North Dakota Law Review

Volume 74 | Number 2 Article 2

1998

Planning for Nursing Home Care in North Dakota

Gregory C. Larson

Melissa Hauer

PLANNING FOR NURSING HOME CARE IN NORTH DAKOTA

GREGORY C. LARSON* AND MELISSA HAUER**

---

* Gregory C. Larson, Esq., a shareholder in Wheeler Wolf Law Firm, Bismarck, North Dakota, received his B.S. degree from the University of North Dakota, his J.D. degree from Gonzaga University, and his Master of Laws in Taxation (LL.M.) from the University of Miami. He is the State Coordinator of the National Academy of Elder Law Attorneys, Inc.

** Melissa Hauer, Esq., an associate attorney with Wheeler Wolf Law Firm, received her B.A. degree from the University of North Dakota and her J.D. degree from Gonzaga University. She is the State Public Policy Liaison for the National Academy of Elder Law Attorneys, Inc.

I. INTRODUCTION

A. THE ELDERLY POPULATION IN THIS COUNTRY IS CHANGING DRAMATICALLY

The rate at which the elderly population is expected to grow in this country in the next several decades will affect nearly every aspect of our society. A century ago, only twenty percent of the population could expect to reach the age of sixty.[1] Today, eighty percent do so and life expectancies are now in the mid-seventies.[2] The fastest growing segment of our population is that of people over age eighty-five.[3] Their numbers increased by more than fifty percent every decade between 1950 and 1980 and they are expected to increase in number by thirty-nine percent during this decade.[4] This subset of the population now has more than 3.3 million members.[5] With the average life expectancy in this country rising every year, it is easy to see why the boom in the elderly population will affect so many aspects of our society.

These statistics also tell us that more and more people will need some form of long term, or "nursing home," care during their lifetime. Experts estimate that as many as forty-three percent of people sixty-five years old will eventually need nursing home care and as many as twenty-four percent of those are expected to spend a year or longer in a nursing home, with nine percent spending as long as five years.[6] How our government and private entities will deal with these changing demographics and the resulting health care needs of an ever increasing elderly population has yet to be seen.

B. ARTICLE PURPOSE

This article reviews the various governmental programs and asset protection planning strategies that can assist the elderly with the cost of long term care, as well as various ways in which the elderly can finance the cost of their care privately.

---

1. U.S. SENATE SPECIAL COMM. ON AGING et. al., 101 st CONG., AGING AMERICA: TRENDS AND PROJECTIONS (1991) (citing tables 1-2).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 18 (1983).

II. PRIVATE METHODS OF FINANCING THE COST OF LONG TERM CARE

A. LONG TERM CARE INSURANCE

1. Overview of Long Term Care Insurance

Many people do not want to be dependent on government benefit programs that may not provide the type or quality of care that they want to receive in a nursing home. Others do not want to see the assets they have accumulated from a lifetime of hard work become depleted in a very short period of time due to a chronic illness. Being able to pass on an inheritance to one's children or grandchildren is also a driving factor for some to consider planning for potential nursing home costs. For some, the answer to these concerns is the purchase of a long term care (LTC) insurance policy. As our elderly population grows and more demand is made for such insurance products, the more diversity there is in the types of policies being offered. This, coupled with increasing tax incentives, will contribute to the growth of the long term care insurance industry and likely drive the market place to continue to produce better insurance products.

Insurance companies are offering LTC policies with more and more flexibility and coverage options than ever before. Many insurance companies no longer require a medical examination before issuing a policy, but instead collect a detailed medical history from the insured or medical providers. Purchasers are also being given more options regarding the elimination period which is the amount of time that must pass before benefits are paid. LTC policies are now being offered that have zero, thirty, sixty, ninety, 180, or 365 day elimination periods. Generally, the shorter the elimination period, the higher the premium.

More policies offer inflation protection as well, which can substantially affect the benefit of the LTC policy when you consider that the yearly increases in medical costs has far outpaced average inflation. A benefit increase option can be incorporated as an additional term of a LTC insurance contract. Most provide for a percentage increase, for example five percent, that is either a simple or compound interest increase in the amount of the benefit that will be paid. Some newer LTC policies allow the purchaser to select only a portion of the policy benefit in order to have inflation protection.

Furthermore, LTC policies can be purchased which provide coverage for home health care. A system of measuring how much the insured can do for himself is usually used to determine whether home health

care benefits will be paid. Referred to as the "activities of daily living" or "ADL's," they address how well the insured can perform such tasks as dressing, bathing, eating, going to the toilet, continence, walking, and transferring from a bed to a chair. Some policies will, for example, pay home health benefits if the insured cannot perform just two of the seven ADL's.

The premiums that one pays for a LTC insurance policy have become more affordable. If the purchaser has a fairly good health history, he or she is given a preferred rating, thereby reducing the premium. Some companies offer premium classifications which range from substandard to standard to preferred. Lower ratings increase the premium by thirty to sixty percent. Therefore, it is best to seek insurance coverage while one is still healthy. Some companies also offer spousal discounts of as much as ten percent when both spouses purchase coverage together.

Although LTC policy premiums are becoming more flexible, not everyone can afford such insurance. Others wait too long to explore the need for such coverage and are denied coverage because of health problems that often crop up later in life. For those who can qualify for coverage and for whom the premium payment makes financial sense, several considerations should be addressed in selecting a LTC policy.

2. Evaluating a Long Term Care Insurance Policy

When the decision has been made to purchase a LTC insurance policy, the following factors should be taken into account to ensure that the purchaser is receiving coverage that is best suited to his or her needs at a price that is competitive:

a. Does the policy provide comprehensive coverage for both nursing home care and home health care?
b. Is the daily maximum benefit (i.e. $50, $60, $80, $100) adequate in light of the average cost of nursing home care in the area, and in avoiding or reducing the depletion of the purchaser's other assets due to long term care?
c. Is the benefit period long enough to avoid or reduce depletion of assets (i.e. one year of coverage versus five years)?
d. Does the policy offer protection against inflation?
e. What is the elimination period (i.e. Does the insured have to pay for ninety days of his or her own care or 180 days of his own care) and how will the insured cover that period of time on his or her own?

f. Is the policy guaranteed renewable, meaning that if the insured pays the premium on time, can the company still drop the coverage?
g. What conditions must be met before benefits will be paid (i.e. Must entry into a nursing home be preceded by a stay in the hospital)?
h. How sound is the insurance company issuing the policy and will it be around ten or twenty years from now? Rating services such as Standard & Poor can be helpful in evaluating this.

3. Tax Incentives for Purchasing Long Term Care Insurance

Congress has recently passed legislation that provides tax incentives to those who wish to purchase LTC insurance. These laws specify that nursing home costs are deductible.[7] The Internal Revenue Code provides that the cost of long term care services which includes home health care services in certain circumstances, may be deducted as a medical expense.[8] Long term care services are defined as "necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and personal care services, which are required by a chronically ill person and are provided pursuant to a plan of care prescribed by a licensed health care practitioner."[9] These costs are deductible to the extent that, when combined with the taxpayer's other non-reimbursed medical expenses, they exceed 7.5% of his adjusted gross income.[10]

The new tax laws also allow premiums paid for LTC insurance to be deducted as a medical expense up to certain specified limits.[11] Premiums paid for health insurance and Medigap supplements are also deductible as a medical expense.[12] Proceeds from LTC insurance will be excluded from income up to the equivalent of $175 per day.[13]

B. REVERSE MORTGAGES

It is not uncommon for the elderly to be "house rich" but "asset poor," meaning that their only major asset is the equity they have built up in their residences. Until recently, a home was generally not very liquid and could be subject to capital gains tax if sold to pay for long

7. *See generally* I.R.C. § 213 (1998).
8. *Id.*
9. I.R.C. § 7702B(c) (1998).
10. I.R.C. § 213(a).
11. I.R.C. § 7702B.
12. *Id.*
13. *Id.*

term care. Reverse mortgages offer a way for the elderly to turn the equity in their homes into cash rather quickly. The lender essentially buys the equity and in return gets a mortgage against the property. Thus, instead of the homeowner paying a mortgage payment to the bank, the bank pays the homeowner. The income stream or cash payment can be used to fund long term care or pay other medical bills.

