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What Hard Work Giveth the Nursing Home Taketh Away: Asset Preservation Under Medicaid

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DAVID J. ZUMPANO†

I. INTRODUCTION

We work our entire lives to provide for ourselves and our family's daily needs. We pay Social Security Tax and many of us purchase disability insurance and workers compensation insurance to ensure that if we become unable to work, our individual and family needs will be provided for. Fortunately, most of us will live-out our working lives without suffering a serious debilitating condition. However, as we become elderly[1] our ability to work is significantly reduced and, in many instances, lost. In order to provide for ourselves in later years, most of us establish various forms of savings and anticipate receiving Social Security from our lifetime of contributions. We expect that our savings and Social Security will be sufficient to sustain us when we are no longer able to work.

Increasingly, elderly Americans are discovering all too late that their lifetime of savings and Social Security benefits are insufficient to meet their needs in the event they require long-term health care. The cost of long-term care is exorbitant and the number of elderly Americans requiring such care is growing rapidly. It is hard to imagine any American that has not had to confront this issue on a personal level for someone close to them. In many instances, the elderly, who require long-term care, are stripped of their lifetime of savings and their autonomy. If we have any respect for the elderly or if we hope to curb their need for long-term care, we must make great efforts to preserve their financial independence and autonomy.

Part of preserving the elderly's autonomy is to ensure they do not become impoverished. Not having the financial means to provide for ones self takes away the ability to be independent. If the elderly become dependent on others, their choices become limited and they are forced to accept a life determined by others. What most people look forward to as being the "twilight" of life can

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† David J. Zumpano, J.D., C.P.A. is a 1992 graduate of Syracuse University College of Law and received his B.S. in Accounting at LeMoyne College, Syracuse, NY in 1987. Mr. Zumpano is an active member of the National Academy of Elder Law Attorneys, the Trusts and Estates Section of the American Bar Association, and the Elder Law Section of the New York State Bar Association, and the New York State Society of Certified Public Accountants. Mr. Zumpano is a practicing attorney in Utica, New York with a vast majority of his practice dedicated to Tax and Estate & Medicaid Planning.

1. Throughout this article, individuals age 65 and older are referred to as "the elderly".

instead be a time of helplessness and despair. We must, therefore, address the cost of long-term care and how the elderly will pay for it if they fall ill.

In most, if not all, instances when the elderly cannot afford the cost of long-term care, the burden falls upon the government. Medicaid is the federal government's long-term care insurance for Americans and is often referred to as an "entitlement." The growing number of elderly on Medicaid and the massive costs to provide for them is beginning to cause lawmakers to rethink who should be entitled to Medicaid. The qualification rules under Medicaid are complex. Because of this, many healthy elderly individuals dispose of their assets and savings to ensure that they qualify for Medicaid, if and when they should require long-term care.

There is an urgent need to address the cost of long-term care and how the elderly can pay for it without becoming impoverished or losing their autonomy. We must also take a hard look at Medicaid to determine its usefulness and effectiveness in dealing with this growing problem. With the federal tax base shrinking and the cost to provide for the elderly exploding, alternatives must be explored to ensure the elderly have other viable options available to them. If we fail to address these issues soon, we are headed for disaster.

This article will provide background information in the form of statistical data in reference to the elderly in America, the cost of nursing home care, and government spending on Medicaid and Medicare. It will also discuss the importance of preserving the autonomy of the elderly and provide a detailed review of the criteria one must meet to qualify for Medicaid including income and asset resource allowances, transfer rules for assets and the related penalty periods, the available exceptions to the Medicaid qualification rules, and the spousal options of last resort. Lastly, Part V will review other estate preservation options.

II. THE COST OF GETTING OLD

America is aging. The number of Americans aged 65 or older has more than tripled in the last ninety years to 12.5% of today's population.[2] The significant increase is due primarily to our longer life expectancies. While an average American's life span at the turn of the century was 47, today's elderly can expect to live to be more than 80.[3] In fact, the fastest growing segment of today's population is composed of those aged 85 or more[4] and the number of

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2. *See Symposium: Legal Issues Relating To The Elderly*, 42 HASTINGS L.J. 683, 688 & 720 (1991), [hereinafter *Symposium*]; *See also* Christopher Farrell et al., *The Economics of Aging*, BUS. WK., Sept 12, 1994, at 60. [hereinafter *Economics*]; Jan Ellen Rein, *Preserving Dignity and Self-Determination of the Elderly in the Face of Competing Interests and Grim Alternatives: A Proposal for Statutory Refocus and Reform*, 60 GEO. WASH. L. REV. 1818, 1820, (1992), [hereinafter *Preserving Dignity*].

3. *See Symposium, supra* note 2, at 689. *See also Economics*, note 2, at 60.

4. *See Symposium, supra* note 2, at 690. *See also Economics*, note 2, at 60.

elderly is expected to nearly double in the next 35 years to an estimated 76 million with 13.3 million representing those over age 85.[5] Currently, one in five elderly over age 85 reside in nursing homes.[6]

Aging in and of itself presents many physical, emotional and social concerns to the elderly. The potential of financial hardship during old age and the elderly's ability to remain autonomous become issues of grave concern to them. The elderly's autonomy is jeopardized if they lack the required physical, emotional, social and/or financial means to remain independent.

The inability of the elderly to remain autonomous has lead to an increasing need for nursing home care.[7] The number of elderly needing long-term care is expected to reach 13.8 million by 2030, up from 7.1 million in 1990, and those requiring nursing home care is expected to increase to 5.3 million from 1.5 million over the same period.[8] The Federal Agency for Health Policy and additional research estimates that half of all elderly men and a third of all elderly women will spend time in a nursing home.[9] Almost half will stay longer than a year, and of those, two-thirds will deplete their entire savings to pay for the care received.[10]

The average yearly cost of nursing home care is between $30,000 and $60,000.[11] The high cost of care forces the elderly to consider how they would pay for care should the need arise. An increasing number of middle-income elderly are concerned with the possibility of being impoverished by future medical care needs. Therefore, they are depleting their assets in order to ensure they are eligible for Medicaid if and when the time comes they require nursing home care.[12] As a result, "Medicaid planning" for better or worse, has lead to a growing debate over whether the qualifications for Medicaid should be drastically changed to prevent such planning. While Medicaid qualifications were severely restricted by the Omnibus Budget Reconciliation Act (OBRA) of 1993, signed into law by President Clinton August 10, 1993,[13] some argue the changes did not go far enough.

