1396r-5(d)(1)(D). The Wyoming legislature recently passed legislation providing that for purposes of determining the amount of the institutionalized spouse's income which must be applied to the cost of care, two-thirds of the maximum amount of allowance authorized by MCCA shall be deducted from the institutionalized spouse's income. 1990 Wyo. Sess. Laws, ch 65, § 1. It is unclear whether this is intended to reduce the personal needs allowance, the community spouse monthly income allowance or the family allowance. It does not appear that MCCA permits such a reduction.
113. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(l) (Proposed).
114. *Id.* ch. II.II, § 14(c)(i).
115. 42 U.S.C.A. § 1396r-5(d)(2) (Supp. 1989).
116. *Id.* § 1396r-5(d)(3)(A)-(C). That allowance increases to 133 percent of the poverty line effective July 1, 1991, and to 150 percent of the poverty line effective July 1, 1992. *Id.* §§ 1396r-5(d)(3)(B)(ii)-(iii). The $1500.00 cap is indexed to inflation. *Id.* § 1396r-5(d)(3)(C); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(m) (Proposed).

shelter allowance is the amount by which the community spouse's housing expenses (rent or mortgage payments plus taxes, insurance and utilities) exceed thirty percent of the poverty line calculation.[117]

Upon request, either spouse is entitled to notice of the monthly income allowance determination and may appeal from that determination.[118] The minimum monthly maintenance needs allowance may be increased because of "exceptional circumstances resulting in significant financial duress," in which case the community spouse is entitled to "an amount adequate to provide such individual income as is necessary."[119] That amount may exceed the $1500.00 monthly cap.[120]

The "family" allowance is the difference between the income available to each family member and "at least" one-third of the poverty line calculation.[121] A "family member" is a minor or dependent child, dependent parents or dependent siblings of either spouse that reside with the community spouse.[122]

The community spouse allowance, family allowance, personal needs allowance and any expenses for medical or remedial care provided to the institutionalized spouse are combined and subtracted from the income previously attributed to the institutionalized spouse.[123] The institutionalized spouse must contribute the difference, if any, to the cost of care.[124]

The end result of the income attribution and community spouse income protection provisions is to reserve a substantial portion of the couple's income for the community spouse. The provisions do not, however, provide any protection for a single person faced with nursing home care.

2. Treatment of Assets.

MCCA contains similar rules for the attribution of spousal resources.[125] Only assets in excess of those allocated to the community spouse are available to the institutionalized spouse.[126]

First, the state must compute the total value of the spouses' interests in resources, whether joint or individual, as of the beginning of a "continuous period" of institutionalization.[127] The spouses' interests include

117. 42 U.S.C.A. § 1396r-5(d)(4).
118. *Id.* §§ 1396r-5(e)(1)(B), 1396r-5(e)(2)(A)(i).
119. *Id.* § 1396r-5(e)(2)(B).
120. *Id.* § 1396r-5(d)(3)(C).
121. *Id.* § 1396r-5(d)(1)(C). The current family allowance in Wyoming is $270.00 per family member minus the income available to that individual. WYOMING PUBLIC ASSISTANCE MANUAL § 6106.02 (effective Oct. 1, 1989).
122. 42 U.S.C.A. § 1396r-5(d)(1)(Supp. 1989); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(n) Proposed).
123. 42 U.S.C.A. § 1396r-5(d)(1)(Supp. 1989).
124. *Id.*
125. *Id.* § 1396r-5(c).
126. *Id.* § 1396r-5(c)(2)(B).
127. *Id.* § 1396r-5(c)(1)(A). A "continuous period" of institutionalization is thirty days. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(f) (Proposed).

"all the resources" of either spouse or both spouses, regardless of community property or marital property laws.[128] "Resources" do not include property excluded under SSI (SSI excludes the home), household goods, personal effects or an automobile, even if the value of such goods, effects or automobile exceeds the SSI limitations.[129] The "spousal share" is one-half of the total spousal assets.[130]

Second, the state must determine what portion of the total spousal resources are available to the institutionalized spouse to contribute to the cost of care. This is done by determining the "community spouse resource allowance," since only resources in excess of that allowance are available to the institutionalized spouse to contribute to the cost of care.[131]

The community spouse resource allowance is determined by computing the greater of: (1) $41,720.00;[132] (2) the lesser of the the spousal share (one-half the total spousal resources) or $62,580.00; or (3) any amount determined after a fair hearing.[133] The community spouse allowance is the amount, if any, by which that figure exceeds the assets otherwise available to the community spouse.[134] The remaining assets which are not part of the community spouse allowance, are considered available to the institutionalized spouse.[135]

There are exceptions to the above attribution rule. Most importantly, the state may approve Medicaid eligibility even if the resources attributable to the institutionalized spouse exceed the Medicaid resource limits if the denial of benefits would "work an undue hardship."[136] The determination of what constitutes an undue hardship has been left to

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128. 42 U.S.C.A. § 1396r-5(c)(2)(Supp. 1989).

129. *Id.* § 1396r-5(c)(5)(A), (B).

130. *Id.* § 1396r-5(c)(1)(A)(ii); RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(q) (Proposed). Either spouse may request a copy of the state's resource assessment and request a fair hearing regarding that assessment. 42 U.S.C.A. § (e)(2)(A)(iii) (Supp. 1989).

131. 42 U.S.C.A. § 1396r-5(c)(2)(B). Wyoming refers to the community spousal allowance as the "spousal allowance." RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(o) (Proposed).