Reverse mortgages can be set up to provide the homeowner with a monthly payment over a period of time or it can provide one lump sum payment. The amount of equity that a homeowner may tap into with a reverse mortgage will vary with each lender. Some lenders will provide up to eighty percent loans to value in a reverse mortgage. The federal government even provides reverse mortgages through its Fannie Mae program.

Before entering into a reverse mortgage, the homeowner should clearly understand the fees and costs associated with it. There is currently a class action against several mortgage companies alleging that they charged illegal fees and misrepresented the costs involved in their reverse mortgages. Comparing fees and costs to those charged in government programs, such as Fannie Mae's, can be extremely helpful in determining whether they are reasonable.

Furthermore, the homeowner should be aware that cashing the equity out of the home through a reverse mortgage can affect public benefits such as Medicaid and Supplemental Security Income (SSI). These programs generally exempt the home. However, if the equity in a home is converted to cash, it may lose its exempt status. The cash from a reverse mortgage could push a recipient over the asset and income limits in means-tested public benefit programs, thereby reducing or terminating the benefit.

C. VIATICAL SETTLEMENTS

Viatical settlements present another way in which the elderly can finance long term care costs without depleting existing assets. A viatical settlement is an agreement between a viatical settlement provider and any person who owns a life insurance policy, called the "viator."[14] The settlement provider pays cash to the viator in exchange for the assignment of his rights to the policy's death benefit.[15] When the viator dies, the death benefit is paid to the settlement provider. This provides a way to get life insurance proceeds before death.

---

14. N.D. CENT. CODE § 26.1-33.1-01(5) (1995).
15. § 26.1-33.1-01(4).

North Dakota law requires all viatical settlement providers to be licensed by the North Dakota Insurance Commissioner.[16] The North Dakota Viatical Settlement Contracts Act also requires settlement providers to comply with certain disclosure and reporting requirements.[17] When considering whether to viaticate a life insurance policy, the following considerations should be observed:

a. Alternatives to a viatical settlement may exist, such as accelerated benefits offered by the life insurance company;
b. Recent changes in the tax law provide that viatical settlement proceeds will not be considered taxable income if they are used to pay for long term care and various other medical expenses.[18] However, some or all of the proceeds of the viatical settlement may be taxable as income if used for other purposes;
c. The viatical settlement may be subject to the claims of creditors;
d. Receipt of a viatical settlement may render the recipient ineligible for means-tested public benefits such as Medicaid and SSI;
e. It may take some time for the settlement provider to actually pay out the proceeds of a viatical settlement;
f. The viatical settlement company should be researched to determine its financial soundness;
g. Will the viator's heirs be adequately taken care of if there are no life insurance benefits;
h. North Dakota law gives the viator the right to rescind a viatical settlement contract within thirty days of the date it is executed or within fifteen days of the receipt of the viatical settlement proceeds by the viator, whichever is less.[19]

III. LONG TERM CARE BENEFIT PROGRAMS

A. MEDICARE

1. Overview of Medicare Program

Medicare is a governmentally sponsored health insurance program which is found in Title XVIII of the Social Security Act.[20] Most people will qualify for Medicare coverage when they turn sixty-five years of

16. § 26.1-33.1-02 (1995).
17. § 26.1-33.1-05 (1995).
18. *See generally* I.R.C. § 101(g)(3)(A)(i) (1998).
19. N.D. CENT. CODE. § 26.1-33.1-08 (1995).
20. Pub. L. No. 89-97, 79 Stat. 291 (codified as amended 42 U.S.C. §§ 1395-1395ll (1994 & West Supp. 1998)).

age, but those who are disabled can also qualify for coverage after they have received social security disability benefits for at least twenty-five months regardless of age.[21] Medicare is not a means-tested program, meaning that income and assets are not eligibility factors. One becomes eligible for Medicare by working and paying into the social security retirement system.[22]

Medicare is much like private health insurance in that premiums, deductibles, and co-payments must be paid by those who participate. Medicare is broken down into two parts: Part A, which is hospital insurance, and Part B, which is supplemental medical insurance. Everyone who is entitled to Medicare coverage automatically receives Part A coverage with no premium required.[23] Part A covers hospital expenses, limited post-hospital nursing home care, part-time home health services, and hospice care.[24] One can elect to purchase Part B coverage which requires them to pay a monthly premium. Part B covers physician's services, outpatient services, home health care, diagnostic tests, medical equipment, and certain prescription drugs.[25]

Medicare is administered by the Health Care Finance Administration (HCFA) and the Social Security Administration (SSA) which are overseen by the federal agency known as the Department of Health and Human Services (DHHS). DHHS contracts with private insurance companies to process and handle Medicare payments for health care providers. In North Dakota, Blue Cross Blue Shield of North Dakota is the insurance company that processes Medicare payments on behalf of the federal government.

2. Medicare Coverage of Nursing Home Costs

Many people mistakenly believe that Medicare will pay for the cost of nursing home care. Medicare's coverage of nursing home care will only be provided if certain, restrictive criteria are met. Even then, benefits are paid only for a very short period of time. In order to qualify for Medicare Part A coverage of nursing home care, the insured must meet the following criteria:

a. The Medicare beneficiary must be hospitalized for medically necessary inpatient hospital care for at least three consecutive

21. 42 U.S.C. § 1395c
22. *Id.*
23. 42 C.F.R. § 406.5 (1997).
24. 42 U.S.C. § 1395ww (1994 & West Supp. 1998).
25. *Id.*

calendar days not counting the day of discharge to be eligible for Part A coverage of subsequent nursing home care costs;[26]

b. Admission to the skilled nursing facility or nursing home must occur within thirty days after discharge from the hospital unless admission would be medically inappropriate during that time in which case later admission is acceptable;[27]
c. The skilled nursing services provided at the nursing home must be ordered by a physician;[28]
d. The nursing home care must require the skills of technical or professional health care personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech pathologists;[29]
e. The care must be furnished directly by or under the supervision of such personnel;[30]
f. The care must be needed by the patient on a daily basis;[31] and
g. The care must be the type which, as a practical matter, can be provided only in a skilled nursing facility or nursing home.[32]

If these criteria are met, Medicare Part A will pay for 100% of the cost of nursing home care for the first twenty days.[33] For days twenty-one through 100, the insured must make a co-payment and Medicare will only pay the remaining balance.[34] The 1998 Medicare co-payment amount for skilled nursing facilities is $95.50 per day.[35] In North Dakota, nursing home care averages only about $94.00 per day which means that most nursing home residents would receive nothing from Medicare on days twenty-one through 100.[36] After day 100, Medicare Part A will pay nothing for the cost of nursing home care.[37] It is clear to see why relying on Medicare to pay for nursing home care has the potential to be financially disastrous.

---

26. 42 C.F.R. § 409.30(a) (1997).
27. *Id.* § 409.30(b).
28. *Id.* § 409.31(a)(1) (1997).
29. *Id.* § 409.31(a)(2).
30. *Id.* § 409.31(a)(3).
31. *Id.* §§ 409.31(b)(1), -409.34 (1997).
32. *Id.* §§ 409.31(b)(3), -409.35 (1997).
33. *Id.* § 409.85 (1997).
34. *Id.*
35. *Id.*
36. N.D. Dep't of Human Serv. Manual, Service 510, ch. 05-35-09-30 (1996).
37. 42 C.F.R. § 409.85.

B. MEDICAID

1. Overview of the Medicaid Program

Medicaid is the medical assistance program contained in Title XIX of the Social Security Act which is jointly sponsored by the federal government and the states.[38] The Medicaid program provides a variety of benefits including physician services, laboratory services, coverage of prescription drugs, and nursing care services.[39] The program is designed to assist individuals who do not have enough income to obtain appropriate health care. Medicaid is a means-tested program, meaning that applicants must meet certain asset and income tests in order to be eligible for benefits.