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5. *See Economics, supra* note 2, at 60. *See also* Melinda Beck, *The Grey Nineties* NEWSWEEK, Oct. 4, 1993, at 65; *Preserving Dignity, supra* note 2, at 1847.

6. *See* Douglas R. Stanton, *The Case for Nursing Home Insurance: Financial Planners Should Consider Long-Term Care Insurance for Their Wealthy, Elderly Clients With Assets to Protect*, 33 TRUSTS & ESTATES 2 at 7.

7. *See* further discussion of this topic *supra*, note *25*.

8. *See Economics, supra* note 2 at 60.

9. *See id.; See also Preserving Dignity, supra*, note 2 at 1820; Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 721 (1992), [hereinafter *Options*].

10. *See Stanton, supra*, note 6 at 2.

11. *See* Christine Dugas, Newsday's Fiscal Fitness, *Keeping Your Money Out Of The Home: Nursing Homes Aren't Your Only Option For Long-Term Care*, NEWSDAY, June 12, 1994, at A88.

12. *Id.*

13. *See* discussion of OBRA '93 in Part IV of this article *infra*.

The cost of Medicaid is becoming more burdensome. The Congressional Budget Office estimates that health care costs for the "elderly, poor, and disabled will account for 18.5% of all government spending in 1994 and 24.1% by 1999."[14] In addition, Medicaid and Medicare is expected to double over the next 10 years.[15] Medicaid and Medicare spending may rise from the current level of 3.8% to 11% of the national income over the next 30 years and their budgets would account for more than half of all current federal taxes collected.[16] In the short term, increases in Medicaid and Medicare will account for half of the growth in federal spending.[17] State spending for Medicaid increased 22% in 1991 and 33% in 1992 and it represents the fastest-growing component of state budgets.[18]

Although the number of elderly are growing and the costs to care for those in need of care is increasing, we cannot blind ourselves to the essential need to preserve the elderly's autonomy. The preservation of the social and economic viability of the elderly will ensure them a more productive life and perhaps enable them to remain physically and mentally fit, ultimately resulting in curbing the costs of care.

III. PRESERVING THE AUTONOMY OF THE ELDERLY

Autonomy is innate at any age, but for the elderly it is critical for their survival. Psychologist have found that many conditions previously considered to be caused by old age are actually caused by a breakdown in environmental conditions which, if corrected, could alleviate the condition altogether.[19] As Professor Rein notes throughout his article, we must proceed with great caution when appointing guardians and conservators for the elderly, especially when it results in the elderly's loss of control over their assets.[20] We must also ensure that our personal desires and feelings do not over power those of the truly competent elderly.[21] The following example illustrates this point.

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14. *See Elderly Care: The Impact of Seniors on Medicaid*, HEALTH LINE, Sept. 29, 1994.

15. *See id.*

16. *See* Robert J. Samuelson, *Unspeakable Runaway Spending*, THE WASHINGTON POST, August 3, 1994, at A17.

17. *See Medicare, Medicaid Curbs Needed To Address Deficit, Schalala Says*, 20 BNA PENSION & BENEFITS REP. 10 at 558 (March 8, 1993).

18. Adam Clymer, *Health Debates Splinters After Initial Consensus*, THE NEW YORK TIMES, April 13, 1994 at B8.

19. *See* Preserving Dignity *supra* note 2 at 1837.

20. *See id.*

21. Note in *Preserving Dignity*, *supra* note 2, at 1828 citing Cummings v. Sanford, 388 S.E.2d 729 (Ga. Ct. App. 1989), wherein the court appointed the daughter of a 65 year old woman, her guardian after finding the mother lacked the capacity to manage her-own money. The only evidence presented showed the mother maintained three homes, took lavish vacations with her other children and could not account for how she expended a few thousand dollars although she had plenty more. Note also *Preserving Dignity*, *supra* note 2, at 1836 citing The Conservatorship of Earl B., No 79,197 Prob (San Mateo County Cal., Jan 1985), wherein Earl B. was "belligerent" and spent most of his assets on the

An elderly couple in their eighties resided together in their countryside home which they shared for more than 60 years.[22] The wife became feeble with age and the children, all of whom lived out of town, became concerned she might fall and hurt herself. They considered placing her in a nursing home but due to her insistence, decided to let her remain in her countryside home and hired nurse aids to assist her during the day. A couple of months later, while cooking, the mother fell and broke her hip, and during her recuperation, she died from causes indirectly related to the surgery. Although her death distressed the family, they found comfort in knowing she remained autonomous and maintained her quality of life until she died.

The death of the wife, however, had a grave effect on the husband. He became depressed and began to turn within himself. The family provided much love and support, but little by little, for fear of him hurting himself and in an attempt to help him, they dispossessed him of his daily chores. For most of his 87 years, the father had utilized his wood stove to heat his home, plowed his driveway, and mowed his lawn. The family removed the wood burning stove and had the lawn and driveway maintained by hired hands. Unknowingly to the family, the father's autonomy was slowly taken away. He turned further and further into himself and within a year, he was placed in a nursing home unable to recognize his children when they visited. He died less than a year later.

If given the choice, most would choose a death with circumstances similar to the wife's than to the husband's. She insisted on staying home regardless of her feebleness and died as a result. However, she was able to maintain her autonomy and enjoy her full quality of life and the ability to make her own decisions up to her death. The husband was not as fortunate. The family was not to blame. Most likely, the wife's death was the principal cause of him turning inward, but perhaps if he had been allowed to remain autonomous, the process of turning inward could have been slowed. Even if the chores which he was accustomed to doing caused him harm, continuing to do them would have preserved his autonomy and would perhaps enabled him to prevent living his last years in oblivion and in a nursing home.

