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# The Medicaid Cost Crisis: Are There Solutions to the Financial Problems Facing Middle-Class Americans Who Require Long-Term Health Care

Kenneth Hubbard

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**THE MEDICAID COST CRISIS: ARE THERE SOLUTIONS TO THE FINANCIAL PROBLEMS FACING MIDDLE-CLASS AMERICANS WHO REQUIRE LONG-TERM HEALTH CARE?**

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Medicaid was originally designed as a welfare program to provide health care to the poor.<sup>1</sup> Despite the initial intentions of Congress, Medicaid has instead become "a multi-billion-dollar insurance policy" for elderly middle-class Americans who require long-term health care.<sup>2</sup> The Medicaid crisis has been described as "a battle between elderly people's desire for long-term care coverage and their concomitant reluctance to pay for it themselves."<sup>3</sup> This battle is waged between the older and younger generations, commencing when the younger generation observes that their inheritance is

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<sup>1</sup>Jeffrey L. Soltermann, *Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care*, 1 ELDER L.J. 251, 251 (1993).

<sup>2</sup>*Id.*

<sup>3</sup>*Id.* at 253.

growing smaller or disappearing altogether due to the immense cost of their parents' long-term health care.<sup>4</sup>

The first section of this note examines the scope of the problem with the Medicaid system. The problem is primarily one of cost overruns. As explained below, the source of these overruns is twofold. First, the system is structured in such a way that unscrupulous health care providers can easily defraud both federal and state governments. In fact, Medicaid fraud is so easy to commit and so difficult to detect that it eats up over one-tenth of the entire Medicaid budget. Second, the program was neither designed nor intended to provide coverage to the middle class. The middle class, however, needs coverage and is able to qualify for Medicaid through the use of rigorous planning tactics, which force the government to spend more and more money on Medicaid.

The second section of this note deals with the history and structure of the Medicaid statute. This history shows numerous failed attempts to rectify the problems with the program. A recent Congressional enactment provided some solutions but left loopholes and severe restrictions.

These restrictions are explained in the third section of this note. Section III addresses the manner in which Medicaid eligibility is affected by transfers of assets, such as those occurring when an elderly middle-class person attempts to qualify for assistance by divesting himself of his life savings. The eligibility criteria regarding assets held in trust is particularly complicated and is dealt with at length, including discussion of discretionary versus non-discretionary and revocable versus irrevocable trusts.

The fourth section describes some solutions which could be implemented to patch the holes in the current system or to replace it altogether. Possibilities for reform fall into three categories. First, a system of universal, publicly-funded health insurance could resolve some of the problems of high costs due to Medicaid planning. Second, health insurance provided by the private sector could reduce costs associated with fraud, since the providers would perhaps be more capable of detecting and preventing fraud. Third, a solution with problems of its own would be to require personal or family responsibility for a greater portion of health care costs.

### I. THE SCOPE OF THE PROBLEM

The range of services required during long-term care is quite broad, consisting of "diagnostic, preventive, therapeutic, and supportive services designed to help individuals compensate for severe, chronic physical and mental disabilities and functional impairments."<sup>5</sup> The costs are staggering. One

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<sup>4</sup>George A. Cooney, *Basic Estate Planning for Long-Term Care*, 69 MICH. B.J. 526, 526 (1990).

<sup>5</sup>Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 722 (1991). Medicaid will cover the cost of many home health care services, such as "nursing services provided by a home health agency or registered nurse; medical supplies, equipment, and appliances; and physical therapy, occupational

survey revealed that providing out-of-pocket long-term care for a family member would be "financially devastating" for ninety percent of middle-class families.<sup>6</sup> Forty percent of middle-class families have already experienced financial difficulty in paying for health care at home.<sup>7</sup> Families that have not yet been required to pay for nursing home care for a family member indicated that providing such services for a three year period would necessitate "major sacrifices."<sup>8</sup> Many families expressed doubt when asked whether they could afford even one year of long-term care for a family member.<sup>9</sup> Greater than ninety percent of families surveyed indicated that they definitely could not afford to pay for three years of long-term care.<sup>10</sup> All too frequently, an elderly middle-class person who requires long-term care spends his or her last days in poverty.<sup>11</sup> Today there is no legal duty to support one's parents. Centuries ago, there was such a duty under the English Poor Law:

The father and grandfather, mother and grandmother, and children of every poor, old, blind, lame and impotent person, or other person not able to work, being of sufficient ability, shall at their own charges relieve and maintain every other such person, in that manner, and according to that rate, as by the justices of that county where such sufficient persons dwell, in their sessions shall be assessed . . . .<sup>12</sup>

When Medicaid was enacted, however, Congress chose not to burden children with this type of family obligation.<sup>13</sup>

Long-term health care not only imposes severe financial burdens on middle-class families but on the government as well. Fourteen percent of our \$700 billion gross domestic product is spent on health care.<sup>14</sup> Even though this cost is split between state and federal governments, the amount still exceeds fifteen percent of the federal budget<sup>15</sup> and is almost always the largest single

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therapy, speech pathology, and audiology services provided by a licensed practitioner." *Id.* at 730 (citing 42 C.F.R. § 440.70(b)(1987)).

<sup>6</sup>Joel C. Dobris, *Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlements and Inheritance*, 24 REAL PROP. PROB. & TR. J. 1, 5 (1989).

<sup>7</sup>*Id.*

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

<sup>9</sup>*Id.*

<sup>10</sup>Dobris, *supra* note 6, at 5.

<sup>11</sup>Soltermann, *supra* note 1, at 270.

<sup>12</sup>Dobris, *supra* note 6, at 7 (quoting English Poor Law Statute 1601, 43 Eliz. ch.42).

<sup>13</sup>42 U.S.C. § 1396a(a)(17)(D) (1982).

<sup>14</sup>Soltermann, *supra* note 1, at 263 n.64.

<sup>15</sup>*Id.*

expense in state budgets.<sup>16</sup> Medicaid covers a significant portion of long-term health care expenses. Experts estimate that within fifty years, the Medicaid program could be paying well over \$50 billion each year for nursing home care.<sup>17</sup>

There are two primary reasons for the rapidly escalating costs of Medicaid. One reason is that rampant fraud on the part of some health care providers causes the government to pay billions of dollars for health care services that were never rendered. The other reason is that Medicaid was never intended to provide benefits to the middle class, which it now does due to so-called "divestment planning," whereby middle-class citizens deliberately impoverish themselves in order to become eligible for Medicaid benefits.

#### A. Excessive Costs Resulting from Medicaid Fraud

While Medicaid fraud is prevalent, only the most blatant and careless acts of fraud get detected. For example, an owner of six home health care agencies in Tennessee padded bills for his services to Medicaid recipients.<sup>18</sup> By doing so, he collected \$4.4 million from Medicaid (and Medicare) over a four year period.<sup>19</sup> He was finally caught and convicted of fraud after his machinations became so blatant that he could no longer escape the notice of insurance investigators.<sup>20</sup> There are numerous other examples. A Florida man was sent to prison in early 1994 for "among other things, billing Medicaid for home care rendered to three people who turned out to be dead."<sup>21</sup> A scheme often used by some telemarketing agencies is offering free home care in order to get a patient's Medicaid billing number, then using that number to submit fraudulent claims for payment.<sup>22</sup>

A congressional estimate of the cost of Medicaid fraud revealed that as much as ten percent of the total home health care revenues are paid to fraudulent Medicaid claims.<sup>23</sup> Since the home health care industry currently generates over \$31 billion a year, the costs due to fraud are well over \$3 billion a year.<sup>24</sup>

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<sup>16</sup>*Id.* at 264.

<sup>17</sup>Kapp, *supra* note 5, at 724. Another interesting statistic is that ten percent of the revenue for an average hospital is paid by Medicaid. Donna K. Thiel & Christopher L. White, *What Happens to Medicare and Medicaid Under the Clinton Reform Plan?*, 10 HEALTHSPAN, Nov. 1993, at 15.

<sup>18</sup>*Is Fraud Poisoning Home Health Care?*, BUS. WK., Mar. 14, 1994, at 70 [hereinafter *Fraud*].

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

<sup>20</sup>*Id.*

<sup>21</sup>*Id.*

<sup>22</sup>*Fraud*, *supra* note 18, at 72.

<sup>23</sup>*Id.* at 70.