132. The $41,720.00 figure is computed by determining the greater of $12,000.00, indexed to inflation (currently $12,516.00) or the amount specified by the State. 42 U.S.C.A. § 1396r-5)f)(2)(A)(i) (Supp. 1989). As of July 1, 1990, the amount specified by the State as the spousal resource standard in Wyoming is two-thirds of the maximum amount authorized by MCCA. 1990 Wyo. Sess. Laws, ch. 65, Section 1. The maximum allowed by MCCA is $60,000.00, subject to changes in the consumer price index (currently $62,580.00). 42 U.S.C.A. § 1396r-5(f)(2)(A)(ii)(II) and (g) (Supp. 1989).

133. 42 U.S.C.A. § 1396r-5(f)(2)(A) (Supp. 1989); *see also,* RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 16(g)(ii) (Proposed).

134. 42 U.S.C.A. § 1396r-5(f)(2)(B)(Supp. 1989). Assume, for example, that the spousal share is $20,000.00. The first step in the computation is to determine which is greater: $41,720.00 (the spousal resource standard in Wyoming), or the lesser of $20,000.00 (the spousal share) or $62,580.00. The answer is $41,720.00.

135. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 16(g)(iii) (Proposed).

136. 42 U.S.C.A. § 1396r-5(c)(3)(C)(Supp. 1987); RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 16(g)(iii)(A)(I) (Proposed). The institutionalized spouse

the states.[137] The provision has been narrowly interpreted in Wyoming.[138] After the institutionalized spouse's eligibility for Medicaid is established, the resources of the community spouse are considered unavailable to the institutionalized spouse during any period of continuous institutionalization.[139]

3. Transfers of Assets.

MCCA made six important changes to the TEFRA transfer of assets provisions: (1) transfers of assets may be considered in determining eligibility only with respect to persons in nursing homes;[140] (2) states must consider transfers of assets in determining eligibility of persons in nursing homes;[141] (3) the period within which transfers are subject to scrutiny was extended;[142] (4) there are additional exceptions to the prohibition on the transfer of homes;[143] (5) certain transfers between spouses and from an institutionalized spouse to a community spouse are permitted;[144] and (6) there will be exceptions for transfers for which the transferor intended to receive fair market value or which were made for reasons other than qualifying for Medicaid.[145] Assets subject to the transfer of assets provisions are "resources" as defined by SSI, without regard to the SSI exclusions.[146]

First, MCCA eliminated the TEFRA provision which permitted states to consider the transfer of assets by persons who do not require nursing home care.[147] Accordingly, a person not in need of nursing home care may now transfer assets for less than fair market value immediately before aplying for Medicaid, provided he or she is not in need of nursing home care. The change is likely to have little impact, however, since most persons age sixty-five or over have Medicare coverage for hospital and other medical expenses and Medicaid becomes significant only when nursing home care is necessary.

Second, MCCA made the transfer of assets preclusion mandatory.[148] Under Boren-Long and TEFRA, Congress permitted states to deny Medicaid to persons who transferred assets for less than fair market

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shall also not be considered ineligible to the extent the institutionalized spouse has assigned to the state any rights to support from the community spouse or if the institutionalized spouse lacks the ability to execute an assignment. 42 U.S.C.A. § 1396r-5(c)(3)(A) & (B) (Supp. 1989).

137. 42 U.S.C.A. § 1396r-5(c)(3)(C) (Supp. 1989).

138. An undue hardship exists only if the denial of eligibility would "impose suffering to an extent that is medically harmful or detrimental to the health and well being of an individual." RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 3(u) (Proposed).

139. 42 U.S.C.A § 1396r-5(c)(4) (Supp. 1987).

140. 42 U.S.C.A. § 1396p(c)(1) (Supp. 1989).

141. *Id.*

142. *Id.* § 1396p(c)(1)(A).

143. *Id.* §§ 1396p(c)(2)(A)-(D).

144. *Id.* §§ 1396r-5(f)(1), 1396p(c)(2)(B) (Supp. 1987).

145. 42 U.S.C.A. § 1396p(c)(2)(C)(Supp. 1989).

146. *Id.* § 1396p(c)(5).

147. Pub. L. No. 100-360, § 303(b), 102 Stat. 760 (1988).

148. 42 U.S.C.A. § 1396p(c)(1)(Supp. 1989).

value within twenty-four months of application. States now "must" deny Medicaid to a person in a nursing home or medical institution who, within thirty months of the date of application, transferred assets for less than fair market value.[149] The period of ineligibility will be the shorter of thirty months or the number of months determined by dividing the uncompensated value of the transferred asset by the the statewide private pay nursing home rate or the community average private pay rate, whichever the state chooses.[150] The State of Wyoming uses the facility private pay rate.[151]

Third, the period within which transfers are subject to scrutiny for Medicaid eligibility purposes has been extended from twenty-four months to thirty months.[152] Therefore, any transfer for less than fair market value made within thirty months of applying for Medicaid will be considered in determining eligibility.