The above scenario illustrates that a fine line exists between preserving and destroying the elderly's autonomy. The elderly's autonomy is seriously threatened when institutionalization and/or financial impoverishment is at issue.[23] Autonomy for the elderly is directly connected to their physical and mental well being. Despite a nursing homes "presumably therapeutic" environ-

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lawsuit" petitioned the court to become Earl's conservator. The court appointed her as such within a year, Earl's mental, physical, and emotional condition had significantly deteriorated. A study on Earl B. cited by Professor Rein raised the question whether the courts decision was correct or whether the decision hastened Earl's condition.

22. This example is taken from the writers personal experience and is being used to illustrate the foregoing point.

23. *See Preserving Dignity*, *supra* note 2, at 1838.

ment, the elderly physically and psychologically deteriorate upon entering a nursing home.[24] The primary cause of this deterioration is due to the elderly's loss of autonomy caused by their loss of control of their surroundings, assets, and the strict regiment and institutional atmosphere of nursing homes.[25]

If cost concerns are eliminated, 87.5% of the elderly would prefer home care over nursing home care.[26] While the elderly view nursing homes as a place to die rather than get better, they still impoverish themselves and enter nursing homes because they want to preserve their lifetime of savings, to provide security for their spouse and/or an inheritance to their children.[27] It is unfortunate that the elderly must give up their autonomy in order to preserve it, that is, give up their financial independence in order to insure that it is not taken from them. How the elderly divest themselves in their pursuit to ensure they qualify for Medicaid, if nursing home care is required, has become as important as how well they care for themselves to ensure their autonomy is preserved.

IV. QUALIFYING FOR MEDICAID

A. INCOME AND ASSET RESOURCE ALLOWANCES

Medicaid was established under Title XIX of the Social Security Act of 1965 and is detailed at 42 U.S.C. §§ 1396-1396s. The corresponding regulations are set forth at 42 CFR § 430 et seq. (as amended). Medicaid is funded by both state and federal monies, and states are given authority to proscribe laws and regulations to administer the program.[28] Some states also require financial participation at the local level.[29]

Federal law provides that any individual receiving assistance under the Supplemental Security Income (SSI) program or Aid to Dependent Children are eligible to receive Medicaid.[30] However, a vast majority of applicants must qualify under the eligibility standards promulgated by each state as provided by federally established guidelines.[31] Each state may establish income and asset limitations which cannot be exceeded unless the applicant can show that they require more than the amounts allowed.[32] The limits usually differ depending upon whether the Medicaid applicant is applying for in-home care or nursing

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24. *See id.* at 1858.
25. *See id*. at 1859.
26. *See id.* at 1860.
27. *See id.* at 1861.
28. *See* 42 U.S.C. § 1396a(a)(10)(1993).
29. For example, in New York, the State requires each of its counties to fund a portion of the Medicaid costs within the county.
30. *See* 42 U.S.C. § 1396a(a)(10)(1993).
31. *See* 42 U.S.C. § 1396a(a)(10) - (17)(1993).
32. If you can show a legitimate need for the excess, your application must be approved. *See* 42 U.S.C. § 1396p(c)(2)(D) and note further discussion of topic at section IV(d) *infra*.

home benefits. Assets or income of the Medicaid applicant, in excess of the stipulated amounts, must be "spent down" to the mandated amounts in order for the applicant to qualify.[33]

In an attempt to avoid total impoverishment of a Medicaid applicant's spouse, the federal guidelines were modified in 1988 to mandate states to provide higher income and asset resource allowance limits if the Medicaid applicant had a spouse who was not institutionalized.[34] Income and asset limits are adjusted annually to reflect increases in the "cost of living"[35] and certain assets are generally exempt from being counted when calculating the available assets of the applicant. These exemptions include an applicant's home, household goods and furnishings, an automobile, a luxury account[36], a prepaid burial account[37] (up to $1500), and personal belongings (i.e. jewelry & clothing)[38]. Also, assets such as IRA's, pensions, and annuities are generally counted as " income streams" rather than available resources.[39]

Other income producing assets valued in excess of asset resource limits may also be exempted if it is shown that the income generated from the asset does not yield the community spouse an income greater than the monthly income allowance.[40] However, if the income producing asset is liquidated, the amount liquidated in excess of the community spouse's asset allowance may be included as income in the month liquidated. The Community spouse would then have to "spend down" the excess to avoid disqualification. Conversely, if the income producing asset is not liquidated, and the community spouse pre-

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33. *See Options, supra* note 9, at 725.

34. *See* 42 U.S.C. § 1396r-5(d), (f) (1993). The non-institutionalized spouse is referred to as the "community spouse."

35. *See* 42 U.S.C. § 1396r-5(g) (1993).

36. The luxury account is a minimum amount retained for the Medicaid recipient for personal needs which may arise. The maximum amount to be retained in such an account is determined by each state and in most states is less then $3,000.

37. Typically this account is set up to pay for funeral expenses which cannot be paid in advance. Caskets, burial plots, costs for death notice, and engraving head stones may be paid in advance but must be reasonable.

38. See 42 U.S.C. § 1382b (1993). There is no limit on the value of an applicant's home with regard to the exemption allowed. However, 42 U.S.C. § 1396p(a) (1993) provides that if the applicant is not reasonably expected to return home, after notice and a fair hearing, the state can impose a lien on the hone for all Medicaid benefits paid on behalf of the applicant.

39. For example: If the applicant or his spouse owns an annuity with a present value of $75,000 but annuitized payments were $750 a month, the $750 would be treated as an "income stream" and included toward the monthly income allowance rather than including the $75,000 toward the asset resource allowance. The annuity must, however, make economic sense (i.e. payout period commensurate with the life expectancy of the annuitant). See State Medicaid Manual Release published by Department of Health, Health Care Financing Administration, § 3258.9 at 3-3-109.12 (Nov 1994).