<sup>24</sup>*Id.*

A lawyer who prosecutes Medicaid fraud in the state of New York said, "Home health care is the next major frontier for fraud and abuse. We've just scratched the surface."<sup>25</sup> The prevalence of health care providers who commit fraud has been compared to "a grossly overstocked fish pond, where the merest attempt easily nets prey."<sup>26</sup> Unfortunately, only the most blatant and careless acts of fraud get detected.<sup>27</sup> "The only ones we get are the fish that jump into the boat."<sup>28</sup>

The reason most fraudulent claims escape detection is that the resources available for uncovering health care fraud are grossly insufficient. Despite increasing workloads, the number of inspectors with the Office of the Inspector General of the Health & Human Services Department has been cut from approximately 300 to about 250 since 1989.<sup>29</sup> This situation, however, may soon change. Recent legislation calls for all states to create effective fraud control divisions.<sup>30</sup> Beginning January 1, 1995 states are required to establish Medicaid fraud units.<sup>31</sup>

Fraudulent services not only pose financial dangers, but also physical ones. Those who bill Medicaid fraudulently often provide no services at all. But others, wary of the ethics of the patient, provide the requested services, but in a very poor or imprudent manner. One patient, for example, had a lethal dose of the wrong drug delivered to her home.<sup>32</sup> Another patient had an untrained, unqualified, unlicensed nurse sent to care for him.<sup>33</sup> In fact, the physical harms caused by Medicaid fraud are perhaps even more dangerous than the financial ones and may provoke enough "moral indignation" to create public and political support for a reform of the Medicaid program.<sup>34</sup>

Without reform to control fraud, other reforms may be pointless. A 1991 study of Medicaid recipients revealed that the federal government saved \$575 million when patients received part of their treatment at home rather than at a hospital.<sup>35</sup> The rampant fraudulent activity, however, could negate the savings that result from home care.<sup>36</sup>

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<sup>25</sup>*Id.*

<sup>26</sup>PAUL JESILOW ET AL., *PRESCRIPTION FOR PROFIT—HOW DOCTORS DEFRAUD MEDICAID* 70 (1993).

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

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

<sup>29</sup>*Fraud, supra* note 18, at 73.

<sup>30</sup>Omnibus Budget Reconciliation Act of 1993, 42 U.S.C. § 1396p (Supp. 1993).

<sup>31</sup>*Budget Bill Restricts Eligibility for Hospital Indigent Care Subsidies*, 4 MEDICARE REP. (BNA) No. 33, at d8 (Aug. 13, 1993). [hereinafter *Budget Bill*].

<sup>32</sup>*Fraud, supra* note 18, at 73.

<sup>33</sup>*Id.* at 70.

<sup>34</sup>Jesilow, *supra* note 26, at 67.

<sup>35</sup>*Fraud, supra* note 18, at 71.

### B. Excessive Costs Resulting from Divestment Planning

Another factor contributing to excessive Medicaid costs is divestment planning. By carefully utilizing planning techniques, a middle-class elderly person can divest himself of assets thereby making himself eligible for Medicaid at about the time when he would have to begin making substantial payments for long-term health care.<sup>37</sup> The government is then required to pick up the tab. Surprisingly, this process is perfectly legal.<sup>38</sup>

In answer to the criticism that such planning tactics are unethical, one commentator responded, "[i]f financing nursing home costs is not unlike the prospect of sending several children to private colleges, then the kind of planning . . . is not unlike positioning a family's finances to qualify for financial aid. Seldom is it alleged that the latter type of planning is in any way improper."<sup>39</sup>

The incentive for middle-class citizens to engage in Medicaid planning is obvious—half of all nursing home residents are poor but were not poor when they began their stay.<sup>40</sup> For this reason, the children of the elderly or aging are frequently the primary impetus for their parents' decision to divest themselves of assets in order to gain Medicaid eligibility.<sup>41</sup> Nevertheless, Medicaid planning, despite being legal and arguably ethical, contributes heavily to the rapidly escalating cost of health care.<sup>42</sup> In an effort to control health care costs, the government (state governments in particular) is attempting to eliminate abuse of the Medicaid system without damaging the availability of government-financed long-term care for those truly in need.<sup>43</sup>

In addition to increasing the cost of Medicaid, divestment planning has other adverse effects. Divestment planning discourages use of savings accounts and investments and encourages dishonesty, such as hiding assets and lying about income.<sup>44</sup> Divestment planning can also have psychological consequences.

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<sup>36</sup>*Id.* at 70.

<sup>37</sup>Soltermann, *supra* note 1, at 265-66.

<sup>38</sup>*Id.* at 270.

<sup>39</sup>Dobris, *supra* note 6, at 22; *see also* Soltermann, *supra* note 1, at 277. ("Bending rules" to obtain financial benefits from the government apparently does not seem morally wrong to many people.) While on the subject of ethics, however, it is interesting to note Soltermann's opinion: "[t]o their credit, the lawyers who specialize in this area are not getting rich by taking advantage of their clients' desperation." *Id.* at 276.

<sup>40</sup>Dobris, *supra* note 6, at 10. Dobris describes the problem as "acquired" poverty, noting, "these people became impoverished and eligible for Medicaid when the cost of care in the nursing home exhausted their personal resources." *Id.*

<sup>41</sup>Soltermann, *supra* note 1, at 272.

<sup>42</sup>*Id.* at 251.

<sup>43</sup>*Id.* at 252.

<sup>44</sup>Dobris, *supra* note 6, at 23.

Any law that forces people who need long-term care to impoverish themselves is likely to have a demoralizing effect on many middle-class citizens.<sup>45</sup> Additionally, children generally do not want to have to put a parent in a nursing home,<sup>46</sup> and the elderly often do not want to go to a nursing home.<sup>47</sup>

By all reports, the financial and psychological costs of long-term health care will continue to increase. Medicaid is currently the primary source of funding for elderly persons who reside in nursing homes.<sup>48</sup> Approximately ten million elderly Americans have some type of long-term health care need, ranging from assistance with daily chores like bathing and eating, to full-time supervision.<sup>49</sup> For middle-class citizens, these health care needs create a difficult choice of whether to live in a nursing home, which will likely deplete a lifetime of savings, or to reside at home, possibly bringing emotional and financial ruin on the family and friends who care for them.<sup>50</sup> Over seven million people received costly, professional home health care services in 1994.<sup>51</sup>

In 1988, more than twelve percent of the nation's population, or thirty million people, were over the age of sixty-five.<sup>52</sup> In less than forty years, this sixty-five-or-older group is expected to increase to twenty percent of the population, or sixty-six million people.<sup>53</sup> The percentage of Americans above the age of eighty-five is increasing even faster.<sup>54</sup> This increase in our nation's elderly population is due to declining mortality rates, resulting from medical advancements, coupled with declining birth rates.<sup>55</sup>

The Medicaid program is immensely expensive to administer.<sup>56</sup> Overall, the bureaucracy that distributes Medicaid causes a tremendous waste of

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<sup>45</sup>*Id.* These negative side effects of divestment planning have caused strong criticisms to be directed at Medicaid in general. *See, e.g.*, Kapp, *supra* note 5, at 745 ("society should not condone such mean-spirited public policy.") *See also*, Dobris, *supra* note 6, at 23 ("any government program that is an enticement to commit fraud is not well conceived.")

<sup>46</sup>Dobris, *supra* note 6, at 7 (quoting R. L. Associates of Princeton, *Survey for the American Association of Retired Persons and the Villens Foundation*, Oct. 1987, at 8, which characterized the desire to keep parents out of institutions as "a strong emotional need.")

<sup>47</sup>*Id.* at 5-6.

<sup>48</sup>Roger E. McEowen, *Estate Planning for the Elderly and Disabled: Organizing the Estate to Qualify for Federal Medical Extended Care Assistance*, 24 IND. L. REV. 1379, 1380 (1991).

<sup>49</sup>Soltermann, *supra* note 1, at 253.

<sup>50</sup>*Id.*

<sup>51</sup>*Fraud*, *supra* note 18, at 70.

<sup>52</sup>Soltermann, *supra* note 1, at 264.

<sup>53</sup>*Id.*

<sup>54</sup>Kapp, *supra* note 5, at 721. Kapp further states that the over-eighty-five group is "the fastest growing segment of both the general and the elderly population." *Id.*

<sup>55</sup>Dobris, *supra* note 6, at 4,5.

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



resources.<sup>57</sup> A means-tested program, such as Medicaid, incurs substantial administrative expenses: the testing process, the appeals process (should a person's eligibility be rejected), record-keeping, and in general maintenance of the bureaucracy itself.

A greater dilemma for the government is that public funding is often used to replace home health care funding formerly provided by family members.<sup>58</sup> In fact, the majority of long-term home health care (as opposed to nursing home care) is provided by family members, usually in an informal and unpaid situation.<sup>59</sup>

## II. HISTORY AND BACKGROUND OF MEDICAID

"The key concept about Medicaid is that no one really knows what it means . . ."<sup>60</sup> Even courts are frequently at a loss to understand the Medicaid statute. Judicial opinions have described Medicaid as "byzantine"<sup>61</sup> and "almost unintelligible to the uninitiated."<sup>62</sup> One commentator listed several other judicial depictions of Medicaid: "a morass of bureaucratic complexity," "Medicaid maze," "an aggravated assault on the English language, resistant to attempts to understand it," and even "a Serbonian bog from which the agencies are unable to extricate themselves."<sup>63</sup> This frustrating complexity is made worse by the scarcity of relevant case law and the numerous amendments of the statute.<sup>64</sup> In addition, rules vary not only from state to state, but even from county to county.<sup>65</sup> In some cases, this degree of complexity gives an unfair advantage to health care providers who have enough resources to invest in deciphering the law and determining how best to respond.<sup>66</sup>

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<sup>57</sup>*Id.* at 29.