Fourth, the exceptions to the prohibition on the transfer of a home have been changed. The transfer of a home for less than fair market value within thirty months of applying for Medicaid will be considered in determining eligibility unless the transfer was made to a:

(1) Spouse;[153]

(2) Child under 21 or a child who is blind or disabled;[154]

(3) Sibling of the transferor who has an equity interest in the home and who resided in the home for two years immediately before the transferor became institutionalized;[155] or

(4) Child who resided in the home for two years immediately before the transferor became institutionalized and who provided "care" to the transferor such that institutionalization was postponed.[156]

Fifth, MCCA permits two types of transfers between spouses. First, a transfer of assets for less than fair market value from one spouse to or for the benefit of the other spouse is permissible so long as the receiving spouse does not transfer the asset to another person for less than fair market value.[157] Second, after the allocation of assets as described above,[158] an institutionalized spouse may transfer assets to the community spouse provided the value of the assets so transferred does not exceed the community spouse resource allowance.[159] Such a

149. *Id.*
150. *Id.* § 1396p(c)(1)(A)-(B).
151. RULES PERTAINING TO MEDICAID, *supra* note 44, ch. II.II, § 15(d)(iii)(C) (Proposed).
152. 42 U.S.C.A. § 1396p(c)(1)(Supp. 1989).
153. *Id.* § 1396p(c)(2)(A)(i).
154. *Id.* § 1396p(c)(2)(A)(ii).
155. *Id.* § 1396p(c)(2)(A)(iii).
156. *Id.* § 1396p(c)(2)(A)(iv).
157. *Id.* § 1396p(c)(2)(B).
158. *See supra* notes 125-129 and accompanying text.
159. 42 U.S.C.A. § 1396r-5(f)(i)(Supp. 1989).

transfer must be made "as soon as practicable" after the date of the initial determination of Medicaid eligibility.[160]

Finally, an otherwise prohibited transfer will not effect Medicaid eligibility if the transferor makes a "satisfactory showing" to the state, in accordance with regulations to be promulgated by HHS, that the individual intended to dispose of the asset for fair market value[161] or other valuable consideration or the assets were transferred "exclusively for a purpose other than to qualify for [Medicaid]."[162] Thus far, HHS has not promulgated such regulations, although the State has proposed rules.[163]

The MCCA transfer of asset provisions apply to assets transferred on or after July 1, 1988, other than transfers from one spouse to another.[164] MCCA applies to inter-spousal transfers made on or after September 30, 1989.[165]

IV. RELATIVE RESPONSIBILITY

A. *Spousal Responsibility*

A spouse is financially responsible for his or her spouse.[166] The MCCA income and asset attribution rules discussed above establish the liability of the community spouse for the costs of care of the institutionalized spouse.[167] In essence, no income attributed to the community spouse is considered available to the institutionalized spouse.[168] Similarly, no resources attributed to the community spouse are available to the institutionalized spouse.[169]

B. *Liability of Adult Children*

The relatives of an individual in need of nursing home care, particularly adult children, are often concerned about their responsibility for the costs of such care. Absent a contractual or other agreement to the contrary, they are not responsible to pay any part of the cost of care.[170] Aside from whatever moral obligation the adult children feel,

160. *Id.*

161. The fair market value is "the amount of money the sale of property would bring on the open market in the community where the property is located." RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 3(zz) (Proposed).

162. 42 U.S.C.A. § 1396p(c)(2)(C) (Supp. 1989).

163. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, §§ 15(d)(ii)(H)-(I) (Proposed).

164. Pub. L. No. 100-360, tit. III, § 303(g)(2)(B), 102 Stat. 764 (1988).

165. *Id.* § 303(g)(1)(B), 102 Stat. 763.

166. 42 C.F.R. § 435.602(b) (1988); RULES PERTAINING TO MEDICAID, *supra* note 44, ch. II, § 3(ddd)(Proposed).

167. *See supra* notes 99-139 and accompanying text.

168. 42 U.S.C.A. § 1396r-5(b)(1).

169. *Id.* § 1396r-5(c)(4).

170. Financial responsibility, other than spousal responsibility, is limited to a parent with a child under age twenty-two that is living with the parent. 42 C.F.R. § 435.602(a)(1988); RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 3(ddd)(Proposed).

there is no obligation for an adult child to contribute to the costs of care of his or her parents.

Although there is no direct relative responsibility, the children or other heirs of Medicaid recipients often bear the cost of nursing home care indirectly. Parents who had planned to leave their property and savings to their children may have to use those assets to pay for nursing home care. As a result, the assets which the children had hoped and expected to inherit are used to pay for nursing home care. Accordingly, while there is no direct responsibility for the care of a parent, one effect of restricting Medicaid to the very poor is to divest many middle class persons of their inheritance.[171]

V. LIENS AND RECOVERIES OF BENEFITS

Planning for nursing home care should include a consideration of the possibility that the state may file liens against the property or the estate of a Medicaid recipient to recover payments made on behalf of that individual. The reason for such planning is that property which is exempt for purposes of Medicaid eligibility may become available to the state, either during the life of a recipient or after the recipient's death, to recover Medicaid benefits paid. A plan which does not consider this potentiality is seriously deficient. It is of little benefit, ultimately, to preserve an individual's property only to see it decimated through the recovery of benefits.

A. Lien's Against a Medicaid Recipient's Property

States may, under certain circumstances, recover Medicaid benefits paid on behalf of a recipient during the recipient's lifetime.[172] This is done through placing a lien against the recipient's property.[173] A lien may be imposed against real or personal property of a recipient only pursuant to the judgment of a court that benefits were improperly paid.[174] Wyoming law expressly authorizes the filing of such liens.[175]

Given the restrictions on recoveries during the life of a recipient, such recoveries are not a particularly significant factor in planning for long term care. The greater concern is that the State may recover Medicaid benefits which were properly paid from a recipient's estate.

B. Liens Against a Medicaid Recipient's Estate

States may recover Medicaid payments from the estates of decedents on whose behalf the state has made such payments.[176] Recovery

171. For a discussion of the social policy implications of requiring the middle class elderly to pay for the cost of nursing home care at the expense of their heirs, see Dobris, *Medicaid Asset Planning of the Elderly: A Policy View of Expectations, Entitlement and Inheritance,* 24 REAL PROPERTY, PROBATE TRUST J. 1 (1989).