Congress establishes the general rules of the Medicaid program, but states are given a fair amount of discretion to tailor the program to the needs of their particular residents. In most states, anyone who would be eligible to receive SSI benefits is also eligible for Medicaid. However, North Dakota elected to become what is known as a "209(b)" state and is thus allowed to use eligibility criteria that is more restrictive than the SSI rules.[40] Therefore, simply because a person qualifies for SSI benefits in North Dakota does not mean that they automatically qualify for Medicaid. However, even 209(b) states may not use rules that are more restrictive than the SSI eligibility rules, unless the state had those more restrictive criteria in place under the state's Medicaid plan as of January 1, 1972, which is the year in which the 209(b) election was made.[41]

2. General Eligibility Requirements

There are several categories of coverage under North Dakota's Medicaid program. This article focuses on nursing home care, and therefore, only the "medically needy" category will be addressed. A Medicaid applicant is considered to be "medically needy" when, although his income is too high to qualify for other Medicaid benefits, he has medical bills that exceed his income and he is aged, blind, or disabled.[42] This is commonly the case with nursing home residents who may have, for instance, an income of $2,000 per month but pay $3,500 per month for their nursing care.

---

38. *See generally* 42 U.S.C. 1396a (1994).
39. *See generally id.* § 1396(a).
40. *Id.* § 1396a(f). "209(b)" refers to § 209(b) of the 1972 Amendments to the Social Security Act.
41. 42 U.S.C. § 1396a(f); Mowbray v. Kozlowski, 914 F.2d 593 (4th Cir. 1990).
42. N.D. ADMIN. CODE § 75-02-02.1-03 (1994).

The requirement of being "aged" is met if the applicant is sixty-five years of age or older.[43] If an applicant applies for benefits asserting that he is blind or disabled, he has the duty to furnish medical records or other evidence to the Medicaid agency that establishes such a disability.[44] In North Dakota, "disabled" and "blind" have the same meaning as that used by the Social Security Administration for purposes of determining eligibility for the Supplemental Security Income (SSI) program.[45] The SSI program defines "disabled" as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve months.[46] "Blindness" is defined in the SSI program as statutory blindness which means that the applicant has central visual acuity of 20/200 or less in the better eye with the use of corrective lenses.[47] Once need is established, the applicant must also meet certain asset limits in order to qualify for Medicaid benefits. The Medicaid recipient is required to use his monthly net income to pay for nursing home expenses and Medicaid will pay whatever that income does not cover.[48]

3. Asset Limits

Applicants must meet certain asset limits before they qualify for Medicaid benefits. A person who is receiving "swing bed care" in a nursing facility is referred to as an "institutionalized" individual.[49] The institutionalized individual may have assets of any type not exceeding $3,000 in value.[50] The institutionalized individual may exempt a home occupied by his family, personal effects, wearing apparel, household goods, and furniture.[51] The institutionalized individual may also exempt one motor vehicle of any value.[52] The institutionalized individual may also exclude the following:[53]

---

43. 42 U.S.C. § 1396a(b)(1); 42 C.F.R. § 435.520 (1997).
44. 20 C.F.R. § 416.912(a) (1997).
45. N.D. ADMIN. CODE § 75-02-02.1-01(9) (1994).
46. 20 C.F.R. § 416.905 (1997).
47. *Id.* § 416.981 (1997).
48. N.D. ADMIN. CODE § 75-02-02.1-41.1 (1996).
49. *Id.* § 75-02-02.1-24(1)(c) (1997).
50. *Id.* § 75-02-02.1-26(1) (1997).
51. *Id.* § 75-02-02.1-27(1), (2) (1997).
52. *Id.* § 75-02-02.1-27(3).
53. Other exclusions exist in N.D. ADMIN. CODE § 75-02-02.1-28 (1997) in addition to the ones listed here.

a. Any pre-paid funeral expenses which total $3,000 or less;[54]
b. Property which is essential to earning a livelihood;[55]
c. Property which is not saleable without working an undue hardship;[56]
d. Various payments received in the way of reparation such as Agent Orange payments or German reparation payments to the survivors of the Holocaust.[57]

4. Spousal Impoverishment Protections

The medically needy coverage category also provides significant protections to prevent the impoverishment of the spouse of a nursing home resident. The institutionalized person's spouse is referred to as the "community spouse" as long as the spouse is not also institutionalized.[58] The assets of both spouses are taken into consideration when determining Medicaid eligibility for either one.[59]

The community spouse may exempt, among other things, the following:[60]

a. A community spouse countable asset allowance which amounts to a minimum of $80,760 for the calendar year 1998.[61] This exemption can be of any type of asset or combination of assets. The asset allowance is increased each year to account for inflation. As discussed below, the community spouse may also be entitled to keep a larger number of assets if a need is established at a fair hearing;[62]
b. A residence of any value occupied by the community spouse.[63] The residence includes all contiguous lands, including mineral interests, upon which it is located[64] This exemption includes all rural land that is contiguous to a community spouse's homestead even if rented or leased to a third party;[65]
c. Household goods, personal effects, and one automobile;[66]
d. $3,000 in any type of assets;[67]

54. *Id.* § 75-02-02.1-28(3).
55. *Id.* § 75-02-02.1-28(1).
56. *Id.* § 75-02-02.1-28(2).
57. *Id.* § 75-02-02.1-28(7)-(9).
58. *Id.* § 75-02-02.1-24(1)(a) (1997).
59. *Id.* § 75-02-02.1-24(2)(b), (c).
60. *Id.* § 75-02-02.1-24 (identifying additional exemptions not discussed here).
61. *Id.* § 75-02-02.1-24(3).
62. *Id.* § 75-02-02.1-24(3)(b).
63. *Id.* § 75-02-02.1-24(4)(a).
64. *Id.*
65. *Id.*
66. *Id.* § 75-02-02.1-24(4)(b).
67. *Id.* § 75-02-02.1-26(1) (1997).

e. Property that is essential to self-support.[68] This can include property which is essential to earning a livelihood such as the community spouse's business;
f. The individual applying for Medicaid may exempt a burial fund of up to $1,500.00 plus earnings on the fund.[69] In addition, the individual may exempt a burial space or agreement which represents the purchase of a "burial space" held for the individual, his spouse, or any other member of the individual's immediate family. "Burial space" includes burial plots, gravesites, crypts, caskets, vaults, headstones, markers, and prepaid arrangements for the opening, closing, and maintenance of the gravesite;[70] and
g. In lieu of the burial exemption discussed above, and at the option of the institutionalized individual, any prepayments or deposits which total $3,000.00 or less and the interest accrued on the burial fund may be excluded.[71]

5. Increasing the Community Spouse Resource Allowance

The Community Spouse Resource Allowance (CSRA) can be increased above the standard amount, which was $80,760 in 1998, through a fair hearing procedure.[72] Either the community spouse or the institutionalized spouse is entitled to such a fair hearing if the application for Medicaid has been made on behalf of the institutionalized spouse, and either spouse is dissatisfied with the CSRA amount.[73] Usually, this request would be made when a Medicaid application is denied due to the couple having assets in excess of the CSRA. Once a request is made, the hearing must be held within thirty days.[74] The hearing is an administrative proceeding in which an administrative law judge presides and the North Dakota Department of Human Services appears to represent its interests. The decision of the ALJ can be appealed to the District Court and subsequently to the North Dakota Supreme Court if desired.