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

<sup>59</sup>Kapp, *supra* note 5, at 729. Kapp specifically notes that "chiefly wives, daughters, and daughters-in-law" provide these services in the home. *Id.*

<sup>60</sup>Dobris, *supra* note 6, at 11 (quoting NATIONAL SENIOR CITIZENS LAW CENTER, REPRESENTATING OLDER PERSONS at 23 (1985)).

<sup>61</sup>Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981).

<sup>62</sup>Friedman v. Berger, 547 F.2d 724, 727 n.7 (2nd Cir. 1976).

<sup>63</sup>Dobris, *supra* note 6, at 12. Dobris comments whimsically that "[t]he list of judges who have figuratively wept in the face of this program's complexity is a decidedly impressive one." *Id.* at 11-12. He also notes some potentially positive reasons for the level of complexity. For example, it creates jobs; it scares applicants away, resulting in lower costs to the government; and it delays payments, allowing the government to use the money longer. *Id.* at 13-14. He suggests that these reasons are mostly illusory. *Id.* at 14.

<sup>64</sup>Soltermann, *supra* note 1, at 273.

<sup>65</sup>*Id.* at 274. Thus, "it is important to know the administrators and their current, unwritten interpretations." Dobris, *supra* note 6, at 13.

<sup>66</sup>Carolyn Tuohy, *The Clinton Reform Plan—Response to the Clinton Proposal: A Comparative Perspective*, 19 J. HEALTH POL. POL'Y & L. 249, 252 (1994).

The original purpose of the Medicaid program was to provide health care to those who truly could not afford it themselves.<sup>67</sup> Despite these innocent intentions, Medicaid has played a major part in causing the current health care crisis.<sup>68</sup> The program grew quickly, exceeded its original purpose as a welfare system and now dominates the long-term health care market.<sup>69</sup> Medicaid programs vary from state to state, both in the scope of services provided and in terms of the individuals covered.<sup>70</sup> All states, however, must follow federal statutory interpretations and regulations put forth by the Federal Health Care Financing Administration.<sup>71</sup> Each state must also develop reasonable standards for determining the extent of coverage and the eligibility assistance.<sup>72</sup>

Medicaid is a "means-tested" program, meaning that eligibility for Medicaid depends on meeting various income and resource tests.<sup>73</sup> Basically, an applicant must satisfy income limits established by the state in order to receive coverage, unless he or she automatically qualifies for coverage by being eligible for receipt of other governmental health-related assistance.<sup>74</sup> Excess income must be spent down—spent on incurred medical expenses—before coverage will be granted.<sup>75</sup> In most states, an applicant will not be eligible if his non-exempt resources exceed two thousand dollars.<sup>76</sup>

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<sup>67</sup>Soltermann, *supra* note 1, at 262.

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

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

<sup>70</sup>*Id.* at 255.

<sup>71</sup>*Id.* at 254-55.

<sup>72</sup>42 U.S.C. section 1396a(a)(17)(1988). The extent of variation from one state to another encompasses many aspects of the Medicaid program:

Individual states have experimented with a variety of reimbursement methods for nursing home care under their respective Medicaid programs. States' plans vary on whether they provide retrospective or prospective cost reimbursement and whether they base ceilings on facility or area characteristics. The states' plans also differ in the height of the ceiling set, and in the provision of inflation adjustments, efficiency incentives, patient outcome-related rates, as well as in their treatment of real property costs.

Kapp, *supra* note 5, at 725-26.

<sup>73</sup>Michael Bagge, *The Eye of the Needle: Trust Planning, Medicaid and the Ersatz Poor*, 64 N.Y. St. B.J. 14, 15 (1992).

<sup>74</sup>Soltermann, *supra* note 1, at 255.

<sup>75</sup>*Id.* at 256.

<sup>76</sup>*Id.* at 257. Soltermann notes, however, that "this limit is subject to monthly income and marital status and is adjusted periodically for inflation." *Id.*

### A. Structure of the Medicaid Statute

The Medicaid program was established in 1965 as Title XIX of the Social Security Act.<sup>77</sup> The program provides federal financial assistance to a state if that state chooses to cover the costs of certain medical treatments for needy persons.<sup>78</sup> The federal government, in essence, "shares the costs of Medicaid with the states that elect to participate in the program . . . ."<sup>79</sup> A state is not required to participate in the Medicaid program but "must comply with the requirements of Title XIX" if it does participate.<sup>80</sup>

Under the 1965 version of Medicaid, all states participating in the program were required to provide medical assistance to anyone who received financial assistance under one of four other programs.<sup>81</sup> The four programs were Old Age Assistance,<sup>82</sup> Aid to Families with Dependent Children,<sup>83</sup> Aid to the Blind,<sup>84</sup> and Aid to the Permanently and Totally Disabled.<sup>85</sup> These people were called "categorically needy" individuals, because, due to family circumstances, age, or disability, they were particularly needy of public assistance.<sup>86</sup>

In addition to providing services to the "categorically needy" group, states have the option of providing care to another group.<sup>87</sup> States were permitted,

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<sup>77</sup>42 U.S.C. § 1396a (1988).

<sup>78</sup>*Schweiker v. Gray Panthers*, 453 U.S. 34, 36 (1981)(citing *Harris v. McRae*, 448 U.S. 297, 301 (1980)).

<sup>79</sup>*Indiana Dep't of Pub. Welfare v. Payne*, 592 N.E.2d 714, 718 (Ind. Ct. App. 1992). Though the total cost is shared between state and federal governments, the state governments actually "bear a substantial part of the cost." *Noland v. Shalala*, 12 F.3d 258, 259 (D.C. Cir. 1994). Governmental responsibilities are divided so that "state law establishes income and resource limits, [while] federal law requires that income and resources be actually available . . . ." *Soltermann*, *supra* note 1, at 257 (citing 42 U.S.C. § 1396a(a)(17)(B) (1988)).

<sup>80</sup>*Roloff v. Sullivan*, 975 F.2d 333, 335 (7th Cir. 1992) (quoting *Harris v. McRae*, 448 U.S. 297, 301 (1980)).

<sup>81</sup>*Schweiker*, 453 U.S. at 37.

<sup>82</sup>Old Age Assistance, 42 U.S.C. § 301 (1970), *repealed by* Pub. L. 92-603 title III, § 303(a), (b), 86 Stat. 1484 (1972) (repealed except with respect to Puerto Rico, Guam and the Virgin Islands).

<sup>83</sup>Aid to Families with Dependent Children, 42 U.S.C. § 601 (1970), *as amended by* 42 U.S.C. § 1381 (1988).

<sup>84</sup>Aid to the Blind, 42 U.S.C. § 1201 (1970), *repealed by* Pub. L. 92-603, title III, § 303(a), (b), 86 Stat. 1484 (1972) (repealed except with respect to Puerto Rico, Guam, and the Virgin Islands).

<sup>85</sup>Aid to the Permanently and Totally Disabled, 42 U.S.C. § 1351 (1970), *repealed by* Pub. L. 92-603, title III, § 303(a), (b), 86 Stat. 1484 (1972) (repealed except with respect to Puerto Rico, Guam, and the Virgin Islands).

<sup>86</sup>*Schweiker*, 453 U.S. at 37.

<sup>87</sup>*Roloff*, 975 F.2d at 335.

but not required, to provide assistance to the "medically needy," defined as "persons lacking the ability to pay for medical expenses, but with incomes too large to qualify for categorical assistance."<sup>88</sup> States were "required to adopt reasonable eligibility standards" for evaluating the financial need of applicants.<sup>89</sup> The evaluation must be based only on income and resources which are actually available to the applicant or recipient<sup>90</sup> and not on that person's financial history or responsibility.<sup>91</sup>

Subsequently, in 1972, three of the categorical assistance programs (all except Aid to Families with Dependent Children) were merged into one new program known as Supplemental and Security Income for the Aged, Blind, and Disabled [hereinafter SSI].<sup>92</sup> One result of the SSI legislation was that a significantly greater number of people became eligible for public assistance.<sup>93</sup> States, however, were still required to provide Medicaid coverage for all individuals who qualified for other public assistance under SSI.<sup>94</sup> Due to the increased number of eligible applicants, Congress feared that many states would conduct a mass exodus from the program as opposed to offering expanded coverage.<sup>95</sup> Therefore, Congress created the "209(b) option," so named because it appeared as § 209(b) of the 1972 amendments to Medicaid.<sup>96</sup> The 209(b) option allows states to choose between accepting this expanded coverage of all those eligible for SSI, or, in the alternative, retaining their more restrictive eligibility requirements which were in place as of January 1, 1972.<sup>97</sup> The 209(b) option allows states to use eligibility tests that are more restrictive than the corresponding federal eligibility tests.<sup>98</sup> States are generally described as being either "SSI states" or "209(b) states."<sup>99</sup>

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<sup>88</sup>Schweiker, 453 U.S. at 37.