172. 42 U.S.C. § 1396p(a)(1982 & Supp. V 1987).

173. *Id.*

174. *Id.* § 1396p(a)(1)(A).

175. WYO. STAT. § 42-4-109(b)(1977).

176. 42 U.S.C. § 1396p(b)(1) (1982).

is limited to the estates of recipients who were sixty-five years of age or older at the time Medicaid was paid.[177] Recovery is accomplished through the filing and execution of a lien against the property of the decedant's estate.[178] Such recovery is specifically authorized by Wyoming law.[179] Recovery is permitted only if the deceased recipient has no surviving spouse, no surviving child under age twenty-one and no surviving child that is blind or permanently and totally disabled.[180]

Although it appears that states could recover a significant amount of benefits through filing liens, few states have aggressively pursued such recoveries, Wyoming not among them.[181] Those which do recover substantial funds.[182]

Recoveries from the estates of former Medicaid recipients appear to be a major, untapped source of funds, which more and more states are likely to pursue, particularly in the face of declining revenues. Since Wyoming law expressly permits such recoveries, the potential recovery of Medicaid benefits through the filing of liens should be a consideration in planning for long term care.

VI. IS ASSET DIVESTMENT APPROPRIATE?

It is possible to avoid the transfer of assets preclusion, the recovery of benefits from the estate of a client and virtually assure Medicaid eligibility through some form of asset divestment.[183] There is, of course, a significant financial incentive to do so. There are, however, reasons not to do so. Accordingly, before embarking on a program of asset divestment to ensure Medicaid eligibility, the question of whether asset divestment is appropriate for a particular individual must be answered. The answer depends on a consideration of several elements.

There are two threshhold questions. First, whether the individual meets the categorical requirements. Second, assuming the answer to

177. *Id.* § 1396p(b)(1)(B); 42 C.F.R. § 433.36(h)(i) (1988). There has been some confusion about whether the age restriction refers to the age at which the recipient is admitted to a nursing home, or simply to the age at which benefits are paid. MEDICAID RECOVERIES FROM NURSING HOME RESIDENTS' ESTATES COULD OFFSET PROGRAM COSTS, GAO REP. HRD-89-56, EXEC. SUMMARY, *reprinted in* Medicare & Medicaid Guide (CCH), ¶ 37,675 (Mar. 7, 1989). It appears that the proper interpretation is that states may recover any benefits paid after the recipient reaches age sixty-five, regardless of the recipient's age at the time of admission to the nursing home.

178. 42 U.S.C. § 1396p(b)(1)(B)(1982).

179. WYO. STAT. § 42-4-109(c)(1977).

180. 42 U.S.C. §§ 1396p(b)(1)(B)(ii)-(iii)(1982). The Social Security Act also permits recovery from the estate of the recipient's spouse. *Id.* § 1396p(b)(2). There is no provision in Wyoming law which permits such recoveries.

181. MEDICAID RECOVERIES FROM NURSING HOME RESIDENTS' ESTATES COULD OFFSET PROGRAM COSTS, GAO REP. HRD-89-56, *reprinted in* Medicare & Medicaid Guide (CCH), ¶ 37,675 (Mar. 7, 1989). It is estimated that fourteen percent of Medicaid nursing home residents own a home with an average value of $31,000.00. *Id.* The GAO estimates that a state which aggressively pursues recoveries from the estates of former recipients could recover up to sixty-eight percent of the benefits paid for nursing home care. *Id.*

182. *Id.*

183. *See infra* notes 193-216 and accompanying text.

the first question is yes, whether the income the individual expects to receive during any period of institutionalization exceeds the applicable eligibility limits. If the answer to either question is no, asset divestment is unlikely to be of any benefit since Medicaid eligibility will be denied regardless of the individual's assets. If the answer to both questions is yes, several additional factors must be considered, including the individual's marital status, estate plan, the availabilty of family or other care givers and the individual's attitude towards welfare. These considerations are discussed below in the context of the individual's marital status, since that profoundly alters any consideration of the need for or appropriateness of asset divestment.[184]

A. Asset Divestment for Single Persons

Since a single person derives no benefit from the MCCA income and attribution rules, the starting point in deciding whether a single person should begin a program of asset divestment is that all the individual's income and assets will be considered available for purposes of Medicaid eligibility unless otherwise exempt.[185] The most important exemption is the home.[186] The failure to divest non-exempt assets in a permissible manner will likely necessitate the liquidation of assets and payment for the cost of care, at which time Medicaid will become available to cover the cost of care.

Asset divestment should be seriously considered for a single person that regards institutionalization as likely to occur within the next several years, hopes to preserve part of his or her estate to pass on to children or other heirs, and is willing to go on welfare. How to divest assets is discussed below.[187]

B. Asset Divestment for Married Persons

The income and asset attribution formulae of MCCA apply to a married person that seeks Medicaid benefits while institutionalized.[188] Therefore, the consideration of whether to divest assets begins with the premise that although the institutionalized spouse must apply some income and assets toward the cost of nursing home care, MCCA protects certain assets and income to permit the non-institutionalized spouse to remain in the community. If a couple's primary objective is

184. The following discussion of asset divestment assumes the applicability of Wyoming law. The underlying principles will apply in any jurisdiction; the primary differences in the consideration will be whether the state's Medicaid program covers medically needy individuals and the income and resource eligibility criteria in that state.

185. 20 C.F.R. § 416.1201(a)(1)(1988); RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, §§ 3(e), 14(c) (Proposed).