It is the burden of the person requesting the hearing to show why the CSRA should be increased. To do this, either spouse must establish that the assets included in the CSRA generate an amount of income inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA), which was $2,019

68. *Id.* § 75-02-02.1-24(4)(f).
69. *Id.* § 75-02-02.1-24(4)(c).
70. *Id.* § 75-02-02.1-24(4)(d).
71. *Id.* § 75-02-02.1-24(4)(e).
72. *Id.* § 75-02-02.1-24(7)(a)-(e).
73. *Id.* § 75-02-02.1-24(7)(b)(5).
74. *Id.* § 75-02-02.1-24(7)(c).

per month in 1998.[75] If this can be shown, then the CSRA must be increased to an amount adequate to provide enough income to meet the MMMNA.[76] In North Dakota, the so-called "annuity method" is used to determine the amount of the increase in the CSRA.[77] The applicant must provide three estimates of the cost of a single premium lifetime annuity that would provide monthly income to the community spouse in an amount adequate to raise his or her income to the MMMNA.[78] The average cost of these three annuity estimates is then substituted for the standard CSRA.[79]

> EXAMPLE: Henry and Jan have only one countable asset, a farm worth $120,000, which they rent on a cash basis. They moved off the farm to live in town after Jan had a slight stroke. The farm lease provides them with $300 per month income, Henry's Social Security is $400 per month and Jan receives social security of $200 per month. Jan has another debilitating stroke and goes into a nursing home. When she applies for Medicaid, she is denied because their assets exceed the standard CSRA of $80,760. Henry requests a fair hearing to increase his CSRA because all of his assets do not generate enough income to allow him to meet the MMMNA of $2,019. The average cost of a single premium lifetime annuity that would generate enough income to raise Henry's income to the MMMNA is $140,000. Therefore, Henry's CSRA should be increased to allow him to keep $140,000 in any type of assets.

It is important to note that the language regarding increasing the CSRA is mandatory: if the community spouse can show that his assets generate an amount of income inadequate to raise his income to the MMMNA, then the CSRA must be increased.[80] This can be an important protection for couples who own assets, like farm land, which renders them "asset-rich" but "income-poor." To date, there has been only one request for an increase in the CSRA in North Dakota. That case is currently on appeal to the North Dakota Supreme Court.[81]

---

75. *Id.* § 75-02-02.1-24(7)(e)(1).
76. *Id.*
77. *Id.* § 75-02-02.1-24(7)(e)(3).
78. *Id.* § 75-02-02.1-24(7)(e)(2), (3).
79. *Id.* § 75-02-02.1-24(7)(e)(5).
80. *Id.* § 75-02-02.1-24(7)(d).
81. Wahl v. Morton County Soc. Serv., 547 N.W.2d 859 (N.D. 1998) (rehearing denied Mar. 30, 1998).

6. Income Protection

In addition to the asset protections available to prevent spousal impoverishment, the law also allows a certain amount of the institutionalized spouse's income to be paid to the community spouse for his or her support.[82] The MMMNA is the minimum amount of income the community spouse is allowed to get from the institutionalized spouse if the community spouse's income does not already meet the prescribed amount.[83] The 1998 MMMNA in North Dakota of $2,019 is adjusted annually.[84]

> EXAMPLE: The community spouse receives as her only income Social Security retirement benefits of $800 per month. Her institutionalized husband receives as his only income Social Security retirement benefits of $1,300 per month. The community spouse is entitled to $1,219 per month from her husband's income in order to boost her income up to the current MMMNA amount.

A higher MMMNA can be set by a hearing officer or court order if "exceptional circumstances resulting in significant financial duress" can be shown.[85] In no event can the community spouse's income be deemed available to the institutionalized spouse.[86]

> EXAMPLE: The community spouse receives $1,000 per month in Social Security retirement benefits and another $1,200 per month from a private pension. The institutionalized spouse has an income of $500 per month from social security benefits only. The community spouse's income exceeds the MMMNA and therefore she is not entitled to any of the institutionalized spouse's income. The institutionalized spouse is not entitled to any of the community spouse's income either.

The institutionalized spouse's income must be used to pay for his or her care.[87] However, in determining how much must be used to pay for the institutionalized spouse's care, the following amounts are deducted from income:

---

82. 42 U.S.C. § 1396r-5(d)(1) (1994 & West Supp. 1998).
83. *Id.* § 1396r-5(d)(3).
84. N.D. ADMIN. CODE § 75-02-02.1-24(5)(b)(2).
85. 42 U.S.C. § 1396r-5(e)(2)(B).
86. N.D. ADMIN. CODE § 75-02-02.1-24(5)(a).
87. *Id.* § 75-02-02.1-34(1)-(6) (1996).

a. A personal needs allowance of forty dollars per month;[88]
b. The community spouse's available MMMNA;[89]
c. A family allowance for each family member;[90] and
d. Amounts for incurred expenses for medical or remedial care for the institutionalized spouse.[91]

7. Where to Apply for Medicaid Benefits

Each county's social services office processes applications for Medicaid.[92] The application may be completed by the applicant, a legal guardian, member of the household, relative, friend, interested party, or other authorized representative.[93] The applicant must provide sufficient information to establish eligibility before a Medicaid application will be approved.[94] It is a good idea to submit as much verification as possible with the application when you submit it to Social Services because an application can be denied for failure to provide required information within the time period allowed.[95] The following is the basic verification that is needed with every application:

a. Birth Certificate (to show citizenship and age);[96]
b. Verification of Social Security Number (i.e., A copy of the applicant's Social Security card);[97]
c. A copy of the applicant's power of attorney or guardianship\conservatorship order (if applicable);[98]
d. Verification of income (i.e., A statement from the Social Security Administration regarding the applicant's gross amount of retirement benefit);[99]
e. Verification of the value of all assets owned by the Medicaid unit;[100]
f. Verification of unpaid medical bills;[101] and
g. Verification of disability (if applicable)[102]

---

88. *Id.* § 75-02-02.1-24(5)(b)(1).
89. *Id.* § 75-02-02.1-24(5)(b)(2).
90. *Id.* § 75-02-02.1-24(5)(b)(3).
91. *Id.* § 75-02-02.1-24(5)(b)(4).
92. *Id.* § 75-02-02.1-02(1)(b) (1994).
93. *Id.* § 75-02-02.1-02(1)(b), (d), (f).
94. *Id.* § 75-02-02.1-02(1).
95. *Id.* § 75-02-02.1-03 (1994).
96. *Id.* § 75-02-02.1-02(1).
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*

8. Verification of Assets

The kind of verification of assets that will be acceptable depends on the type of property involved. It is the applicant's responsibility to furnish reasonably reliable valuation information.[103] If the applicant does not provide a valuation of assets, benefits will be denied due to an inability to determine eligibility. Medicaid rules do not require full, certified appraisals of all property but, on the other hand, the applicant will not be allowed to provide his own estimate of the value of assets either. The following are acceptable means of verifying the type of property described:

a. Personal Property:

(1) Liquid Assets, such as bank accounts, may be verified simply by providing the most recent statement or accounting to Social Services;[104]
(2) Publicly traded stocks, bonds and securities may be valued by a stock broker;[105]
(3) Stocks not publicly traded may be appraised by an appraiser or accountant;[106]
(4) Vehicles, boats, motor homes, etc. may be valued by reference to a published valuation guide accepted in the trade (i.e. National Auto Dealers Association's "blue book");[107]
(5) Grains and produce may be valued by grain buyers, elevator operators, or produce buyers;[108] and
(6) Any other type of personal property may be appraised by a dealer or buyer of that type of property.[109]

b. Real Property:

(1) Mineral interests may be valued by an appraiser, mineral buyer, or geologist;[110]
(2) Residential real property (and any real property other than mineral or agricultural property) may be valued at the "true and full" value from tax records (contact your County Auditor

103. *Id.* § 75-02-02.1-32 (1997).
104. *Id.* § 75-02-02.1-32(1).
105. *Id.* § 75-02-02.1-32(2)(a).
106. *Id.* § 75-02-02.1-32(2)(d).
107. *Id.* § 75-02-02.1-32(2)(b).
108. *Id.* § 75-02-02.1-32(2)(c).
109. *Id.* § 75-02-02.1-32(2)(e).
110. *Id.* § 75-02-02.1-32(3)(a).

for this information) or by an appraisal. However, if the valuation furnished by the applicant varies greatly from the true and full tax value, an explanation must be made for the difference, particularly if the applicant may be able to influence the person who furnished the valuation;[111]

(3) Agricultural land must be valued by an appraiser, real estate agent, a loan officer in local agricultural lending institution, or other person known to be knowledgeable of land sales in the area. The true and full value from tax records will not be accepted.[112]

c. Divided or Partial Interests:

(1) Liquid Assets: the value of a partial or shared interest in a liquid asset is equal to the total value of that asset;[113]

(2) Life Estate and Remainder Interests: the value of the life estate or remainder interest is calculated by reference to a life estate and remainder interest table. The age of the owner is found in the table and the corresponding number is multiplied by the fair market value of the property;[114]

(3) Other: the value of personal property other than liquid assets and real property other than life estates and remainder interests is a proportionate share of the total value of the asset equal to the proportionate share of the asset owned by the applicant.[115]

d. Contractual Rights to Receive Money Payments:

The method of valuing contracts for deed and other contractual payment arrangements is done by a discounting formula specified in the North Dakota Administrative Code.[116]

9. Determination of Eligibility

Social Services has forty-five days in which to make a decision on a Medicaid application and ninety days in disability cases.[117] If an applicant has problems gathering all the necessary verification within the forty-five day time limit, the deadline can be extended if the caseworker

111. *Id.* § 75-02-02.1-32(3)(c).
112. *Id.* § 75-02-02.1-32(3)(b).
113. *Id.* § 75-02-02.1-32(4)(a).
114. *Id.* § 75-02-02.1-32(4)(c)(4).
115. *Id.* § 75-02-02.1-32(4)(b).
116. *Id.* § 75-02-02.1-32(5)(b).
117. *Id.* § 75-02-02.1-03(1) (1994).

documents in the case file why there is a delay.[118] When a decision has been made, Social Services must notify the applicant.[119]

Once an applicant is deemed eligible for Medicaid benefits, he is still responsible for contributing a certain amount of his income toward his own medical care.[120] This amount is called the "recipient liability" and functions somewhat like an insurance deductible.[121] Medicaid benefits are paid only when the Medicaid recipient has paid medical expenses in excess of his recipient liability.[122] For instance, if the recipient's liability is $800 per month, a Medicaid beneficiary must incur medical expenses in excess of that amount each month before Medicaid will pay any benefits. If so, the Medicaid beneficiary must pay the first $800 and Medicaid will pay for medical expenses in excess of that. The recipient liability is calculated using gross income less specified deductions.[123]

10. Estate Recovery

The state has the right, if certain conditions are met, to total reimbursement from the estate of the recipient for all Medicaid benefits paid.[124] North Dakota law provides that upon the death of any recipient of medical assistance who was fifty-five years of age or older when such benefits were paid, and if the recipient's spouse has predeceased, the total amount of Medicaid benefits paid must be allowed as a preferred claim against the decedent's estate.[125] Payment of certain expenses are allowed before such a lien will be asserted such as funeral expenses not in excess of $3,000.00,[126] expenses of last illness,[127] expenses of administering the estate,[128] and certain claims made under North Dakota Century Code §§ 50-01, 50-24.5, and 50-06.3.[129]

It is the duty of every personal representative to serve a copy of the petition or application commencing probate on the North Dakota Department of Human Services (DHS) together with list of the names of the heirs of the estate.[130] It is this notice that allows DHS to determine if

118. *Id.*
119. *Id.* § 75-02-02.1-03(3); 42 C.F.R. §§ 431.210-214 (1997).
120. N.D. ADMIN. CODE § 75-02-02.1-41.1(1)(a)-(f) (1996).
121. *Id.*
122. *Id.* §75-02-02.1-41.1(2)
123. *Id.* § 75-02-02.1-41.1.
124. N.D. CENT. CODE § 50-24.1-07 (1994 & Supp. 1997).
125. *Id.*
126. *Id.* § 50-24.1-07(1)(a).
127. *Id.* § 50-24.1-07(1)(b).
128. *Id.* § 50-24.1-07(1)(c).
129. *Id.* § 50-24.1-07(1)(d)-(f).
130. *Id.* § 50-24.1-07(3).

the decedent was ever paid medical assistance benefits and whether a claim can be made against the estate for recovery of such benefits. However, estate recovery claims must not be paid during the lifetime of the decedent's surviving spouse, nor while there is a surviving child who is under the age of twenty-one years, or is blind, or permanently and totally disabled.[131] However, no claim filed in a timely manner may be disallowed for these reasons.[132]

IV. MEDICAID ELIGIBILITY AND TRANSFER OF ASSETS

A. OVERVIEW OF TRANSFER RULES

Transfers of assets in order to become eligible for Medicaid benefits are subject to certain rules which may require a period of ineligibility for nursing care services. In 1993, Congress passed the Omnibus Budget Reconciliation Act of 1993 ("OBRA-93") which changed Medicaid rules governing the transfer of assets.[133] Accordingly, North Dakota law provides that any outright transfers made in the thirty-six months before the applicant was both institutionalized and has applied for Medicaid benefits will be considered and a penalty period assessed if those transfers were disqualifying.[134] This is called the "look-back period." The look-back period for transfers to trusts is sixty months.[135] It is unclear why Congress decided to extend the look-back period for transfers to trust since the ultimate result of divesting oneself of assets is the same whether such transfers are made to a trust or not.

If a disqualifying transfer was made, a penalty period is calculated based on the value of the assets transferred.[136] The resulting penalty period begins on the first day of the first month during which income or assets were transferred for less than fair market value,[137] and continues to run until exhausted. There is no longer a limit on the number of months that a Medicaid applicant may be penalized for disqualifying transfers, although under previous law, the transferror could not be penalized for more than thirty months.[138]

---

131. *Id.* § 50-24.1-07(2).
132. *Id.*
133. Pub. L. No. 103-66, § 13611, 107 Stat. 622 (codified at 42 U.S.C. § 1396p (1994)).
134. N.D. ADMIN. CODE § 75-02-02.1-33.1(1)(b) (1997).
135. *Id.*
136. *Id.* § 75-02-02.1-33.1(1)(d).
137. *Id.* § 75-02-02.1-33.1(1)(c).
138. *Id.* § 75-02-02.1-33.1(1)(d).

B. NON-DISQUALIFYING DISPOSAL OF ASSETS

1. Non-Disqualifying Transfers

There are certain transfers of assets that can be made with no resulting penalty period. These are considered non-disqualifying transfers and are protected for public policy reasons. An individual shall not be prevented from obtaining Medicaid benefits due to the following kinds of transfers:

a. There is no period of ineligibility when an individual transfers his or her home to a spouse,[139] to a child who is under age twenty one, blind, or disabled,[140] to a sibling who has an equity interest in the house and who was residing in the home for a period of at least one year before the individual became institutionalized,[141]or to the individual's child who was residing in the home for a period of at least two years before the individual became institutionalized, and who provided care which permitted the individual to reside at home rather than in an institution;[142]
b. There is no period of ineligibility when an individual transfers income or assets to a spouse or to another for the sole benefit of the spouse;[143]
c. There is no period of ineligibility when an individual's spouse transfers assets to another for the sole benefit of the individual's spouse;[144]
d. There is no period of ineligibility when assets are transferred to a trust established solely for the benefit of the individual's child who is blind or disabled;[145]
e. There is no period of ineligibility when assets are transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.[146] The provision for unlimited transfers between spouses is deceptively charitable because all assets of both spouses are taken into consideration when determining eligibility for the institutionalized spouse.[147]

---

139. *Id.* § 75-02-02.1-33.1(2)(a)(1).
140. *Id.* § 75-02-02.1-33.1(2)(a)(2).
141. *Id.* § 75-02-02.1-33.1(2)(a)(3).
142. *Id.* § 75-02-02.1-33.1(2)(a)(4).
143. *Id.* § 75-02-02.1-33.1(2)(b)(1).
144. *Id.* § 75-02-02.1-33.1(2)(b)(2).
145. *Id.* § 75-02-02.1-33.1(2)(b)(3).
146. *Id.* § 75-02-02.1-33.1(2)(b)(4).
147. *Id.* § 75-02-02.1-25 (1997).