<sup>89</sup>Indiana Dep't. of Pub. Welfare v. Payne, 592 N.E.2d 714, 720 (Ind. Ct. App, 1992).

<sup>90</sup>42 U.S.C. § 1396a(a)(17)(B) (1988).

<sup>91</sup>42 U.S.C. § 1396a(a)(17)(D) (1988).

<sup>92</sup>Supplemental and Security Income for the Aged, Blind, and Disabled, 42 U.S.C. § 1381 (1988).

<sup>93</sup>Schweiker, 453 U.S. at 36.

<sup>94</sup>*Id.* at 38. This requirement "threatened to swell the Medicaid roles and place a large financial burden on those states." *Morris v. Morrow*, 783 F.2d 454, 456 (4th Cir. 1986).

<sup>95</sup>Schweiker, 453 U.S. at 38.

<sup>96</sup>Section 209(b) is now codified at 42 U.S.C. § 1396a(f), but it is still referred to as § 209(b).

<sup>97</sup>Schweiker, 453 U.S. at 38-39. "Section 209(b) does not provide an independent basis for Medicaid eligibility, but is merely an exception that permits States to exclude those individuals who would not have been eligible for Medicaid in 1972 prior to the passage of the [SSI] Act." *Morris*, 783 F.2d at 459.

<sup>98</sup>*Mowbray v. Kozlowski*, 914 F.2d 593, 594 (4th Cir. 1990). "In 209(b) states, a person's eligibility or ineligibility for SSI is largely irrelevant to his or her Medicaid eligibility. . . ." *Noland v. Shalala*, 12 F.3d 258, 260 (D.C. Cir. 1994).

Important rules apply to the 209(b) states. One rule is that states exercising the 209(b) option must provide benefits to the medically needy group, as well as the categorically needy.<sup>100</sup> Another is the requirement that the state allow an applicant to "spend down" his or her income to become eligible.<sup>101</sup> This means that an individual whose income is too high to allow him to receive aid may become eligible once he has paid for enough medical services to place his income below the limit.<sup>102</sup> For instance, if a state has decided that a Medicaid applicant will only be accepted if his or her income is below \$600 per month, then the applicant with a monthly income of \$700 must spend one hundred dollars on medical care each month before Medicaid will cover the remaining medical bills. If the applicant incurred medical expenses totaling \$1,000 that month, Medicaid would then pay \$900.

The spend down requirements have positive and negative consequences. On the positive side, an individual will be provided with Medicaid coverage for medical care once he descends to the income level where he can no longer afford to pay for medical care himself. Without the spend down provision, this individual would never be eligible for Medicaid benefits, even when he ran out of money. On the negative side, the incentive to "spend down" has actually increased the costs of health care. In percentage of income and in actual dollars, the average elderly citizen spends more on total health care today than in 1965 when Medicaid was enacted.<sup>103</sup>

The spend down requirement is mandatory for 209(b) states, and is optional for SSI states.<sup>104</sup> In SSI states that do not offer the spend-down option, needy applicants often suffer from an inability to obtain care due to the depletion of their personal assets. That is, if the income of an applicant is even one dollar higher than the limit set by the state, that individual cannot receive Medicaid benefits regardless of the cost of his care.

### *B. Previous Attempts to Correct the Problems*

Several times, Congress has tried to amend Medicaid or establish a different, more effective program. These attempts essentially have been universal failures. In 1987, Representative Claude Pepper introduced a bill in Congress which was intended to greatly expand long-term care benefits under the Medicare program.<sup>105</sup> The bill was voted down by a substantial margin.<sup>106</sup> In

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<sup>99</sup> See, e.g., *Roloff v. Sullivan*, 975 F.2d 333 (7th Cir. 1992).

<sup>100</sup> *Morris*, 783 F.2d at 457.

<sup>101</sup> *Roloff*, 975 F.2d at 336-38.

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

<sup>103</sup> *Kapp*, *supra* note 5, at 726.

<sup>104</sup> *Roloff*, 975 F.2d at 336.

<sup>105</sup> *Kapp*, *supra* note 5, at 739.

<sup>106</sup> *Id.*

1988, Senator George Mitchell sponsored a bill which would have provided coverage for nursing home stays in excess of two years, although the beneficiary would still be required to pay thirty percent of the cost.<sup>107</sup> This bill never reached the congressional floor.<sup>108</sup> Also in 1988, Representative Henry Waxman introduced legislation similar to Medicaid, but more comprehensive, which would have provided long-term nursing home or community-based care to the poor.<sup>109</sup> This bill also failed to reach the floor.<sup>110</sup> In 1988, Congress enacted the Medicare Catastrophic Coverage Act [hereinafter MCCA], in an attempt to protect the elderly from impoverishment in case of a catastrophic illness requiring lengthy hospitalization.<sup>111</sup> The MCCA was repealed the following year after elderly taxpayers "refused to foot the bill."<sup>112</sup>

One program, however, actually met with some success. The Robert Wood Johnson Foundation [hereinafter Foundation] allowed individuals who purchased private long-term care insurance to be eligible for Medicaid once their insurance benefits were consumed.<sup>113</sup> These individuals remained Medicaid-eligible even if their resources exceeded the limit set by the state, up to the dollar amount of the coverage they had purchased.<sup>114</sup> In passing new legislation, however, Congress chose to restrict this apparently successful program.<sup>115</sup> States which already utilized the Foundation were permitted to continue, but no new state may now establish the program.<sup>116</sup>

The most recent attempt to revise the American health care system was the Clinton health care plan. In excess of 1,300 pages, this proposed system was possibly even more complex than Medicaid. The proposal was essentially "a complicated package of compromises."<sup>117</sup> One admirable goal of the plan was to eliminate the "second class status" often associated with Medicaid.<sup>118</sup> A more important goal, a primary purpose of the plan, was to provide universal health

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<sup>107</sup>*Id.*

<sup>108</sup>*Id.* at 739, n.147.

<sup>109</sup>Kapp, *supra* note 5, at 739-40.

<sup>110</sup>*Id.* at 740 n.149.

<sup>111</sup>Soltermann, *supra* note 1, at 253. The Medicare Catastrophic Coverage Act of 1988, Pub.L. No. 100-360, was contained in various sections of 26 U.S.C. and 42 U.S.C.. *Id.* at 253 n.9.

<sup>112</sup>*Id.* at 253, n.9.

<sup>113</sup>Kapp, *supra* note 5, at 748.

<sup>114</sup>*Id.*

<sup>115</sup>Robert Freedman, *Protecting Hard Earned Assets—Paying for Long-Term Care*, in UNDERSTANDING BASIC ESTATE PLANNING 1994, at 119, 123 (PLI Comm. Law & Practice Course Handbook Serv.s No. D4-5252, 1994).

<sup>116</sup>*Id.*

<sup>117</sup>Thiel & White, *supra* note 17, at 20.

<sup>118</sup>*Id.* at 15.

insurance through organizations known as "Regional Health Alliances."<sup>119</sup> The Alliances would oversee relationships among insurance providers to prevent pricing measures which defeat the advantages of healthy competition.<sup>120</sup> This purpose was to be facilitated by combining small employers into larger groups so as to reduce the costs and risks of insurance and to provide employers with more buying leverage.<sup>121</sup>

The plan also would have offered expanded long-term care benefits, including revision of the Medicaid spend-down requirements to allow exclusion of additional assets.<sup>122</sup> Applicants would have been allowed to retain up to \$12,000 in personal assets and a \$70 monthly living allowance.<sup>123</sup> Finally, the proposal would have provided a wider range of services outside of hospitals to Medicaid recipients who need home care.<sup>124</sup> The proposal barely got off the ground and was ultimately discarded.

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<sup>119</sup>*Id.*

<sup>120</sup>*Id.* at 15-16. The Alliances were intended to be the key element in a three-tiered structure. Dean R. Jerry, *The Clinton Administration's Health Insurance Proposal*, 3 KAN. J.L. & PUB. POLY 120, 121 (1994). Prior to its failure to become enacted, the plan was described in the following way:

A National Health Board oversees the entire system and sets general performance criteria and monitors performances. The health alliances are the key structural element. These are the purchasing cooperatives established in each region to monitor and manage the way in which the private health insurance market operates. Health plans are the individual health insurance companies offered to the population in each area through the health alliances.