186. 42 C.F.R. § 416.1212(b)(1988). The home consists of "the dwelling in which the applicant/recipient resides. The buildings on the land and the land upon which the home is located are included." RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 3(eee)(Proposed). The home remains exempt so long as it is lived in by the individual's spouse, dependent relative or if the individual provides a written statement of intent to return to the home. *Id.* § 14(d)(v).

187. *See infra* notes 193-216 and accompanying text.

188. 42 U.S.C.A. § 1396r-5(a) (Supp. 1989)

to provide for the community spouse in the event one of them is institutionalized, the MCCA income and resource attribution formulae may adequately address concerns about long term nursing care. For persons with other objectives, such as preserving an estate for children, MCCA may not be adequate.

The determination of whether MCCA adequately protects a specific individual or individuals should go beyond a consideration of its effect during the institutionalization of one spouse, which is a relatively simple matter of determining whether the community spouse will be left with sufficient income and assets to be self-sufficient under the MCCA formulae. There are two additional considerations.

First, MCCA's ultimate effect should be considered. That is, if the community spouse dies during the period of institutionalization, the income and assets previously attributed to that spouse may become available to the institutionalized spouse through inheritance[189] or rights of survivorship. In that case, MCCA will be of no value in preserving for heirs the assets previously attributed to the community spouse. The home, and other previously exempt property, will become property of the institutionalized spouse and will likely lose its exempt status.[190] The institutionalized spouse will then lose Medicaid benefits because of the acquisition of such assets. Medicaid benefits will become available only after the institutionalized spouse has liquidated the assets previously attributed to the community spouse and exhausted them paying for nursing home care.[191]

Such a result may be avoided by structuring the community spouse's estate plan so that no additional assets are left to the institutionalized spouse. Alternatively, there is no prohibition on the community spouse transferring for less than fair market value those assets which have been attributed to him or her under MCCA unless those assets were transferred to the community spouse by the institutionalized spouse.[192] If the community spouse requires nursing home care within thirty months after any such transfer, however, that transfer would be subject to the general transfer of assets provisions.

If the institutionalized spouse dies first, Medicaid eligibility may become a concern to the surviving spouse, in which case the considerations change. The surviving spouse must evaluate his or her situation as a single person, as discussed above.

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189. "Resources" includes inherited property. RULES PERTAINING TO MEDICAID, *supra* note 44, ch. II, § 14(c)(viii) (Proposed).

190. The home, for example, is exempt so long as the community spouse lives there. *Id.* The home will become available unless one of the other exemptions applies. *Id.*

191. Medicaid eligibility must be redetermined at least every twelve months and whenever there is a significant change in a recipient's financial condition. 42 C.F.R. §§ 435.916 (a), (c)(2)(1988). The death of a community spouse and the acquisition of the community spouse's assets by the institutionalized spouse is such a significant change.

192. 42 U.S.C.A. § 1396p(c)(2)(b) (Supp. 1989).

C. Avoiding the Transfer of Assets Preclusion

1. Transfer of Property

Since the transfer of assets preclusion only applies to transfers within thirty months of the date of applying for Medicaid, it is self-evident that the denial of Medicaid may be avoided by transferring the property more than thirty months before the date of application for Medicaid.[193] Such a transfer is beyond the scope of the statute and will not affect Medicaid eligibility, regardless of the value of the transferred property. Such a transfer does, however, present a variety of potential problems.

First, transferring property puts the property beyond the control of the transferor. The trusted friend or family member to whom the property is transferred will be under no legal obligation to use the transferred property to support the transferor after the transfer and before institutionalization is required. The transferee may sell or mortgage the property or put it to other use. The property may be involuntarily transferred through execution on a judgment. In short, a myriad of things could happen to the property, leaving the transferor without assets with which to support himself in the event institutionalization is not required or if institutionalization is required within thirty months after the transfer.

Second, if the transferor requires long term nursing home care at any time during the thirty months after the transfer, the transferred assets will be considered available for purposes of Medicaid eligibility. Medicaid will be unavailable unless the state grants an "undue hardship" waiver.[194]

Third, there is the practical difficulty of knowing when to transfer property. Nursing home care often is required because of an acute medical problem. Predicting such an occurence is impossible. It may be possible, however, to predict with some certainty when a person suffering from a chronic condition will require nursing home care.

Fourth, the prospect of going on welfare is repugnant to many people. Some individuals are proud of having always taken care of themselves and their families. The thought of asking for a government handout and bearing the stigma of being a welfare recipient is not acceptable, under any circumstances.

Fifth, the Medicaid reimbursement rates for nursing home care in some states are so low that nursing homes prefer non-Medicaid resi-

193. The transfer of assets also eliminates the possibility that the state will recover Medicaid benefits from the property of the recipient or the estate of the recipient.