40. For example: if a states monthly income allowance for the community spouse is $1800 and the community spouse's monthly income from Social Security and other income streams is $800, a $100,000 C.D. earning 12% ($1000/monthly) may be excluded since the C.D.'s income is required to ensure that the community spouse's monthly income does not fall below the minimum allowance amount.

deceases the institutionalized spouse, the state may have a right to recover against the deceased spouse's estate.[41]

B. TRANSFER RULES

A Medicaid applicant must meet the income and resource limits set forth above to qualify for Medicaid. As a result, many elderly transfer or dispose of assets to ensure they qualify for Medicaid. However, if the transfers made by the elderly individual are not done properly, the disposed assets will be included when determining his or her Medicaid eligibility. In addition, at least one state has attempted to apply the fraudulent conveyance argument under debtor/creditor law to Medicaid planning type asset transfers.[42]

Generally, any asset (1) transferred by the Medicaid applicant or spouse to a third party (2) for less than its fair market value[43] (3) within 36 months[44] of the submission of the Medicaid application is considered an asset owned by the applicant at the time of the application.[45] Assets the Medicaid applicant is entitled to, but refuses to accept[46], are deemed an uncompensated transfer and are also considered an asset of the applicant.[47] If the transfer consisted of a payment "from" a trust which is beyond the reach of Medicaid, a 60 month lookback period is applied instead of a 36 month look back period.[48] Although the extended lookback period applies to all trusts, transfers from revocable trusts can, if properly done, be subject to the shorter look-back period.[49]

Much debate exists among elder law attorneys on the interpretation of the lookback provision. Many interpret the statute to include transfers "to" a trust as requiring a 60 month lookback period while many others read the provision literally and argue that such transfers are not included under the provision and

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41. *See* discussion of a States right to recovery against the Estates of the Medicaid recipient or his/her spouse, *infra* note 82.

42. *See* Cynthia L. Barrett, *President's Column: Debtor/Creditor Law and Medicaid Recovery*, 7 NAELA QUARTERLY 1, at 2 (1994). *But see* Michael Gilfix, *Fraudulent Conveyances: Alien to The World Of Public Entitlement*, 7 NAELA QUARTERLY 2, at 1 (1994); Frances M. Pantaleo and Robert M. Freedman, *In Defense of Medicaid Planning: Federal Law Prohibits States From Applying Debtor-Creditor Laws To Transfer Assets*, 7 NAELA QUARTERLY 4, at 15 (1994).

43. Also referred to as an "uncompensated transfer".

44. The number of months is commonly referred to as the "Lookback Period" See 42 U.S.C. § 1396p(c)(B)(i) (1993).

45. *See* 42 U.S.C. § 1396p(c) (1993).

46. Examples include a waiver or refusal to accept inheritance, pension income, tort settlements or failure to take legal action to enforce court ordered payments not being made. See State Medicaid Manual, *supra* note 39, at § 3257 at 3-3-109.

47. *See* 42 U.S.C. § 1396p(e) (1) (1993).

48. *See* 42 U.S.C. § 1396p (c)(B)(i) (1993). A trust is beyond the reach of Medicaid if it consists of assets disposed of by the Medicaid applicant that are not subject to re-inclusion under the asset transfer rules.

49. If an Applicant transfers assets from a revocable trust to himself/herself and then retransfers the assets to the intended recipient, a 36 rather than 60 month lookback period will apply since the transfer to the third party was made by the Applicant and not the trust.

are subject to the 36 month lookback period.[50] In support of the latter argument, the financial burden on Medicaid would be less if transfers "to" a trust were only subject to the 36 month waiting period. Transfers to retained income trusts[51] provide the Medicaid applicant with additional income which is included as a resource when applying for Medicaid. The additional income results in a reduction in the amount of Medicaid benefits required for the applicant. Applying a 60 month lookback period on transfers made "to" a trust, penalized applicants who retain income and encourages outright transfers which places the income earned on the transferred asset outside the reach of Medicaid. The Health Care Financing Administration (HCFA), the agency responsible for enforcing Medicaid laws, is itself unclear as to the proper interpretation of the statute.[52]

When planning for Medicaid eligibility, it is important to understand the distinction between the lookback period and the lookback date. As discussed, the lookback period is 36 or 60 months depending upon the type of transfer made by the applicant. The lookback date, however, is the specific day the lookback period begins. This date is 36 (or 60) months before the date an individual is institutionalized *and* applies for Medicaid.[53] Therefore, the date an institutionalized individual applies for Medicaid becomes critical because it is from that date that the lookback period is calculated and which the transfer rules will apply.[54]

C. THE PENALTY PERIOD

If a Medicaid applicant improperly "spends down" excess resources or makes transfers of property to a third party for less than its fair market value during the lookback period, (s)he may be ineligible for Medicaid. The period in which an applicant is ineligible is commonly referred to as the "penalty period". The penalty period is calculated by dividing the total uncompensated transfers within the lookback period by the average monthly cost of a private pay individual of a nursing facility within the state (or local community if distinguished

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50. *See* Ellice Fatoullah, *"Income Only" Trusts and Trusts for the Disabled*, 7 NAELA QUARTERLY 3, at 15 (1994). *See also* Clifton B. Krouse Jr., *Self Settled Trusts Following the Omnibus Budget Reconciliation Act of 1993*, 7 NAELA QUARTERLY 2, at 11-12 (1994), wherein the author interprets a 36 month lookback period for transfers to income only trusts.

51. Retained Income Trusts are commonly referred to as "income only" trusts which provide the beneficiary only the income from the trust with no rights to any of the trust principal.

52. *See* Fatoullah *Supra*, note 50, at 15.

53. *See* 42 U.S.C. § 1396p(c)(1)(B) (1993).

54. When planning, assume the individual is institutionalized for some period of time prior to application for Medicaid or that the individual does not enter an institution until the penalty period for uncompensated transfers has expired (concept discussed at length in next section). In the second instance, the lookback date is 36 (or 60) months before the date the individual applies for Medicaid *or* the date which the individual disposes of his/her assets for less than fair market value, whichever is *later*. See 42 U.S.C. § 1396p (c)(1)(B)(ii)(I) (1993).

by the state).[55] Once calculated, the result is the number of months in which the applicant is ineligible for Medicaid benefits.