Health alliances are required to accept all health plans in each area that meet minimum criteria, unless those health plans offer prices that exceed 120% of the area-wide average premium, in which case the alliance is allowed to bargain and refuse to accept the health plan. That's the basic way health alliances exercise purchasing power.

*Id.*

<sup>121</sup>Jerry, *supra* note 120, at 125.

<sup>122</sup>Thiel & White, *supra* note 17, at 19.

<sup>123</sup>*Id.* Thiel observes, however, that "the long-term care proposal [fell] short of most American's hopes." *Id.*

<sup>124</sup>*Comprehensive Long-Term Care Benefits Not Anticipated in Clinton Reform Plan*, 4 MEDICARE REP. (BNA) No. 34, at d8 (Aug. 20, 1993). As a final comment on previous attempts at health care reform, there was an attempt bearing similarity to the Clinton proposal about twenty years ago:

[I]n 1974, it appeared for a time that a bipartisan coalition might achieve a comprehensive national health insurance plan built up on a combination of private carriers and government programs. In the partisan maneuvering leading up to the 1974 congressional elections under the cloud of Watergate, however, the moment was lost.

Tuohy, *supra* note 66, at 252.

### C. The Omnibus Budget Reconciliation Act of 1993

Congress recently enacted the Omnibus Budget Reconciliation Act of 1993 [hereinafter OBRA '93].<sup>125</sup> The changes under this new statute mainly affect the rules relating to self-settled trusts, as well as transfers of assets and corresponding periods of Medicaid ineligibility.<sup>126</sup> The changes, which are described below, will likely have a dramatic impact on divestment planning techniques.<sup>127</sup> One report indicates that the changes will result in an "estimated savings to the federal government [of] \$25 million in fiscal 1994 and \$650 million over the next five years. . . ."<sup>128</sup>

### III. RESTRICTIONS AND LOOPHOLES IN MEDICAID ELIGIBILITY

In the past few years, a typical question before state courts has been whether a trust beneficiary is eligible to receive Medicaid benefits. The question is whether the assets of the trust are considered "available" to the beneficiary for purposes of determining his or her eligibility.<sup>129</sup> Unfortunately, determining whether the eligibility tests are satisfied is not an easy task.<sup>130</sup>

#### A. Transfers

When a person transfers assets for less than their fair market value prior to applying for Medicaid, he or she will be ineligible for Medicaid benefits for a certain period of time.<sup>131</sup> The period of ineligibility is equal to the number of months during which the applicant could have paid for his own care had he not transferred the asset. In most states, the cost of nursing home care is approximately \$3,000.00 per month.<sup>132</sup> Thus, for example, if an applicant transfers a \$30,000.00 asset, he will be ineligible to receive Medicaid benefits

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<sup>125</sup>Omnibus Budget Reconciliation Act of 1993, 42 U.S.C. § 1396p (1993).

<sup>126</sup>Sanford J. Schlesinger & Barbara J. Scheiner, *OBRA '93 Makes Sweeping Changes in Medicaid Rules*, 21 EST. PLAN. 74, 74 (1994).

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

<sup>128</sup>*Budget Bill*, *supra* note 31, at d8.

<sup>129</sup>Ronald R. Volkmer, *Trust Construction Suit and Medicaid Eligibility*, 21 EST. PLAN. 189 (1994). Volkmer discusses a case which "illustrates how disputes over the sole issue of the eligibility for Medicaid, might, for all practical purposes, be litigated simultaneously in the courts and in the administrative channels." *Id.* (citing *Young v. Dep't of Public Welfare*, 624 N.E.2d 110 (1993)).

<sup>130</sup>Soltermann, *supra* note 1, at 290 n.29.

<sup>131</sup>42 U.S.C. § 1396p(c)(1)(a) (1988).

<sup>132</sup>Schlesinger & Scheiner, *supra* note 126, at 76. However, "the average cost of private nursing home care varies among states and even among areas within states." *Id.*



for ten months. Before OBRA '93, the period of ineligibility was limited to thirty months.<sup>133</sup> Now, however, there is no limit on the period of ineligibility.<sup>134</sup>

If the uncompensated transfer is made three to five years prior to the Medicaid application, then the transfer will not be counted for eligibility purposes.<sup>135</sup> This three to five year period prior to Medicaid application is known as the "look-back period."<sup>136</sup> Any transfer of assets for less than fair market value during the look-back period will result in a period of ineligibility. Before OBRA '93, the look-back period was only thirty months.<sup>137</sup> The new legislation extended the period to thirty-six months for most transfers, and to sixty months for transfers from a trust.<sup>138</sup>

For example, under OBRA '93, if a Medicaid applicant transfers \$150,000 on January 1, 1995, and subsequently applies for Medicaid on December 1, 1997 (thirty-five months later,) the penalty period would be calculated by dividing \$150,000.00 by \$3,000.00 (the average cost of a nursing home stay per month,) resulting in a fifty-month period of ineligibility from the date of the transfer (that is, until March 1, 1999.) If this person waited until the thirty-seventh month (February 1, 1998) to apply for Medicaid, however, then the transfer made in January 1995 would not be within the thirty-six month look-back period and would not be relevant in the determination of Medicaid eligibility. The applicant would be eligible for Medicaid assistance beginning in January, 1998.

If the \$150,000.00 transfer were made from a trust, a sixty-month look-back period would apply. In that case, the applicant would not become eligible for Medicaid until January 1, 2000, regardless of when he or she applied!

The statute uses a "first day of the month" rule to determine when the period of ineligibility begins.<sup>139</sup> This rule allows a slight advantage for persons

<sup>133</sup>*Id.*; see also Barbara J. Collins, *Summary: Recent Changes in Federal Medical Assistance Law*, in Elder Law Institute 1994, at 123, 127(PLI Est. Plan. & Admin. Course Handbook Services No. D-235, 1994).

<sup>134</sup>42 U.S.C. § 1396p(c)(1)(a).

<sup>135</sup>42 U.S.C. § 1396p(c)(1). Section 1396p(c)(1)(B)(i) specifically relates to trusts.

<sup>136</sup>Schlesinger & Scheiner, *supra* note 126, at 75.

<sup>137</sup>*Id.* See also Collins, *supra* note 133, at 129.

<sup>138</sup>42 U.S.C. § 1396p(c)(1)(B)(i). "Most practitioners . . . contend that the language of the new provision is so confusing that a technical amendment will be necessary prior to its implementation." Schlesinger & Scheiner, *supra* note 126, at 74. The confusing portion of the statute reads as follows:

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) [relating to revocable trusts] or (3)(B)(ii) [relating to irrevocable trusts] of subsection (d), 60 months before the date specified in clause (ii).

<sup>139</sup>42 U.S.C. § 1396p(C)(1)(B)(i).

<sup>139</sup>42 U.S.C. § 1396p(c)(1)(D).

making disqualifying transfers at the end of a month in that the ineligibility period will be considered to have started at the beginning of the month. This is a small advantage, however, in proportion to the three to five year look-back period and the potentially unlimited ineligibility period. In the case of multiple transfers prior to OBRA '93, the periods of ineligibility would run concurrently, and the transferor could benefit by over-lapping periods.<sup>140</sup> Now, however, the periods of ineligibility will run consecutively.<sup>141</sup> Thus, before OBRA '93, if a person made a transfer in January that resulted in ten months of ineligibility, then made another transfer in March (two months later) that resulted in eight months of ineligibility, the person would have been eligible for Medicaid at the end of November (eight months after the second transfer) for a total period of ineligibility of ten months. Under the new law, however, these two transfers would be aggregated, and the individual would have to endure eighteen months of ineligibility.

The period of ineligibility can be avoided if an applicant can overcome the presumption that he transferred assets for the sole purpose of qualifying for Medicaid.<sup>142</sup> Generally, an applicant will not be penalized for the transfer if he makes a gift without retaining any interest in the property, provided his intent was not to become eligible for Medicaid, but to avoid probate or to reduce taxes.<sup>143</sup> Also, a period of ineligibility may be eliminated by "undoing" the transfer, meaning that the transferee must return the assets to the applicant so that they can be spent on his care.<sup>144</sup> OBRA '93 also requires states to develop standards for approving Medicaid despite the rules, in situations when denial of Medicaid benefits would cause "undue hardship."<sup>145</sup> Each state will provide its own standards as to what constitutes undue hardship.<sup>146</sup>

OBRA '93 provides exemptions for certain transfers. The statute specifically exempts any transfers by one spouse made for that spouse's benefit.<sup>147</sup> Also, a transfer to a spouse or to someone else for the sole benefit of the spouse will

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<sup>140</sup>Collins, *supra* note 133, at 123.

<sup>141</sup>Soltermann, *supra* note 1, at 259.