194. The State interpets the "undue hardship" waiver very narrowly. Such a hardship exists only if: the applicant is incompetent and the transfer was made by an individual legally responsible for handling the applicant's property; the applicant is incompetent and inherits non-liquid assets which cannot be quickly converted to cash; or a hearing officer makes a determination of undue hardship. WYOMING PUBLIC ASSISTANCE MANUAL, § 6105.07D.b(11) (effective Oct. 1, 1989).

dents.[195] The transfer of assets may result in an inability to obtain placement in an appropriate facility.[196]

Finally, there is no guarantee that the law will not change again. Congress has changed the transfer of assets provisions three times in nine years. The period within which transfers may result in the denial of Medicaid has been increased from two years to thirty months.[197] Congress may decide to require or allow states to look back even longer, thereby destroying, at least in part, the best laid of plans.[198]

Alternatively, one with sufficient assets to pay for nursing home care for more than thirty months can ensure that at least those assets in excess of the amount necessary to pay for thirty month's care are protected. Upon entering the nursing home, the individual simply transfers everything in excess of the amount which will pay for more than thirty months care. At the end of thirty months, the individual is "poor" and there is no problem with the transfer of assets preclusion.[199]

For some persons it is useful to consider transferring assets from one form to another. The reason is that some assets, most notably the home, are exempt.[200] A couple with liquid assets may want to consider transferring those assets into exempt assets.[201] There are limitations on the value of such transfers, however. When the first spouse enters a nursing home, the home is exempt. It may even be transferred to the community spouse.[202] If the community spouse subsequently enters a nursing home, the home may cease to be exempt and there are significant restrictions on transferring the home.[203] Furthermore, if the community spouse predeceases the institutionalized spouse and the home becomes and remains the property of the institutionalized spouse

195. *Meeting the Needs of the Elderly While Responding to Rising Federal Costs,* GAO REP. NO. HRD-86-135 (Sept. 30, 1986), *reprinted in* Medicare & Medicaid Guide (CCH), ¶ 36,301.

196. Medicaid rates in Wyoming have been adequate, thus far, to avoid discrimination against the admission of Medicaid recipients. Interview with Charles Simineo, Director, Office of Health Facilities Compliance, Wyoming Department of Health and Social Services, March 1, 1990.

197. *See supra* note 152 and accompanying text.

198. States have attempted to impose look back periods as long as seven years. See, Buckner v. Maher, 424 F. Supp. 366, 377 (D.Conn. 1976).

199. Assume, for example, that an individual in need of long term care has assets worth $250,000.00. Thirty months of long term care will cost approximately $60,000.00, assuming $2000.00 per month. At the time of institutionalization, the individual may simply transfer $190,000.00 to whomever he or she wishes, pay for the cost of care for thirty months, and then apply for Medicaid (assuming no changes in the transfer of assets preclusion). This ensures that the bulk of the individual's estate passes to others.

200. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II, § 14(d) (Proposed).

201. For example, a couple with $100,000.00 in the bank is in a much different position than a couple that owns a home worth $100,000.00. In the former case, Medicaid will be denied because of excess assets. In the latter case, Medicaid will be available because the home is exempt so long as one of the spouses resides there.

202. 42 U.S.C.A. § 1396p(c)(2)(A)(i) (Supp. 1989).

203. *See* text accompanying footnotes 153-160. Those same restrictions substantially reduce the benefit to a single individual of transferring assets from nonexempt to exempt assets.

at the time of death, it may be available to the state if the state chooses to recover benefits paid.[204]

Rather than the outright transfer of the property to a third party, there are other, potentially better alternatives.

2. The Medicaid Qualifying Trust

Assets may be transferred to a trust which, if properly drafted, will not preclude Medicaid eligibility. A so-called "Medicaid qualifying" trust must place the property beyond the reach of the grantor and the trust corpus must be beyond the reach of the trustee.[205] Accordingly, the trust must be irrevocable and the trustee may not have the authority to invade the principal. If either of these conditions fails, all assets which the trustee has discretion to distribute, including principle, will be considered available for purposes of Medicaid eligibility.[206] If the trust is properly drawn, only the amount which the trustee has authority to distribute will be considered available to the grantor/beneficiary for purposes of Medicaid eligibility.[207] The creation of a Medicaid qualifying trust has the advantages, therefore, of eliminating the possibility that the income from transferred property will not be available to provide for the grantor if institutionalization is unnecessary. And such a trust will significantly reduce the amount considered available to the grantor in the event institutionalization is required.

A Medicaid qualifying trust is not, however, an unmixed blessing. Such a trust is, by definition, irrevocable. The grantor may not subsequently change his or her mind. Generally, the creator of the trust must also maintain a hands-off position regarding the management of such a trust. In addition, there are tax implications.[208] Such costs must be carefully weighed against the potential benefits to be derived from such a trust, including the potential of Medicaid eligibility.[209]

3. The Life Estate

Another alternative is for the transferor to retain a life estate in the property, with the remainder to the person or persons to whom the transferor wishes to leave the property. This option may be particularly attractive when the primary asset is the home. The retention of a life estate preserves the right of the owner to live in the house during his or her lifetime, while ensuring that the intended beneficiaries ultimately receive the property. If it is necessary to apply for Medicaid,

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204. *See supra* notes 176-182 and accompanying text.

205. 42 U.S.C. § 1396a(k)(2) (Supp. V 1987)

206. RULES PERTAINING TO MEDICAID ELIGIBILITY, *supra* note 44, ch. II.II, § 15(c)(i) (Proposed).

207. 42 U.S.C. § 1396a(k)(1)(Supp. V 1989). If the income available to the beneficiary exceeds the Medicaid income limits, Medicaid eligibility will be denied in any event.

208. The tax implications of an irrevocable living trust are beyond the scope of this article. For a discussion of those implications, *see* S. KESS & B. WESTLIN, CCH ESTATE PLANNING GUIDE 154.1 (1989 ed.).

209. The State may waive ineligibility if the denial would result in an undue hardship. 42 U.S.C.A § 1396a(k)(4)(Supp. 1989).

the life estate is exempt to the same extent as a home.[210] If it ceases to be exempt, only the value of the life estate will be considered in determining Medicaid eligibility, provided the transfer was made more than thirty months before application.[211] Assuming the grantor is of advanced age, that value will be slight.