There is also no period of ineligibility for other types of transfers if the individual can make a satisfactory showing that he or she intended to dispose of the asset either at fair market value or for other valuable consideration, and he or she had an objectively reasonable belief that fair market value or its equivalent was received,[148] if the asset was transferred exclusively for a purpose other than to qualify for Medicaid,[149] or if the transferred assets have all been returned to the individual.[150] The applicant may also be eligible for benefits despite a previous transfer of assets if the denial of benefits would work an undue hardship. Undue hardship exists when application of the transfer of assets penalties would deprive the applicant of medical care such that his or her health or life would be endangered.[151] Undue hardship also exists when application of the transfer of asset penalties would deprive the applicant of food, clothing, shelter, or other necessities of life.[152] Undue hardship does not exist when application of the transfer penalties merely cause the individual inconvenience, or when his lifestyle might be restricted but it does not put him at risk of serious deprivation.[153]

Specific items can also be transferred without incurring a penalty period, such as:

a. household goods and personal effects;[154]
b. one vehicle;[155]
c. a burial fund of up to $1,500.00 plus the earnings on the fund or a burial space;[156]
d. certain property that is essential to earning a livelihood;[157]
e. assets set aside by a blind or disabled person as part of a plan approved by the Social Security Administration to help that person achieve self-support;[158]and
f. various types of assistance.[159]

These kinds of assets are not disqualifying because they can be exempted by the Medicaid applicant anyway.[160] Therefore, a transfer of these items would not assist the person in becoming eligible.

---

148. *Id.* § 75-02-02.1-33.1(2)(c)(1).
149. *Id.* § 75-02-02.1-33.1(2)(c)(2).
150. *Id.* § 75-02-02.1-33.1(2)(c)(3).
151. Dep't of Health and Human Serv., Health Care Finance Admin. § 3258.10(5), Transmittal No. 64 (Nov. 1994).
152. *Id.*
153. *Id.*
154. N.D. ADMIN. CODE § 75-02-02.1-33.1(2)(e)(1) (1997).
155. *Id.*
156. *Id.* § 75-02-02.1-33.1(2)(e)(2), (3).
157. *Id.* § 75-02-02.1-33.1(2)(e)(4), (5).
158. *Id.* § 75-02-02.1-33.1(2)(e)(6).
159. *Id.* § 75-02-02.1-33.1(2)(e)(7)-(11).
160. *Id.* § 75-02-02.1-33.1(2).

2. Non-Disqualifying Spend Down of Assets

Individuals applying for Medicaid nursing care benefits are penalized only when they have transferred assets for less than fair market value.[161] Using assets that would otherwise not be exempt to purchase assets that are exempt carries no penalty period unless fair market value is not received. Making improvements to a home or updating a vehicle are some of the ways in which countable assets can be used to purchase exempt assets. Paying a guardian or agent under a power of attorney a reasonable fee for their services is also non-disqualifying if adequate consideration is received for the fee paid.

EXAMPLE 1: Ed and Mary rent an apartment and have $150,000 in countable assets. When Ed needs nursing home care, Mary can exempt $80,760 as her CSRA, $3,000 as her personal exemption, $3,000 for Ed's personal exemption, and $3,000 in a pre-paid burial contract. Mary spends $62,000 to pay fair market value for a condominium in which she will live. The condominium is exempt since it is the community spouse's residence. Ed and Mary have made no disqualifying transfers to bring their assets within the limits to allow Ed to qualify for benefits.

EXAMPLE 2: William and Betty own a home, a used vehicle, and have $110,000 in countable assets. When Betty needs nursing home care, William can exempt $80,760 as his CSRA as well as $3,000 for his personal exemption, $3,000 for Betty's personal exemption, and the $3,000 for burial expenses. William spends $10,000 to fix the roof on his house and paint it. He also spends $12,000 to buy a newer vehicle and trades in the old one. Betty and Ed have made no disqualifying transfers.

C. DISQUALIFYING TRANSFERS AND NURSING HOME PLANNING

1. Calculating the Penalty Period for Disqualifying Transfers

The penalty period imposed for a transfer of assets for less than adequate consideration is calculated by dividing the fair market value of the asset transferred by the average cost of nursing home care in North Dakota.[162] The average cost of nursing home care is called the "average

161. *Id.* § 75-02-02.1-33.1(1)(a).
162. *Id.* § 75-02-02.1-33.1(1)(d).

private pay rate" or "APPR." In 1998, the APPR in North Dakota is $94.31 per day or $2,869 per month.[163] This figure is revised each year as the cost of nursing home care increases. The resulting figure is the number of months the applicant is disqualified from receiving benefits.

> EXAMPLE 1: John resides in a nursing home and pays an average of $2,500 per month for his care. On January 1, 1998, John transferred $50,000 to his son and received nothing in return. John will be ineligible for Medicaid nursing care services for 530.17 days or approximately seventeen and a half months (50,000 ÷ 94.31 = 530.17 or 50,000 ÷ 2,869 = 17.42).

If the applicant's actual cost of nursing care exceeds the APPR, the actual cost can be used to calculate the penalty period, as those costs are incurred, with respect to periods when the applicant is otherwise eligible for Medicaid.[164]

> EXAMPLE 2: Anne resides in a nursing home and pays an average of $3,500 per month for her care. On January 1, 1998, she transferred $50,000 to her niece and received nothing in return. Anne is otherwise eligible for Medicaid. Anne will be ineligible for Medicaid nursing care services for approximately fourteen months and eight days (50,000 ÷ 3,500 = 14.28).

Under previous law, when multiple transfers were made, each penalty period expired separately from the other penalty periods assessed. OBRA-93 changed the rules regarding the assessment of penalty periods for multiple transfers. Now all transfers made during the "look-back period" are aggregated and the period of ineligibility begins on the date of the first transfer.[165] When OBRA-93 was first passed, many read this aggregating requirement to mean that penalty periods for later transfers could be "back-dated" to earlier transfers in order to get the penalty period running as of the first transfer. However, although 42 U.S.C. § 1396p(c)(1)(E) (OBRA-93) seems to suggest that all transfers in the look-back period are aggregated to arrive at one penalty period,[166] the provisions of the Act clarify that the penalty period does not always run continuously from the date of the first transfer since it depends on the timing of the transfers.[167] For instance, where a transfer was made when a previous penalty period was still

---

163. *Id.*; N.D. Dep't of Human Serv. Manual § 05-35-09-30(1)(f) (1996).

164. N.D. ADMIN CODE §75-02-02.1-33.1(2)(d); N.D. Dep't of Human Serv. Manual § 05-35-09-30(3)(b).

165. 42 U.S.C. § 1396p(c)(1)(D) (1994 & West Supp. 1998).

166. *Id.* §1396p(c)(1)(E).

167. *Id.* §1396(c)(1)(D).

running, the penalty period for the later transfer cannot begin to run until the first penalty period has expired.[168] However, where the later transfer occurs after the previous penalty period has expired, the penalty period for the most recent transfer will begin on the date of the transfer and does not relate back to the previous transfer.[169]

> EXAMPLE 1: Hal transfers $30,000 on September 15, 1997, $20,000 on January 1, 1998, and $40,000 on April 1, 1998. The transfers would be added together and a penalty period of approximately 31 months would be assessed (90,000 ÷ 2,869 = 31.36) because there are no gaps in the penalty periods for any one of these individual transfers (10.45 months for the September transfer, 6.97 months for the January transfers and 13.94 months for the April transfer). The penalty period will run from September 1, 1997, until approximately April 11, 2000.
>
> EXAMPLE 2: Harriet transfers $5,000 on September 30, 1997, $5,000 on January 1, 1998, and $80,000 on April 1, 1998. The transfers will each be assessed a separate penalty period because there are gaps between one penalty period and the next. The first transfer will result in a penalty period of 1.74 months (September 1, 1997 through approximately October 23, 1997). The second transfer will also result in a penalty period of 1.74 months but will not start to run until January 1, 1998, and will continue until approximately February 21, 1998. The third transfer will result in a penalty period of 27.88 months and will run from April 1, 1998, through approximately July 20, 2000. Note that transfers made on any day of the month cause the penalty period to begin on the first day of that month.[170]

These examples illustrate that different penalty periods may be assessed for the same amount of assets transferred depending on how those transfers are timed.