The penalty period begins on the first day of the month during or after which assets were transferred for less than fair market value *and* which does not occur during any other periods of ineligibility.[56] The first part of the penalty period calculation is simple; it begins on the first day of the month in which the uncompensated transfer occurred.[57] The second part of the provision was added by OBRA '93 and is meant to ensure the penalty periods on succeeding transfers tack on to each other rather than overlap.[58] The Omnibus Reconciliation Act of 1993 also expanded the application of the penalty period to non-institutionalized individuals and removed the limitation on the number of months of ineligibility.[59]

To avoid the unnecessary assessment of a longer penalty period, the Medicaid applicant must ensure (s)he "spends down" excess resources properly and that all uncompensated transfers are well thought out. Excess resources spent on incidentals, medical expenses, food, maintenance of other assets held by the applicant or community spouse, or for the applicant's or community spouse's entertainment or pleasure will not result in any penalty period.[60] When planning to make a transfer of assets for less than fair market value, the Medicaid applicant must be cognizant of the transfer rules, the length of the lookback period and the calculation of any penalty period which may result. The interrelationship between these rules becomes more important as the amount of uncompensated transfers increase.

If an individual makes large amounts of uncompensated transfers (i.e. those which would result in a penalty period greater than the lookback period), (s)he should ensure (s)he retains sufficient assets to pay for his/her institutionalization

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55. *See* 42 U.S.C. § 1396p(c)(1)(E) (1993).

56. *See* 42 U.S.C. § 1396p(c)(1)(D) (1993).

57. However some Elder law practitioners interpret the phrase "or after which" within the provision to mean the month *prior* to the first month of an uncompensated transfer, thus giving an additional month or credit towards the penalty period. *See* Gregory Wilcox, *Transfer of Assets Puzzles After OBRA '93*, 7 NAELA QUARTERLY 6 (1994).

58. For example: Pre-OBRA '93, if a transfer in January of year 1 caused a penalty period of 5 months and a transfer in February of Year 1 caused a penalty period of 4 months, the applicant would be eligible in June of Year 1 because the penalty period for each transfer ran simultaneously. Post OBRA '93 the penalty periods for each transfer run concurrently. Therefore under the current law, the applicant will not be eligible until October of Year 1 (5 months penalty for the January transfer and 4 months penalty for February transfer).

59. Prior to OBRA '93, the penalty period did not apply to non-institutionalized individuals and the penalty period could not exceed 30 months (the lookback period prior to OBRA '93).

60. Popular techniques to spend down include using excess resources to make improvements to the applicant or community spouse's home which is not subject to the resource allowance limits, prepaying for funeral costs, dining out, vacationing, traveling and other leisure activities for the applicant (prior to application) or community spouse. Care should be taken, however, not to use the excess to purchase assets which are subject to the allowance limits.

or remain outside an institution, during the lookback period. Such planning ensures a maximum penalty period equal to the lookback period rather than the unlimited period set out in the statute.

To illustrate the foregoing point: An individual anticipates entering a nursing home and transfers $250,000 to his/her children.[61] Assuming the average private monthly nursing home costs $5000 in the applicant's region, the penalty period on the transfer is 50 months (250,000/5,000). If the individual enters a nursing home within 36 months of the transfer (the lookback period since the transfer was not "from" a trust) and applies for Medicaid, (s)he will be deemed ineligible for 50 months from the date of the transfer. However, if the applicant waits 36 months before entering a home (or enters sooner and privately pays for the home until 36 months have elapsed) and then applies for Medicaid, (s)he will be eligible upon his/her application. Since there will not have been any uncompensated transfers within the applicant's lookback period (36 months from institutionalization *and* application), no penalty period will apply.

As illustrated, understanding the interrelationship between the transfer rules and the penalty period can result in substantial estate preservation for large estates, but it can also be applied to preserve smaller estates. More than half of any estate can be preserved if planning begins prior to institutionalization. In fact, the further in advance to institutionalization planning begins, the greater the amount of the estate that can be preserved. Assuming the average private monthly cost of nursing home care equals the actual cost of care, an individual can transfer one half of his/her estate on the date (s)he is institutionalized and the half (s)he retains will be available to pay the cost of care during the penalty period.[62] This is commonly referred to as the "rule of halves".

Elder law attorneys must, however, be extremely careful when advising clients on transferring assets to qualify for Medicaid. As previously discussed, transferring a substantial portion of estate assets outright impoverishes the elderly and may strip them of their autonomy and quality of life. Transferring assets to a retained income trust with no provision for principal distributions until the death of the grantor can help preserve the client's autonomy and quality of life. Under such a plan, the issue of whether a 60 month lookback period applies to transfers "to" income only trusts becomes more relevant and the potential benefits to Medicaid and the elderly becomes evident.

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61. This example does not consider the potential gift tax ramifications of large transfers, which are also considered when engaging in Medicaid planning.

62. For example, if an individual transfers $50,000 of his/her $100,000 estate the day (s)he is institutionalized *and* applies for Medicaid, a 10 month penalty period will be assessed. However, the $50,000 retained by the individual can be used to pay for his/her care during the 10 month penalty period and (s)he will be eligible for Medicaid in Month 11, the same month his/her money will run out.