As with a Medicaid qualifying trust, there are tax implications associated with transferring property held in fee into a life estate with the remainder given to others. Such a transfer has gift tax implications,[212] and may be included in the federal estate.[213]

4. Structuring Family Care Giving

It may be possible to avoid the transfer of assets preclusion as it applies to the home by falling within one of the exceptions. As discussed above, a home is not considered available for Medicaid purposes if it is transferred to a child who is under twenty-one or disabled, a sibling of the transferor who has an equity interest in the home and who resided in the home for two years immediately before the transferor was institutionalized, or a child of any age who resided in the home for two years immediately before the transferor became institutionalized and provided care to the transferor such that institutionalization was postponed.[214] These exceptions make it possible to plan for family members to reside with and/or provide care for an elderly or disabled family member in a manner that maximizes the benefit to all.

The majority of persons in need of assistance receive it from family members, who receive no compensation for that assistance.[215] Such assistance frequently permits persons to remain in their homes far longer than would otherwise be possible. Institutionalization occurs only after family members are no longer able to provide adequate care.

If an individual expects to receive care from family members, it may be advisable to consider structuring that care to take advantage of one of the above exceptions. If such care is to be provided by adult children or siblings, and the caregiver resides with the home owner for the requisite time period, the subsequent transfer of the home to the caregiver at the time institutionalization becomes necessary may well be exempt.[216]

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210. RULES PERTAINING TO MEDICAID, *supra* note 44, ch. II.II, § 15(d)(v)(Proposed).

211. WYOMING PUBLIC ASSISTANCE MANUAL, § 6105.7 15 (effective Oct. 1, 1989).

212. For a discussion of the gift tax implications of the transfer of a remainder interest, *see* S. KESS & B. WESTLIN, *supra* note 208, 132.1 (1989 ed.).

213. *Id.* ¶ 206 at 340-42.

214. *See supra* notes 153-156 and accompanying text.

215. In 1985, eighty percent of the elderly lived at home. LONG TERM CARE FOR THE ELDERLY, *supra* note 1 at 19,510. Most of them received care from family members. *Id.* The primary caregivers for men are their wives. *Id.* The primary caregivers for women are their adult children. *Id.*

216. *See supra* notes 155-156 and accompanying text.

There are, of course, many reasons that such an arrangement will not be feasible. Moving in with an elderly parent or sibling that requires care poses numerous potential problems. If, however, such care-giving appears to be likely, the Medicaid eligibility ramifications ought to be considered.

5. Summary

However assets are divested, it must be done more than thirty months before the date of Medicaid application to avoid the reach of the transfer of assets statute. The creation of a Medicaid qualifying trust or a life estate within thirty months of application is a transfer of assets for purposes of Medicaid eligibility. Any such transfers are subject to the possibility of Congress extending the look-back period. Furthermore, the Medicaid laws in the state or states in which the individual resides or plans to be institutionalized need to be considered. The variations among states make it imperative to consider each state individually.

There is no right or wrong answer for everyone. There are, however, numerous considerations and choices with clear ramifications. Whatever the "right" choice for a specific client, it should be made with a clear understanding of the implications of that choice and a consideration of the options.

VII. SOME SUGGESTIONS FOR CHANGE

The dilemma of how to finance nursing home care cannot be resolved until society decides whether long term care is an entitlement, available to all who need it, or a luxury for the wealthy and a right for the poor. Currently, nursing home care is available to those with few assets, who qualify for Medicaid, and those with substantial assets, who can afford to pay their own way. Those in the middle must divest their assets in order to qualify for Medicaid or exhaust the savings of a lifetime before eventually becoming Medicaid eligible.

There is no obvious reason to treat nursing home care differently than other types of health care. Why Medicare covers hospitalization and other medical expenses, and not long term nursing home care, is probably an accident of history. Objectively, there is no reason to consider nursing home care as any less necessary than those types of care which Medicare already covers. It is, arguably, "more" necessary when one considers the financial and emotional burdens imposed on persons in need of such care and their families.

How to finance nursing home care will become an increasingly significant issue. Advances in medical care will, undoubtedly, increase longevity. And the demographics of the baby boom generation will result in substantially larger numbers of elderly persons, many of whom will

require nursing home care.[217] The issue is not whether the costs of nursing home care will rise, but by whom will those costs be paid.[218]

A. Private Insurance

Private nursing home insurance is unlikely to play a major role in financing nursing home care. It is very expensive, often provides limited coverage, many persons covered by Medicare and MediGap insurance believe they have coverage for long term nursing home care, and most policies are available to individuals only, not groups.[219] As a result, only one and one-half percent of the elderly have such coverage.[220]

Nor does it seem likely that any of the other options for nursing home care will provide care for a significant number of persons.[221] The only realistic alternative, therefore, is an expanded government role, either through one of the existing programs—Medicaid or Medicare—or a new program.

B. Expansion of Medicaid

The Medicaid program suffers from two fundamental flaws. First, it varies widely from state to state (and from state to territory). Second, it unsuccessfully straddles the line between a welfare program and a social insurance program.

The variations among states' Medicaid programs are pronounced. There are, in reality, fifty-four different Medicaid programs plus a demonstration program in Arizona.[222] Persons who are eligible in some states are not eligible in others.[223] Services which are covered in some

217. The number of persons needing nursing home care is expected to increase from 1.3 million today to 4.2 million by the year 2020. LONG TERM CARE FOR THE ELDERLY, *supra* note 1 at 19,510. At the same time, the availability of informal caregivers is expected to decrease because of the increasing number of women working outside the home, the decrease in family size, family members living far apart, and the high divorce rate. *Id.*

218. A. RIVLIN & J. WIENER, *supra* note 8 at 237.

219. LONG TERM CARE FOR THE ELDERLY, *supra* note 1 at 19,521.

220. *Id.*

221. The other common option is continuing care retirement communities (CCRCs). CCRCs are residential campuses with a variety of living arrangements, from independent apartments to full nursing care. In exchange for a lump sum entry fee and monthly payments, a resident is guaranteed care for the rest of his or her life in whatever setting is appropriate. Less than one percent of the elderly reside in CCRCs. A. RIVLIN & J. WIENER, *supra* note 8 at 83.