<sup>142</sup>*Id.*

<sup>143</sup>Bagge, *supra* note 73, at 15.

<sup>144</sup>Collins, *supra* note 133, at 128. Collins points out another perplexing ambiguity in the Medicaid statute:

The statute provides that all assets transferred for less than fair market value be returned. Can a period of ineligibility be reduced rather than eliminated by a return of a portion of the transferred assets? What about multiple transfers? . . . Will it be possible to reduce the period of ineligibility by returning the value of one or more, but not all of the transfers?

*Id.* These questions indicate a degree of risk in relying on the "undoing" provisions.

<sup>145</sup>42 U.S.C. § 1396p(c)(2)(D), 1396p(d)(5).

<sup>146</sup>Collins, *supra* note 133, at 125.

<sup>147</sup>42 U.S.C. § 1396p(c)(2)(B).

not result in a period of ineligibility either.<sup>148</sup> The new rules are thus very protective of the spouse of a Medicaid recipient.<sup>149</sup> The changes were necessary to eliminate a problem, known as "spousal impoverishment," which had previously plagued the Medicaid system.<sup>150</sup>

Some assets are exempt from consideration when calculating a Medicaid applicant's available resources. If these assets are sold, however, the proceeds of the sale will be held as an available resource. One exempt asset is the home of the applicant, the value of which is not counted towards available re-

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<sup>148</sup>Soltermann, *supra* note 1, at 260. Federal rules use the "name-on-the-instrument" rule to determine which spouse has the income available. *Id.* at 261. If both spouses' names are on the check, then each will be considered to have half of the amount available for eligibility determination. *Id.* The spouse who has applied for Medicaid only needs to spend down his or her half, rather than the entire assets of the couple, in order to reach the Medicaid resource limit. *Id.*

<sup>149</sup>Freedman, *supra* note 115, at 122 (citations omitted). Two elements of the Medicaid statute illustrate this spousal protection. The Community Spouse Resource Allowance [hereinafter CSRA], 42 U.S.C. § 1396r-5(c)(3), and the Minimum Monthly Maintenance Needs Allowance, 1396r-5(a)(1)(B) "have been the biggest secret in the whole Medicaid, long-term care process." David G. Lupo, *Medicaid—An Update on the C.S.R.A. and M.M.M.N.A. and the Effect of OBRA '93 on Asset Preservation*, 50 J. MO. B. 73, 85 (1994). The CSRA is especially useful for spouses:

The community spouse has the right to refuse to contribute resources in excess of [the CSRA] for the institutionalized spouse's care. This is a very important right. While this right exists in every state, it is commonly exercised only in New York . . . . If the community spouse exercises his or her refusal right, the [government] has the right to bring an action or proceeding to require the Community Spouse to contribute to the cost of the institutionalized spouse's health care . . . . The law allows unlimited transfer of assets from the institutionalized spouse to the community spouse without affecting Medicaid eligibility . . . . The community spouse could then refuse to use those assets to pay for the institutionalized spouse's care.

Freedman, *supra* note 115, at 124 (citations omitted).

<sup>150</sup>Cooney, *supra* note 4, at 528. The problem of spousal impoverishment is a function of the low resource ceiling set by the states, combined with the very high cost of care. The problem arises in the following way:

One spouse (statistically, the husband) becomes ill and unable to be cared for at home. Because the husband and wife together own too much in assets to qualify for Medicaid, he enters a nursing home as a private-pay patient. As his nursing home stay continues and the couple's income-producing capital is depleted, the wife, still residing at home in the community and incurring her own living expenses, finds herself less and less able to keep her head above water financially. By the time their assets are down to Medicaid qualification levels, the couple is impoverished and the community spouse is unable to support herself, although the institutionalized spouse now has all his expenses paid by Medicaid.

*Id.*

sources.<sup>151</sup> A distressing situation arises when a person spends down his or her assets to qualify for Medicaid and subsequently recovers from the illness. With insufficient resources to pay the costs of living, the person may be forced to sell his or her home. Then, if another illness transpires, the proceeds from the sale of the home, no longer an exempt asset, would be countable.

### B. Trusts

Medicaid eligibility and trust construction are issues which, though technically separate, are actually intertwined.<sup>152</sup> There are three characteristics of trusts that are relevant to eligibility determination. The most crucial trust characteristic is whether the trustee has any discretion in making distributions from the trust. Only assets in non-discretionary trusts will be exempt from consideration when calculating Medicaid eligibility. Another crucial characteristic is whether the trust is self-settled. If it is, the beneficiary will eventually become eligible but will have to endure a period of ineligibility. Additionally, the question of whether a trust is revocable or irrevocable relates directly to whether the assets are available to the applicant.

#### 1. Restrictions on Discretionary Trusts

Before OBRA '93, a person could place his assets in trust and obtain Medicaid benefits, provided that distributions could not be made at the trustee's discretion.<sup>153</sup> The key concept is the lack of discretion on the part of the trustee, because then the trust assets would not be legally considered available to the beneficiary.<sup>154</sup> The result was that the trust assets were protected from the spend-down requirement, thus preserving the potential of an inheritance for the family.<sup>155</sup> "Planned impoverishment" was simply a matter of making "a last minute pit stop at an attorney's office to erect a trust shield around assets."<sup>156</sup>

In cases where the trustee retains discretion, assets in self-created trusts have been held to be available to the beneficiary, solely because of the trust's discretionary nature.<sup>157</sup> One court held,

It is irrelevant that in creating the discretionary trust for [the settlor's] benefit, the settlor did not intend to defraud her creditors or was

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<sup>151</sup>42 U.S.C. § 1382b(a)(1). Since the home is exempt, one can buy home improvements or pay down a mortgage and thereby convert countable assets into non-countable assets. Cooney, *supra* note 4, at 532.

<sup>152</sup>Volkmer, *supra* note 129, at 189.

<sup>153</sup>Clifton B. Kruse, Jr., *Self-Settled Trusts Following OBRA 1993*, 23 COLO. LAW. 1297, 1297 (1994).

<sup>154</sup>*Id.* at 1298.

<sup>155</sup>*Id.*

<sup>156</sup>Bagge, *supra* note 73, at 16.

<sup>157</sup>Kruse, Jr., *supra* note 153, at 1297.

solvent at the time of the creation of the trust. It is against public policy to permit the settlor-beneficiary to tie up her own property in such a way that she can still enjoy it but can prevent her creditors from reaching it.<sup>158</sup>

This common law doctrine was codified in the Consolidated Omnibus Budget Reduction Act of 1985 [hereinafter COBRA '85].<sup>159</sup> This statute denied Medicaid benefits to persons who placed their assets in discretionary trusts for their own benefit, or for the benefit of their spouse.<sup>160</sup>

The term used in COBRA '85 to describe these trusts was "Medicaid qualifying trust" [hereinafter MQT].<sup>161</sup> The MQTs were described as trusts "established by an individual or spouse under which the individual may be beneficiary of all or part of payments from the trust, and where [the] trustee has discretion with regard to amounts to be distributed."<sup>162</sup> The assets held in the trust would be considered available for health care costs regardless of whether they actually were, even if the trustee refused to use his discretion to distribute them.<sup>163</sup> Essentially, a state will treat a discretionary trust, for purposes of Medicaid eligibility, as if the trustee had made the maximum distribution possible under the language of the trust instrument.<sup>164</sup>

Although OBRA '93 repealed the MQT provisions, the eligibility rules regarding discretionary trusts are substantially the same. The new rules still require assets held in discretionary trusts, as well as assets in other types of trusts, to be counted when determining whether the applicant's resources exceed the ceiling set by the state.<sup>165</sup> OBRA '93 replaced the MQT provisions with a similar, but even more restrictive, set of rules.<sup>166</sup> Despite these additional restrictions, loopholes still exist. For example, a trust can be worded so as to keep the income and principal available only until the need for long-term care

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<sup>158</sup>*Id.* (citing *Vanderbilt Credit Corporation v. Chase Manhattan Bank*, 473 N.Y.S.2d 242, 246 (N.Y. App. Div. 1984)).

<sup>159</sup>42 U.S.C. § 1396a(k) (1988)(repealed 1993).

<sup>160</sup>Kruse, Jr., *supra* note 153, at 1298.

<sup>161</sup>Consolidated Omnibus Budget Reconciliation Act of 1985, 42 U.S.C. § 1396a(k) (1988) *repealed by* Omnibus Budget Reconciliation Act of 1993, 42 U.S.C. § 1396p (1993). The MQT name, however, was poorly chosen, perhaps to keep a consistent level of confusion throughout the statute. A Medicaid "qualifying" trust actually *disqualifies* an applicant from eligibility.

<sup>162</sup>Collins, *supra* note 133, at 128.

<sup>163</sup>*Id.*

<sup>164</sup>Soltermann, *supra* note 1, at 267-68.