D. EXCEPTIONS TO QUALIFICATION RULES

As evidenced, the clash between the elderly's need for autonomy and the government's need to control the cost of Medicaid is a never ending battle. Congress, however, has recognized certain circumstances where the specific need of an applicant or his/her dependents outweigh the government cost concerns. The principal exception to the transfer rules regards transfers by the Medicaid applicant to his/her spouse. To avoid spousal impoverishment, a Medicaid applicant may transfer any asset to his/her spouse or to an individual for the sole benefit of his/her spouse without incurring any penalty period.[63] Such transfers, however, will be subject to the spousal allowance limits[64]. Any reconveyance by the community to a third party is subject to the transfer rules which may create a penalty period to the institutionalized spouse.[65]

A Medicaid applicant may also transfer his/her home without being subjected to the transfer rules or penalty period, if it is transferred (1) to his/her spouse, (2) to a child who is under age 21, blind or disabled, (3) to a sibling who has an equitable interest in the home *and* resided there with the Medicaid applicant for a period of at least one year prior to the applicant's institutionalization, or (4) to a child who resided with the applicant for a period of a least 2 years prior to his/her institutionalization *and* said child provided care to the applicant which enabled the applicant to remain home rather than be institutionalized.[66]

There are also trusts to which a Medicaid applicant may transfer assets without incurring any penalty period. Trusts exempted under the Medicaid statute include those funded for the benefit of a blind or disabled child or an individual under age 65 who is disabled[67]. Other exempt trusts include those for the benefit of a disabled individual, created by his/her parents, grandparents, legal guardian, or a court which provides for reimbursement to Medicaid upon the death of the individual for amounts Medicaid paid on his/her behalf.[68] Supplemental Needs Trusts may also be established by non-related individuals and nonprofit associations.[69] Using exempt trusts in Medicaid planning can be

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63. *See* 42 U.S.C. § 1396p(c)(2) (1993).

64. *See supra,* note 34.

65. *See* 42 U.S.C. § 1396p(c) (1993) and discussion of Transfer Rules, *supra.*

66. *See* 42 U.S.C. § 1396p(c)(2)(A) (1993).

67. *See* 42 U.S.C. § 1396p(c)(2)(B)(iii) - (iv) (1993). Under said provision, disabled is defined 42 U.S.C. § 1382c(a)(3) as unable to earn a living by reason of any medically determinable physical or mental impairment which can be expected to result in death or expected to last for a period of not less than 12 consecutive months.

68. *See* 42 U.S.C. § 1396p(d)(4) (1993). These trusts are commonly referred to as "supplemental needs trusts" (SNT) and can be used by a Medicaid applicant to provide benefits to his/her children or grandchildren not otherwise provided by Medicaid. These trusts are also becoming very popular with disabled individuals who receive modest settlements or lawsuit verdicts. The SNT allows the award to be available to provide additional benefits not provided by Medicaid without jeopardizing Medicaid eligibility.

69. *See* 42 U.S.C. § 1396p(d)(4)(B) - (C) (1993).

complicated. While the rules set out in the statute are quite specific, their application can be confusing.[70]

In addition to the specific exemptions discussed, Congress recognized that other circumstances may exist which it could not foresee, but which would warrant an exception to the transfer rules. As a result, Congress provided that the Medicaid transfer rules will not apply to a Medicaid applicant who can show (s)he intended to transfer the assets for full value, transferred the assets for a purpose other than to qualify for Medicaid or has received back those assists transferred for less than full value.[71] If the applicant intended to receive full value of the asset, but was unable to, Medicaid may have recourse against the transferee if fraud, undue influence or some similar tactic was used.

A strong argument can be made that transfers of exempt property are not subject to the transfer rules. Since the property is exempt from Medicaid qualifications, a transfer of such property would not be done to qualify for Medicaid. Other transfers done for a purpose other than to qualify for Medicaid may include transfers incident to a divorce, estate planning,[72] or a valid business reason. A Medicaid applicant will also be exempt from the transfer rules if (s)he can show that application of the transfer rules would cause "undue hardship".[73] The criteria establishing an undue hardship are promulgated by the individual states, but must conform to those set by the secretary for Public Health and Welfare.[74] The undue hardship exemption also applies to transfers made in trust.[75]

E. SPOUSAL OPTIONS OF LAST RESORT

If all estate preservation options have been considered, but the community spouse wants to retain more assets than allowed by the spousal impoverishment

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70. *See* Wilcox, *supra*, note 57 at 8-9, wherein he notes the distinctions between the § 1396p(c)(2)(B)(iii) - (iv) and the § 1396p(d)(4) exempt trusts.

71. *See* 42 U.S.C. § 1396p(c)(2)(C)(ii) (1993).

72. Common estate planning transfers include those made under Internal Revenue Code § 2503(b), which allows a donor to transfer $10,000 per donee, per year without incurring any gift tax. Case law had suggested that for the exemption to apply, the donor must show a history of such transfers prior to institutionalization or reasonable knowledge of impending institutionalization. *See* Matter of Klapper, N.Y.L.J. 26 (August 9, 1994). The Judge who decided Klapper, however, expanded his decision in Matter of Beller, N.Y.L. J. 23 (August 31, 1994) and Matter of Goldberg, N.Y.L.J. 24 (August 31, 1994) and stated that guardians of incompetent individuals can perform "Medicaid Planning" without a prior pattern of gifts. Further, the Court noted that the guardian could transfer the incompetent's assets to those whom the incompetent intended them to go (determined via totten trusts, joint account, testamentary disposition, etc.), as long as sufficient assets were retained for a pre-paid burial account, the incompetent's luxury account, and to pay for the incompetent's care during any ineligibility period assessed by Medicaid. The Courts reasoning was that incompetent individuals should have the same opportunity as competent persons to preserve assets.

73. *See* 42 U.S.C. § 1396p(c)(2)(D) (1993).

74. *See id.*

75. *See* 42 U.S.C. § 1396p(d)(5) (1993).

allowances, (s)he may elect to divorce the institutionalized spouse or refuse to contribute toward his/her care. Divorce, because of its religious, social and psychological impact on the elderly, is rarely used. Most elderly equate such a scenario as an "abandonment", even if done solely for financial reasons. Additionally, divorce may effect a community spouse's right to pension and/or social security benefits received on behalf of the institutionalized spouse, and subject the community spouse's entire estate to Medicaid's reach if (s)he should fall ill and require nursing home care.[76] The divorcing spouse would also most likely be subject to any equitable distribution rules under state law and if the institutionalized spouse is incompetent, his/her rights may be protected by a court appointed representative.