2. Coordinating the Look-Back Period with the Penalty Period

It is important to consider the effect of the unlimited penalty period when making any transfer. There is a trap for the unwary in failing to

168. *Id.*
169. *Id.*
170. N.D. ADMIN. CODE § 75-02-02.1-33.1(1)(c) (1997).

coordinate the look-back period and the penalty period. This occurs when a disqualifying transfer results in a penalty period in excess of thirty-six months. If the application for Medicaid is made when any disqualifying transfers are no longer in the look-back period, those transfers cannot be considered in determining eligibility. However, if the application is made when disqualifying transfers were made within the look-back period, then the penalty period is assessed. This can result in ineligibility if an individual applies for benefits too soon.

> EXAMPLE 1: Jane transferred $135,000 outright to her son on January 1, 1997. She goes into a nursing home and applies for Medicaid on January 1, 1999. A forty-seven month penalty period will be assessed against her because the transfer was within the thirty-six month look-back period for outright transfers (135,000 ÷ 2,869 = 47.05). The penalty period will run from January 1, 1997, through November, 2000.
>
> EXAMPLE 2: David transferred $135,000 outright to his niece on January 1, 1997. He goes into a nursing home but does not apply for Medicaid until February, 2000. The disqualifying transfer is outside the thirty-six month look-back period and therefore a penalty cannot be assessed. Note that the average monthly cost of nursing facility care (APPR) to be used to determine the number of months of ineligibility or the penalty period) is that which is in place at the time of the application.[171]

3. Nursing Home Planning Options Available and Related Considerations

a. Overview of Options

Even though a penalty period may be assessed for a transfer of assets for less than fair market value, such transfers can enable an individual to qualify for Medicaid nursing care services more quickly than if no transfers were made. Transfers can be made outright or to trust. Deciding whether to make a transfer outright or in trust depends upon the needs and wishes of the transferor while considering the restrictive trust rules discussed below. A transfer to trust may be preferable when beneficiaries are young, have spendthrift ways, or if divorce or bankruptcy are looming on the horizon. Outright transfers have the advantage of being easy to set up and accomplish and do not entail the

171. *Id.* § 75-02-02.1-33.1(1)(d).

expense and administration fees that go along with establishing and maintaining a trust.

b. Criminal Penalties for Assisting with Disqualifying Transfers

Various transfer options, their advantages and disadvantages, as well as their effect on Medicaid eligibility are discussed below. Before embarking on such transfers, any professional who may be involved in assisting or counseling a client with a disqualifying transfer of assets should be aware of a recently enacted federal law which makes it a crime to give such advice or counsel even though the act of making such transfers is perfectly legal in itself.[172]

This law arose out of a another law, that has since been repealed, which was dubbed the "send granny to jail" law.[173] The Health Insurance Portability and Accountability Act of 1996, ("the Act") which was signed into law by President Clinton on August 21, 1996, and became effective January 1, 1997. The Act contained a provision which made it a crime to knowingly and willfully transfer assets away in order to qualify for Medicaid benefits if disposing of such assets resulted in a period of ineligibility.[174] This provision first appeared in the final version of the Bill shortly before it was voted on and passed without any committee hearings, debates, public discussion, press coverage, or effort on the part of any member of Congress to claim authorship. After the Bill passed, many members of Congress admitted that they were unaware of the provision. To date, no one has claimed authorship of it and no one is sure how the provision got into the final bill.

The law was so poorly written that it was uncertain what actions could be considered criminal and whether those actions were a misdemeanor or felony. In any event, Congress repealed the "send granny to jail" law but in its place enacted what is being called the "send granny's lawyer to jail" law.[175] The new law, passed on August 5, 1997, purports to make it a crime for a paid advisor to knowingly and willfully counsel or assist another to dispose of assets for the purpose of obtaining Medicaid benefits where the disposition of assets results in the imposition of a Medicaid penalty period.[176]

---

172. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4734, 111 Stat. 522 (codified at 42 U.S.C. § 1320a-7b (West Supp. 1998)).

173. *Id.* § 4734, 111 Stat. at 522.

174. Pub. L. No. 104-191, § 217, 110 Stat. 2008-09 (codified as amended at 42 U.S.C. 1320a-7b)

175. § 4734, 111 Stat. at 522.

176. *Id.*

Since the language of this new law is no more clear than that of the old "granny goes to jail" law, no one is certain as to how it might be interpreted or enforced. One interpretation is that it is only a crime when a paid advisor not only counsels someone to transfer assets for the purpose of obtaining Medicaid, but also counsels that person to apply for Medicaid during the resulting penalty period. A more expansive reading of the statute would be that a crime has been committed even though the person was not counseled by the paid advisor to apply during the penalty period.

Both of these scenarios assume that there can be no criminal liability unless an actual penalty period is imposed against the Medicaid applicant (i.e., The Medicaid application is made too soon while the penalty period is still running). This is a reasonable interpretation given the language of a case that was brought regarding the original "granny goes to jail" law. In a lawsuit filed in an Oregon federal district court by an elderly Medicaid applicant named Peebler against Attorney General Janet Reno, the government provided its interpretation of the law which stated that criminal sanctions can only apply if the transfer of assets actually results in the imposition of a period of ineligibility for Medicaid benefits.[177] In other words, if a person transfers assets, waits out the penalty period and then applies for prospective Medicaid benefits, such that a period of ineligibility is not imposed, the applicant would not be subject to prosecution. It is important to remember, however, that *Peebler* would only be viewed as dicta by many courts since the case was not decided on the merits. In addition, *Peebler* interpreted the since repealed "granny goes to jail" law rather than interpreting the new law that targets paid advisors such as lawyers, accountants, and financial advisors. It appears that granny is still at risk even under the new law since it could be argued that she is guilty of aiding and abetting her paid advisor when she decides to make disqualifying transfers.

It is difficult to determine what kind of conduct Congress intended to curtail by the enactment of the provision targeting professionals who advise clients regarding asset transfers. The question is whether Congress was seeking to prohibit lawyers and other advisors from discussing with their clients the options they have available, even if lawful in themselves, for transferring assets to qualify for Medicaid. This is a critical question because the act of giving away assets is always lawful but may bring about the civil penalty of a period of ineligibility for benefits. It also raises the question whether Congress will enact similar legislation designed to prohibit the dissemination of information regarding perfect-

177. Peebler & Nay v. Reno, 965 F. Supp. 28, 31 (D. Or. 1997).

ly legal acts, such as making it a crime for an accountant to advise his client of a perfectly legal tax deduction. Since the law is poorly written, it could also ensnare those who transfered assets in order to reduce the size of their taxable estates and who later happen to need nursing home care. The difficullty lies in attempting to prove that a transfer of assets was not done for the sole purpose of becoming eligible for Medicaid.

A bill has been introduced in Congress to repeal the "send granny's lawyer to jail" law.[178] However, even if Congress does not repeal this law, there is a question as to whether it can withstand judicial scrutiny. On December 4, 1997, the New York State Bar Association filed a lawsuit in a federal district court against U.S. Attorney General Janet Reno seeking to declare this law which criminalizes advising people of lawful Medicaid asset transfers unconstitutional. The complaint asks the court to find that the law violates the First Amendment protection of free speech because it criminalizes protected speech in terms of an act that is, in itself, not criminal and that it violates the Due Process clause of the Fifth Amendment because it is unconstitutionally vague. At the time this article was written, no opinion had been delivered by the court on this complaint. If the court reaches the merits of the case, the most likely interpretation of the law is that it is unenforceable as an unconstitutional infringement on free speech.

Until the law is repealed or struck down as unconstitutional, professionals who may advise or counsel clients regarding their options for transferring assets in order to attain Medicaid eligibility will have to decide for themselves whether to continue giving such assistance and risk prosecution. Some professionals believe that criminal liability can be avoided by ensuring that the client does not apply for Medicaid during a penalty period. This can be risky if the client misunderstands the professional's advice and inadvertently applies for benefits too soon.