CCRCs are also very expensive. The entrance fees alone for a one bedroom apartment in a CCRC range from $38,000.00 to $68,000.00. CONSUMER REPORTS, 125 (Feb. 1990). Monthly fees vay considerably; the average monthly charge for a one bedroom apartment is $965.00. *Id.* In addition, a number of CCRCs have experienced financial problems and declared bankruptcy or been placed in receivership. *Id.* at 128.

222. Medicare & Medicaid Guide (CCH), ¶ 15,504.

223. For example, some states, such as California provide nursing home coverage for the medically needy. Medicare & Medicaid Guide (CCH) ¶ 15,560. Others, such as Wyoming, do not. *Id.* 15,660. The income and asset limitations also differ from state to state. *Id.* ¶¶ 15,520-15,660.

states are not covered in others.[224] Reimbursement levels in some states are so low that providers of health care, particularly long term care services, discriminate against Medicaid recipients.[225]

The variations create an incentive for persons in need of major medical services, such as long term care, to shop around for a state with liberal eligibility standards, extensive covered services and generous reimbursement methodologies. That incentive then works as a disincentive for states to liberalize eligibility requirements, expand the scope of covered services or improve reimbursement rates. Such actions may result in paying for the care of nonresidents who move to the state and establish residency for the purpose of Medicaid eligibility.

At its best, the Medicaid program, a key strand of the social "safety net," is filled with gaping holes. In those states, as Wyoming, which have chosen to restrict eligibility and the scope of covered services, the net is but a few tattered strands.

Without substantial restructing, Medicaid is not a viable solution to the problem of providing universal nursing home care. The current structure which grants states broad discretion in establishing eligibility criteria, deciding which services to cover and how much to pay for such services needs to be eliminated. Whatever benefits there might be from state administration are far outweighed by the disadvantages caused by significant variations from state to state and the incredible bureaucracy in which federal supervision (or interference, as the case may be) and state discretion have combined to create a program of "labyrinthine complexity."[226] That complexity, which renders the program "virtually unintelligible to the uninitiated"[227] makes informed planning nearly impossible.

Furthermore, the restrictive income and asset limitations which encourage asset divestment only penalize the unsophisticated and unwary. The system should not be designed to encourage voluntary impoverishment.

Only the very wealthy and the very poor can afford to ignore the potential need for and cost of nursing home care. Middle-class Americans face a choice between voluntary or mandated impoverishment. Only the ill-advised or the very proud will stand by and watch the savings of a lifetime be exhausted to pay for nursing home care when appropriate, and legal, planning will preserve those savings for the next generation.[228]

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224. The coverage of optional services varies from Massachusetts, which covers thirty-two optional services, to Puerto Rico and the Virgin Islands, which cover one optional service. Medicare & Medicaid Guide (CCH), ¶ 15,504. Wyoming covers nine optional services. *Id.*

225. *See supra* note 195 and accompanying text.

226. Friedman v. Berger, 547 F.2d 724, 727 (2d Cir. 1976).

227. *Id.* at 727 n.7.

228. It is, of course, very easy to assert that one's parents ought not to be impoverished before becoming eligible for Medicaid. It is rather more difficult to take the position that one will gladly pay higher taxes so that other persons' parents are not forced into impoverishment.

C. Expansion of Medicare

Medicare is a social insurance program, not a welfare program. Eligibiliy is not restricted to those who meet stringent income and asset guidelines, as is Medicaid. It is the only existing program which can be modified to provide universal nursing home care. Expanding Medicare to cover long term nursing home care would require a substantial increase in social security trust fund taxes. At the same time, it should result in a substantial savings of federal and state Medicaid funds since the costs absorbed by Medicare would be eliminated from Medicaid budgets. Such an expansion would likely result in an increase in overall long-term care expenses by broadening the class of persons who would be eligible for such care. Absent a significant increase in available nursing home beds, however, a major increase in nursing home residents is simply not possible.[229]

In addition, the Medicare administrative mechanism already exists. While it is far from perfect and would doubtless require expansion, there would be no need to create an additional bureaucracy.

VIII. CONCLUSION

Through informed long-term planning the benefits of the Medicaid program are available to almost everyone. Without such planning, persons of modest means who require nursing home care face certain impoverishment. Asset divestment to ensure Medicaid eligibility is not for everyone. Informed planning is.

Attorneys have a central role in advising clients concerned with estate and financial planning. Such planning should include a consideration of the need for and financing of long term nursing home care.

It is, in many instances, probably ill-advised, to structure one's life around the possibility of nursing home care. In other instances, that possibility cannot reasonably be ignored. In all instances, it should be intelligently considered.

229. The expansion of nursing home beds is controlled in many states. In Wyoming, for example, the growth of beds is controlled by requiring ninety-two percent occupancy in existing beds before additional beds can be licensed. WYO. STAT. § 35-2-906(b) (Supp. 1989). Whether the number of nursing home beds is a function of the number of persons who need nursing home care or the number of persons who need nursing home care is a function of the number of available beds is open to debate.