An outright refusal to contribute to an institutionalized spouse's care also presents some concerns. While Medicaid cannot be denied to an applicant who, but for a spousal refusal, qualifies for Medicaid, states can implement methods to recover from the community spouse for Medicaid benefits paid.[77] New York, for example, provides that spousal refusals must be in writing for the Medicaid applicant to receive benefits.[78] In addition, New York's Department of Social Services has authority to commence a proceeding against the community spouse to compel support.[79] New York goes so far as to allow its Department of Social Services to "elect" against the estate of a deceased spouse of Medicaid recipient, for any interest (s)he may have under the law.[80] New York also allows recovery of Medicaid benefits paid for an institutionalized spouse from the estate of a deceased community spouse.[81] Federal law does not provide for such recovery but does require recovery against the"estate" of the Medicaid recipient.[82]

The Omnibus Reconciliation Act of 1993 grants each state the authority to define "estate" for purposes of recovery of Medicaid benefits paid. Estate, may include real and personal property or assets which the Medicaid recipient had a legal interest in at the time of death including: joint tenancies, life estates, living trusts, or other similar arrangements.[83] If a state were to enact such a liberal

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76. As a single person, the community spouse is subject to Medicaid income and asset limitations which are drastically less than (s)he receives as a community spouse.

77. *See* Medicaid Catastrophic Coverage Act (MCCA) of 1988.

78. *See* New York Social Services Law § 366 (McKinneys, 1995).

79. *See id.*

80. *See id.* In New York a decedent cannot disinherit his/her spouse. If the surviving spouse is not provided for in the will of the deceased spouse, the surviving spouse is entitled to "elect" to receive the greater of 1/3 of the estate or $50,000. Other states may refer to such provisions as "dower rights".

81. The state's right of recovery is based on a theory of implied contract but, is limited to assets of the community spouse which were "available" resources (i.e. those which exceed the spousal allowance limits). *See* Matter of State of Craig, 592 N.Y.S. 2d 164 (App. Div., 4th Dept. 1992), *aff'd* 624 N.E. 2d 1003, 604 N.Y.S. 2d 908 (N.Y. 1993).

82. *See* 42 U.S.C. § 1396p(b)(1) (1993), but note exceptions thereto.

83. *See* 42 U.S.C. § 1396p(b)(4) (1993).

definition of "estate" it would, arguably, be able to dispossess joint tenants or remaindermen of interest in property shared with a Medicaid recipient.[84] It is obvious that the current trend is to expand Medicaid laws to allow recovery for benefits paid from all available sources. Therefore, any attempt to use an option of last resort must be carefully reviewed and all the potential consequences weighed.

V. OTHER ESTATE PRESERVATION OPTIONS

While Medicaid is a principal source in providing care for the elderly facing institutionalization, other sources are available which if utilized properly can provide additional benefits to the elderly in their attempt to preserve assets. Medicare, like Medicaid is a government provided health insurance program for those age 65 or older and the disabled.[85] Medicare consists of two parts; Part A, which insures the costs of hospitals, skilled nursing facilities, home health care and hospice care[86] and Part B, which covers physician's charges, outpatient care, ambulance, and medical equipment services.[87] Medicare benefits can subsidize the cost of care during any ineligibility period under Medicaid.

Home health care benefits under Medicare cover the costs of skilled nursing visits and certified home health aids for up to 35 hours per week. The insured must require skilled nursing services for less than five days a week (but at least once every 60 days) or therapy services of less than 8 hours a day.[88] Medicare also covers the first 100 days of care received in a nursing home if the insured was hospitalized for at least three days within the 30 day prior to admission to the nursing home and (s)he requires daily skilled nursing services (7 days a week or 5 days of therapy services).[89] The unlimited duration of Medicare home care benefits and/or more than three months of nursing home benefits received, act simultaneously as a credit toward any penalty period assessed to a Medicaid applicant.

In addition to Medicare, other sources of aid to the elderly included Veteran Administration benefits and private nursing home insurance. In some instances, Veteran Administration benefits pay the cost of the first six months of care in a nursing home for qualified veterans.[90] The Veteran Administration may also

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84. For example if a Medicaid recipient transferred his/her home to his/her children but reserved a life estate, the home would be subject to Medicaid's right of recovery. A legal question arises, however, whether the deceased Medicaid applicant has any "legal title" at death to assets which said title is defeated by death.

85. *See* 42 U.S.C. § 426 (1988).

86. *See* 42 U.S.C. § 1395(d) - 13959(i) (1993).

87. *See* 42 U.S.C. § 1395(j) - 1395(w) (1993).

88. *See* 42 U.S.C. § 1395(d) (1988). *See also* 42 C.F.R. 401.40 (1995).

89. *See* 42 U.S.C. § 1395d(a)(2) (1988). *See also* 42 C.F.R. 409.30 - 409.31 (1995).

90. The Veterans Administration provides various benefits to veterans depending whether they are of active status, the availability of nursing home beds within VA facilities and the recommendation of

provide monthly benefits to the spouse of the institutionalized veterans. Private nursing home insurance, on the other hand, may be purchased by anyone willing to pay for it. The cost of $150 per day coverage for up to three years for a 65 year old is approximately $1,355 per year.[91] The actual cost of the insurance, however, will depend upon the health of the applicant, the options purchased, and the age when the policy is first obtained.[92]

Residents of a limited number of states have a special form of nursing home insurance available to them under the Partnership For Long-Term Care, sponsored in part by the Robert Wood Johnson Foundation.[93] Under the Partnership, an individual purchases a policy which provides minimum benefits for three years of coverage in a nursing home. Policy premiums are standardized and upon completion of the benefit period, the applicant is eligible under the state Medicaid system regardless of the amount of assets (s)he owns.[94] The Partnership was established in an effort to provide the elderly an alternative to impoverishment when facing the possibility of institutionalization.

For individuals with significant estates, the best Medicaid planning may be avoiding Medicaid planning. If an individual's assets generate sufficient income to pay for his/her care upon institutionalization, a simple solution is to place the assets into a revocable trust. A revocable trust provides a vehicle for asset management in the event of an individuals' incapacity and enables him/her to avoid probate in states that require it. Revocable trusts also enable an elderly individual to retain control of all of his/her assets until (s)he is unable or chooses to relinquish it.[95] Most importantly, the trust can be as flexible or as rigid as the grantor decides and can provide a myriad of scenarios for trust management in the event of his/her incompetency.