<sup>165</sup>*Id.* at 257-58.

<sup>166</sup>Collins, *supra* note 133, at 129.

arises. If properly worded, the trust then causes the assets to be unavailable for the duration of the need for costly medical care.<sup>167</sup>

## 2. Restrictions on Self-settled Trusts

Even self-settled, non-discretionary trusts are not without restrictions for eligibility purposes. Although a self-settled trust giving no discretion to the trustee will not be considered as an available resource, the settlor will still be required to wait out an ineligibility period. When the settlor places his assets in trust, he will not be eligible for Medicaid for a period of time, just as if he had transferred the assets for less than fair market value.<sup>168</sup> OBRA '93 has not changed this aspect of non-discretionary trusts.<sup>169</sup>

OBRA '93 has, however, taken a more restrictive approach to other aspects of non-discretionary trusts, particularly those containing assets of the Medicaid applicant, whether or not the applicant actually settled the trust himself.<sup>170</sup> The definition of self-settled trusts was broadened to further restrict Medicaid eligibility. The new definition now takes into consideration the owner of the assets that are actually used to fund the trust, instead of just the person who creates the trust.<sup>171</sup> If a trust containing assets of an applicant is established by the applicant, the applicant's spouse, a court, or anyone acting upon the request of the applicant or his spouse, then the trust is considered self-settled, and the applicant will undergo the ineligibility period.<sup>172</sup> Additionally, if a trust is funded with assets of more than one person, that portion of the trust which

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<sup>167</sup>Bagge, *supra* note 73, at 16. Bagge provides an example of trust language which would accomplish this purpose:

One day prior to the admission of a Grantor as a permanent or chronic care resident or patient in a skilled nursing facility, nursing home or other like institution as defined in the Medicare Catastrophic Coverage Act of 1988, all distributions of income and principal to said Grantor shall cease and said Grantor shall have no further legal or beneficial interest in this trust. Payments of income only, however, shall continue solely in the discretion of the trustee to the other Grantor who is not a permanent or chronic care resident or patient in a skilled nursing facility. . . . Upon the termination of one Grantor's interest in this trust as provided above, other than by death, all distributions of principal to the Grantor who is not a permanent or chronic care resident or patient in a skilled nursing facility shall cease and the Trustee shall have no discretion to distribute principal to or for the benefit of said Grantor.

*Id.*

<sup>168</sup>Freedman, *supra* note 115, at 128.

<sup>169</sup>*Id.*

<sup>170</sup>Schlesinger & Scheiner, *supra* note 126, at 77.

<sup>171</sup>*Id.* at 78.

<sup>172</sup>42 U.S.C. § 1396p(d)(2)(A)(i-iv).

consists of the applicant's assets will be considered self-settled by the applicant, again requiring a period of ineligibility.<sup>173</sup>

### 3. Restrictions on Revocable Trusts

For eligibility purposes, a distinction is made on the basis of whether a trust is revocable or irrevocable. If the trust is revocable, it will be considered as a resource available to the applicant, potentially rendering him ineligible for Medicaid benefits.<sup>174</sup> No period of ineligibility results from a transfer to a revocable trust, because the assets are still regarded as available.<sup>175</sup> Any payments from the trust to third parties will be considered as assets transferred for less than fair market value and will therefore remain subject to the sixty month look-back period.<sup>176</sup>

If the trust is irrevocable, then available resources will consist of whatever portion of the trust *could* be paid to the applicant under any circumstance (such as at the discretion of the trustee).<sup>177</sup> Furthermore, any part of the trust assets or income which cannot be paid to the individual will be considered as assets disposed of by the individual, subject to the sixty month look-back period.<sup>178</sup>

### 4. Exempt Trusts

OBRA '93 specifies three types of trusts which are exempt from being counted as available resources for Medicaid eligibility purposes.<sup>179</sup> The three types of trusts are expressly approved under the new statute and do not affect the beneficiary's eligibility for Medicaid assistance.<sup>180</sup> The first exemption to the restrictions on self-settled trusts occurs when the beneficiary is disabled and the trust is managed by a non-profit association. The association must "pool" trust funds from multiple individuals and then use the pool for the benefit of all.<sup>181</sup> In that case, the trust funds will not be counted as resources available to the applicant, provided that either the funds will remain in the pool at the beneficiary's death, or the trust funds will be used to reimburse the state for Medicaid benefits paid to that applicant.<sup>182</sup>

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<sup>173</sup>42 U.S.C. § 1396p(d)(2)(B). See also Schlesinger & Scheiner, *supra* note 126, at 77-78.

<sup>174</sup>Schlesinger & Scheiner, *supra* note 126, at 78.

<sup>175</sup>Collins, *supra* note 133, at 130.

<sup>176</sup>Schlesinger & Scheiner, *supra* note 126, at 78.

<sup>177</sup>*Id.*

<sup>178</sup>*Id.*

<sup>179</sup>See Renee R. Neeld, *Medicaid Planning: 1993 OBRA Asset Transfer Restrictions and Estate Recovery*, 37 RES GESTAE 329, 330-31 (1994).

<sup>180</sup>*Id.* See also Kruse, Jr., *supra* note 153, at 1299.

<sup>181</sup>Schlesinger & Scheiner, *supra* note 126, at 79.

<sup>182</sup>42 U.S.C. § 1396p(d)(4)(C).

This reimbursement requirement is also applied to the second form of exempt trust. Any trust containing only pensions or Social Security income is exempt if the state is entitled to reimbursement when the beneficiary dies.<sup>183</sup> This type of trust is known as a "Miller trust."<sup>184</sup> Miller trusts allowed the beneficiary to become eligible for Medicaid, as long as the trustee only has authority to distribute an amount of income that is below the eligibility limit set by the state.<sup>185</sup> Miller trusts are expressly permitted under OBRA '93.<sup>186</sup>

Finally, the third type of trust exempted under OBRA '93 is any trust funded with the assets of a disabled person who is under the age of sixty-five.<sup>187</sup> Such trusts are often created when an individual receives a disabling injury and a subsequent tort settlement. The tort money is then used to fund the trust. Once again, however, the state must be reimbursed with any funds remaining in the trust at the death of the disabled beneficiary.<sup>188</sup>

The reimbursement requirement actually runs throughout OBRA '93. The statute mandates recovery from the recipient's estate of all benefits paid to the extent possible.<sup>189</sup> Recovery may be had from either trusts or probate assets.<sup>190</sup>

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<sup>183</sup>Schlesinger & Scheiner, *supra* note 126, at 80.

<sup>184</sup>"Miller trusts" are so named because they were first judicially sanctioned in *Miller v. Ibarra*, 746 F. Supp 19 (D. Colo. 1990). *Miller* involved four mentally incompetent nursing home patients who had been denied Medicaid benefits because they were beneficiaries of trusts which contained assets in excess of the maximum limit set by the state. *Id.* at 20. The court held that since the trusts had been judicially created, the funds therein could not be considered available for purposes of determining Medicaid eligibility. *Id.* at 27. Furthermore, since the patients had not voluntarily transferred their assets into the trusts, the court held that there would be no period of ineligibility due to the judicially imposed transfer. *Id.* at 31.

<sup>185</sup>In *Miller*, the trustees had discretion to distribute an amount which, when combined with any other income the beneficiary might receive, would still be twenty dollars less than the monthly income eligibility standard. 746 F. Supp at 21.

<sup>186</sup>Collins, *supra* note 133, at 131.

<sup>187</sup>Neeld, *supra* note 179, at 331.

<sup>188</sup>*Id.*

<sup>189</sup>42 U.S.C. § 1396p(b)(1). This was not true prior to OBRA '93, as one commentator explains:

Under former law, recovery was optional. The new law requires a state to recover Medicaid expenditures from the estate of an individual who was 65 years of age or older (the text of the law says age 55, which is probably an error) when the individual received Medicaid benefits and from the estate of an individual who has received benefits under a long-term care insurance policy under certain circumstances.

Neeld, *supra* note 179, at 331.

<sup>190</sup>Neeld describes the scope of recovery as follows:

The recoverable estate must include all real and personal property and other assets included within the individual's estate as defined for purposes of state probate law. The state, at its option, may recover payments from non-probate assets. The statute says the recoverable estate may include any other real or personal property and other



Prior to OBRA '93, twenty-eight states had already enacted estate recovery laws, recovering over \$34 million in 1992 alone.<sup>191</sup>

#### IV. SOLUTIONS

Although OBRA '93 severely tightens the restrictions on trusts, loopholes remain. In attempting to restrain divestment planning, Congress may have inadvertently created the potential for divestment planning at an even more extreme level, as potential applicants attempt to fit between the cracks in the new law. It also remains to be seen whether the new fraud control provisions of OBRA '93 will have any effect on the billions of wasted dollars. More revisions or reforms will be necessary before the costs to both the government and the citizens can be controlled. There are three possibilities to consider for potential reform. First, the government could make another attempt at a universal, publicly-financed health care system, like the Clinton plan. Second, Congress could enact measures to encourage private insurers to expand their coverage. Third, laws might be passed which would force those who could actually pay for their own care to accept the personal obligations and family responsibilities.

##### A. Public Insurance

Before the government intervened in the health care system, both doctors and patients were encouraged to opt for less expensive medical procedures by the fact that private insurance coverage was far less extensive than it is today.<sup>192</sup> After Congress enacted Medicaid (and Medicare), however, health care providers could obtain reimbursement for almost any expense.<sup>193</sup> Therefore, as one would expect, health care costs spiraled upward.<sup>194</sup> The rising costs naturally caused insurance premiums to increase; today only three percent of the population carry private long-term care insurance because it is simply too expensive.<sup>195</sup>

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assets in which the individual had any legal title or interest 'at the time of death,' including property passing by joint tenancy, survivorship, life estate, living trust or other arrangement. This probably means "before death" since a Medicaid recipient has no interest in, for example, a life estate at the time of death.

Neeld, *supra* note 179, at 331-32.

<sup>191</sup> *Attempts to Shield Assets from Medicaid Will Go on Despite New Law, Panel Says*, 4 MEDICARE REP. (BNA) No. 42, Oct. 22, 1993, at d15.

<sup>192</sup> Soltermann, *supra* note 1, at 262-63.

<sup>193</sup> *Id.* at 263.

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

<sup>195</sup> *Id.* at 264. One way in which health insurance actually contributes to increasing costs is in the form of "moral hazard":

[O]nce insurance coverage for a particular service is created, insureds tend to take advantage of that benefit, often unneces-

One potential solution is compulsory, government-sponsored insurance. Since only very few people (three percent) voluntarily buy long-term care insurance, a program would benefit from, if not require, a compulsory aspect.<sup>196</sup> The mandatory system is condoned in the automobile insurance industry, so there is little reason why it would not work successfully in the health insurance industry as well.<sup>197</sup> A public system of insurance, with mandatory participation, may actually be superior to a private system because the elimination of both the profit margin and the marketing expenses could make the public sector more competitive in terms of the ratio between benefits and premiums.<sup>198</sup> Another reason in support of a public over a private program is that a publicly-controlled program would be subject to political pressures, allowing voters to respond directly to unfavorable cost increases.<sup>199</sup> Senior citizen lobbying groups, which tend to have strong political influence, could likely prevent unwarranted cost increases and possibly persuade politicians to regularly adjust benefits to account for inflation.<sup>200</sup>

### B. Private Insurance

The problem with public long-term care insurance is that the government has historically demonstrated an inability to restrain the rise in costs in other publicly financed health care programs.<sup>201</sup> An attempt to create a universal government-financed long-term care program would face a substantial risk of uncontrollable public expenditures.<sup>202</sup> Thus, private insurance may be a better solution. Despite the fact that private long-term care insurance has developed

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sarily. . . . [T]he concept of moral hazard is based on the theory of induced demand; the supply (insurance coverage) creates more demand (use of that coverage). In the context of long-term care, it is hypothesized that many older individuals who now cope without public financing, or who receive only minimal public financing to assist them, would "crawl out of the woodwork" and suddenly "need" public financial assistance if it were more widely available. There is particular worry about possible disappearance of informal, unpaid care that presently is provided to elders by their families and friends, in favor of reliance on newly available public financing for the same services.

Kapp, *supra*, note 5, at 734.

<sup>196</sup>Soltermann, *supra* note 1, at 280. Soltermann notes that young, healthy people often "cannot conceive that they will ever need such insurance." *Id.*

<sup>197</sup>Dobris, *supra* note 6, at 26. "Parentalism seems to be in order. Forced small payments over a life time of work are needed to provide the requisite funding." *Id.*

<sup>198</sup>Kapp, *supra* note 5, at 743.

<sup>199</sup>*Id.*

<sup>200</sup>*Id.*

<sup>201</sup>Soltermann, *supra* note 1, at 286.

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

at "a snail-like pace" since the 1980's when the idea first became reality, the number of policies sold has been increasing.<sup>203</sup> As more and more people become aware of the risk of losing their life savings, sales of long-term care insurance may increase even more.<sup>204</sup> Private insurance also removes the "perverse" incentives inherent in the Medicaid program<sup>205</sup> which can cause people to impoverish themselves or to fraudulently conceal assets. Use of private long-term care insurance could be encouraged (rather than mandated) by the federal government by allowing tax-free savings for long-term care and by further development of health maintenance organizations.<sup>206</sup> This type of encouragement could be generated by linking benefits directly to any increased costs to the taxpayers, so as to reduce resentment at paying higher taxes.<sup>207</sup>

### C. Family Responsibility

A third potential solution is for the federal government to encourage family responsibility for health care costs.<sup>208</sup> Federal Medicaid regulations already allow states to enact legislation requiring certain relatives to assist financially in paying for the costs of long-term care services provided to family members who are unable to pay for the care if the family members are collecting Medicaid benefits.<sup>209</sup> The problem with laws of this nature is that they may have severe disruptive effects on the relationships among family members. Such financial obligations, in light of the high cost of health services, could conceivably cause feelings of resentment or guilt which, if severe enough, may lead to neglect of one's family or even physical abuse.<sup>210</sup> On the positive side, however, a person paying his or her family's medical bills may qualify for tax

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<sup>203</sup>Kapp, *supra* note 5, at 747.

<sup>204</sup>Soltermann, *supra* note 1, at 282.

<sup>205</sup>*Id.* Soltermann describes some of the traits of "quality" long-term care insurance policies, indicating that they should have some form of inflation protection, a guaranteed renewability feature, and should provide for home care, as well as institutionalized care. *Id.* at 283. The amount of benefits paid is generally between \$40 to \$250 per day. *Id.*

<sup>206</sup>Kapp, *supra* note 5, at 749-50.

<sup>207</sup>*Id.* at 745.

<sup>208</sup>One commentator raises the persuasive question of: "Why else do people save money and other assets during their lives except to pay for the satisfaction of their and their loved ones' needs when they grow old?" Kapp, *supra* note 5, at 746.

<sup>209</sup>*Id.* at 750-51 (citing *Treatment of Contributions from Relatives to Medicaid Applicants or Recipients*, 2 DEPT OF HEALTH AND HUMAN SERV., HEALTH CARE FINANCING ADMIN., STATE MEDICAID MANUAL, § 3812 (1983)). See also 42 U.S.C. § 1396a(a)(17)(D) (requiring parents to provide the cost of medical care to minor children.)

<sup>210</sup>Kapp, *supra* note 5, at 751.

deductions.<sup>211</sup> Nevertheless, many feel that this type of solution would be so unpopular as to make it politically impossible.<sup>212</sup>

#### V. CONCLUSION

The current consensus among commentators is that any potentially effective solution to the dual problem of governmental cost overruns and financial devastation of the elderly, must involve both the public and private sectors acting cooperatively rather than competitively.<sup>213</sup> "We are going to have these costs. It's just a matter of we spread them."<sup>214</sup>

Congress needs to tighten Medicaid eligibility requirements even further than it has with OBRA '93. Only by reducing the number of people eligible for Medicaid can the cost overruns be halted. Unfortunately, reducing the number of Medicaid recipients would only solve part of the problem. With tighter restrictions, many middle class Americans would be left with no source of affordable long-term health care. Even though Medicaid was not intended to cover the middle class, it has been doing so for years. If coverage for the middle class is eliminated, a new source of coverage must be provided.

A better solution for both the government and the people of this country would be to replace the entire Medicaid system with another system for the middle class. One idea that has not yet been attempted is to reverse the traditional lines of thinking. Perhaps a publicly-funded system of health care should be constructed specifically for the middle class, while private insurers are offered incentives to cover the poor. A program of this nature would eliminate the incentive for middle-class divestment planning, since the middle class would already be covered. This solution would also allow relaxation of the restrictive and confusing rules regarding transfers and trusts. An elderly person would no longer have to worry as much about being able to leave an inheritance to his or her family.

To help the government control its costs, the program could be established with the requirement of co-payment from the health care recipient or the family. Although this family responsibility would create some of the problems outlined above, the extent of the problems would be slight because the family's responsibility would be partial, rather than total. Finally, co-payers and private insurers will be on guard against fraudulent billings which will thus have the effect of reducing costs even further.

KENNETH HUBBARD

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<sup>211</sup>I.R.C. of 1986, § 213 (1986). This section allows deductions to the extent that medical expenses exceed 7.5% of Adjusted Gross Income.

<sup>212</sup>Dobris, *supra* note 6, at 7.

<sup>213</sup>See, e.g., Kapp, *supra* note 5, at 741.

<sup>214</sup>*Id.* at 754.