VA physicians, to name a few. Veterans should contact their regional Veterans Administration office to determine what, if any, benefits (s)he may be entitled.

91. *See* Dugas, *supra*, note 11, at A88.

92. The multiplicity of options available when purchasing nursing home insurance are vast and outside the scope of this paper. Options such as the length of the waiting period, built-in inflation protection, non-forfeiture provisions, home care coverage and medi-gap coverage (which covers the deductibles on Medicare or other health insurance benefits) are the more significant options to consider. *See* Jerry L. Soltermann, *Medicaid Alternatives*, 1 THE ELDER LAW JOURNAL 281, 284 (1993) [hereinafter *Medicaid Alternatives*].

93. *See* Gary Enos, *States Try to Ease Burden of Long-Term Care: The Question is, Will it Save the Public Some Money?* PTS PROMT, April 12, 1993, City & State, at 3. *See* also Dugas, *supra*, note 11, at A88. OBRA '93 prohibited States from implementing these programs after May 14, 1993. *See* 42 U.S.C. § 1396p(b)(1)(C)(i) - (ii). California, New York, Connecticut, and Indiana were among the states that initiated these programs before the OBRA '93 prohibition.

94. *See id.*

95. The use of a Power of Attorney or Joint Accounts can also prevent the need for probate. Such techniques, however, do not protect the elderly individual's assets from abuse by the appointed attorney in fact or from the creditors of a joint account holder (i.e. account in the name of the elderly individual and his/her child will subject the account to the creditors of the child).

VI. CONCLUSION

The number of elderly Americans is growing rapidly, the cost of care for the elderly is skyrocketing, the frustration of taxpayers is mounting, and the elderly's fear of impoverishment is materializing. Some argue Medicaid was meant to provide care to the "less fortunate", and consider Medicaid planning an abuse while others contend Medicaid is a right and must be made available to everyone. Regardless of how an individual views Medicaid qualification and benefits, the "government" by its policies or the "greed of the health care system providers" are often laid to blame for the "crisis" in long-term health care for the elderly. It is time to stop philosophizing and pointing fingers and time to recognize the problem and address it before it is thrust upon us with impending magnitude. The government's role should be to act as a partner to help us achieve our goals, not to be the sole provider of our needs.

The elderly's ability to remain autonomous and free from the threat of impoverishment is as important an element of the solution to the problem as is the need to control cost and provide sufficient care. Hopefully, everyone agrees that the elderly are not to blame for the problem and that they deserve our respect and concern as we attempt to resolve this issue. The preservation of the elderly's autonomy and their ability to preserve the dignity should be at the forefront of any proposed solution. As suggested by Professor Rein, such a goal may in fact result in a reduction of long-term benefits required, resulting in a reduced need for nursing home care.[96] For the same reason, we should also seek to preserve the financial independence of the elderly.

To avoid impoverishment of the elderly, we must provides avenues for the elderly to preserve assets. The Partnership for Long-Term Care was a good start. The annual cost of premiums for significantly less than the cost of one months stay in a nursing home.[97] Few of us argue the need to obtain insurance to protect our homes, automobiles and other personal assets. Why then should we hesitate in purchasing nursing home insurance to protect our financial security and lifetime of savings. Arrangements under the Partnership guarantee the preservation of the Medicaid applicant's assets and subsidized the cost of care by requiring the income on the retained assets to be used for the support of the applicant. With 87.5% of elderly preferring home care to nursing home care,[98] great effort must be made to increase its availability. Perhaps the Partnership program should be expanded to include home-care benefits in addition to nursing home benefits.

Allowing individuals to establish income only trusts without being subjected to a penalty period may eliminate some Medicaid planning and enable assets

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96. *See Preserving Dignity, supra*, note 2.
97. *See* Enos *supra*, note 93, at 3. *See also* Dugas *supra*, note 11, at A88.
98. *See Preserving Dignity, supra*, note 2 at 1860.

which otherwise may have been transferred to generate income and subsidize the cost of care. Such a proposal would also help to preserve the elderly's financial autonomy. Perhaps using the income from such a trust to purchase some form of long-term care insurance could also be implemented.

Any attempt to have the government finance universal long-term care for all Americans is unrealistic and insurmountable.[99] The government, however, through tax incentives[100] can be the impetus to encourage individuals to seek alternate means of payment for long-term care.

Assisted living arrangements should also be encouraged. Many elderly do not require full time nursing care, but rather only require assistance with some daily chores. Private investors could stand to profit if assisted living residences are created wherein the elderly can have his/her own apartment with a nurse or aid available 24 hours at the push of a button if required. Providing volunteers and/or visitors to the elderly can also assist in preserving the elderly's autonomy. The cost of assisted living housing should be far less than the costs of nursing home care which would serve to preserve the elderly's estate and their autonomy and relieve the system of having to pay for nursing home care for those individuals who otherwise do not require it.

The responsibility of addressing the problem of long-term care belongs to everyone. If not addressed, the young will be strapped with paying for runaway costs of care for the ever-growing number of elderly; the middle age will become elderly and seek benefits which may or may not be available; and the elderly may face death with despair rather than dignity. The Medicaid qualification rules are becoming ever more complicated. The Medicaid system is expensive and burdened with costs of government bureaucracy. The ultimate solution lies with us, with the government acting only as a partner to assist us in achieving our goals, not to mandate its solutions nor bear the burden of the costs.

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99. *See Medicaid Alternatives*, *supra* note 92 at 286.

100. Such incentives could include deductibility of the costs of nursing home insurance, tax-free withdrawals from untaxed sources (i.e. IRA's, pensions, etc.) to pay for nursing home insurance or long-term health care costs, tax credits to private investors who finance long-term care facilities (i.e. similar to the low income housing and historic tax credits under the Internal Revenue Code) or charitable type deductions for payments made to a national fund for health care.