4. Trusts—Why They Can be a Trap for the Unwary

Trusts have been used as a way to shelter resources and income in order to become eligible for Medicaid. Congress has determined that trusts are being abused and has acted to limit the efficacy of trusts in Medicaid planning. Since the look-back period for transfers to trusts is now sixty months[179] and the penalty period can be unlimited, trusts can be a trap for the unwary. If too much is transferred to trust and application for benefits is made within the look-back period, a person could disqualify himself for Medicaid benefits almost indefinitely.

178. H.R. 2396, 105th Cong. (1997).
179. N.D. ADMIN. CODE § 75-02-02.1-33.1(1)(b) (1997).

> EXAMPLE: On February 1, 1995, Robert transferred $300,000 to an irrevocable trust. His children are the only beneficiaries of this trust and therefore, Robert has no right to receive any of the income or principal from the trust. Robert needs nursing home care and applies for Medicaid benefits on January 1, 1998. He will be disqualified from receiving benefits for approximately 105 months, which is about nine years, from the date he transferred his assets to the trust (300,000 ÷ 2,869 = 104.57). Had Robert waited to apply for Medicaid until March, 2000, the transfer to trust would have been outside the look-back period and no penalty could have been assessed.

This example demonstrates why trusts should be used only when their implications are fully understood. Additionally, certain types of trusts offer no protection from the cost of long term care as discussed below.

a. Revocable Trusts

A revocable trust is a trust which can be revoked by the grantor.[180] Medicaid rules also count as revocable a trust which provides that the trust can only be modified or terminated by a court since the grantor could petition the court to terminate the trust.[181] Trusts which are called irrevocable, but which terminate if some action is taken by the grantor, will also be considered revocable.[182] The entire corpus of revocable trusts are considered assets available to the Medicaid applicant and payments from the trust to or for the benefit of the applicant, will be considered income.[183] Therefore, revocable trusts shelter no assets or income for Medicaid eligibility purposes.

b. Irrevocable Trusts

An irrevocable trust is defined as one which cannot be revoked by the grantor.[184] If there are any circumstances in which payment from the trust could be made to the Medicaid applicant, the portion of the corpus from which payment could be made will be considered available assets.[185] Likewise, any income from the trust corpus that the applicant is entitled to will be counted as income.[186] When all or a portion of trust

180. *Id.* § 75-02-02.1-31.1(1)
181. Dep't of Health and Human Serv., Health Care Finance Admin. § 3259(a)(5), Transmittal No. 64 (Nov. 1994).
182. *Id.*
183. N.D. ADMIN. CODE § 75-02-02.1-31.1(3)(a)(1).
184. *Id.* § 75-02-02.1-31.1(1).
185. *Id.* § 75-02-02.1-31.1(3)(b)(1).
186. *Id.*

corpus or income cannot be paid to the applicant, all or any such portion will be considered a transfer of assets for less than the fair market value and thus a penalty period will be assessed.[187]

c. Annuities

An annuity is a right to receive fixed, periodic payments, either for life or a term of years. Medicaid rules provide that the definition of "trust" includes any legal instrument or device, whether written or not, which is similar to a trust.[188] The term trust has been defined to include an annuity to the extent and in such manner as the Secretary of the Department of Health and Human Services ("DHHS") specifies.[189] Although no federal regulations on the treatment of annuities have been promulgated to date, DHHS has provided guidance to states on how to treat annuities. The state is supposed to make a determination with regard to the ultimate purpose of the annuity (i.e., Whether it was purchased to provide a source of income for retirement or to shelter assets so the individual can become eligible for Medicaid).[190] If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.[191] A life expectancy table is consulted to make this determination. If the individual is not reasonably expected to live longer than the guaranteed period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. Thus, the annuity is not actuarially sound and a transfer of assets for less than fair market value has occurred subjecting the individual to a penalty period.[192]

> EXAMPLE 1: Ray, who is age sixty-five, purchased a $10,000 annuity to be paid over ten years. His life expectancy is 14.96 years therefore the annuity is actuarially sound.
>
> EXAMPLE 2: Charlie who is age eighty purchases a $10,000 annuity to be paid over ten years. Since his life expectancy is only 6.98 years, the annuity is not actuarially sound and a penalty must be assessed. The payout of the annuity for approximately three years is considered a transfer of assets for less

187. *Id.* § 75-02-02.1-31.1(3)(b)(1)(b).
188. *Id.* § 75-02-02.1-31.1(6)(b).
189. Dep't of Health and Human Servs., Health Care Finance Admin. § 3258.9(B), Transmittal No. 64 (Nov. 1994).
190. *Id.*
191. *Id.*
192. *Id.*

than fair market value and that amount is used to calculate the penalty period.

It is important to keep in mind that an annuity payment to a Medicaid recipient is still counted as income even if it is deemed actuarially sound.[193] Therefore, the income from the annuity could end up being paid to the nursing home as part of the individual's recipient liability.

5. Exceptions to Trust Penalty Rules

Congress decided to provide an exception to the penalty rules for certain types of trusts. These trusts are treated differently for public policy reasons.

a. Special Needs Trusts

A trust containing the assets of an individual under age sixty-five who is disabled and which is established for the sole benefit of that individual by a parent, grandparent, legal guardian, or court qualifies for the exception to the trust rules.[194] The trust must contain a provision stating that, upon the death of the individual, the state receives all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of the individual.[195] When such a trust is established, the exception from trust rules continues even after the individual reduces age sixty-five.[196] However, nothing can be added to the trust after the individual reaches age sixty-five.[197] Establishment of this type of trust does not constitute a transfer of assets for less than fair market value.[198]

b. Pooled Trusts

Assets of disabled individuals are pooled into one trust fund established and managed by a non-profit association.[199] A separate account is maintained for each beneficiary. The trust must pay to the state the amount remaining in the account upon the death of a beneficiary up to the total amount of medical assistance paid on behalf of that beneficiary.[200]

---

193. N.D.ADMIN. CODE. § 75-02-02.1-34 (1996).

194. Dep't of Health and Human Servs., Health Care Finance Admin. § 3259.6, Transmittal No. 64 (Nov. 1994).

195. N.D. ADMIN. CODE § 75-02-02.1-31.1(3)(b)(2) (1997).

196. Dep't of Health and Human Servs., Health Care Finance Admin. § 3259.7(A), Transmittal No. 64 (Nov. 1994).

197. *Id.*

198. *Id.*

199. N.D. ADMIN. CODE § 75-02-02.1-31.1(4)(b)(1).

200. *Id.* § 75-02-02.1-31.1(4)(b)(4).

c. Undue Hardship Exception

When application of the trust penalty provisions would work an undue hardship, these rules must not be applied.[201] States are required to acknowledge this exception by implementing an undue hardship provision in the Medicaid State Plan.[202] To date, North Dakota's Administrative Code does not reflect that this exception is part of the state's Medicaid Plan. Undue hardship is not defined by the state nor does it provide for how the exception will be implemented. The Department of Health and Human Services, the federal Medicaid agency, provides that states have considerable flexibility in implementing the undue hardship provision. However, the states' definition of undue hardship must include that undue hardship exists when application of the trust penalty provisions would deprive the individual of medical care such that his or her health or life would be endangered, or when the individual would be deprived of food, clothing, shelter, or other necessities of life.[203]

6. The Most Common Scenarios in Nursing Home Planning

Many of the planning options that were available prior to the passage of OBRA-93 are still available for those who wish to plan for the cost of long term care. The following are the most common scenarios that will present themselves in the Medicaid planning area:

(1) Husband and wife who are both healthy;
(2) Husband and wife with one in a nursing home;
(3) Husband and wife with both in a nursing home;
(4) Single adult who is healthy; and
(5) Single adult in a nursing home.

Some of the available planning strategies for each of these scenarios is discussed below. Some strategies work well for almost any situation while others are very specific and may require the presence of a community spouse in order to be applicable.

a. Medicaid Case Study of Healthy Couple

Abraham and Sarah are husband and wife and neither of them resides in a nursing home. Both are healthy and foresee no immediate

201. Dep't of Health and Human Servs., Health Care Finance Admin. § 3259.8, Transmittal No. 64 (Nov. 1994).
202. *Id.*
203. *Id.*

need for nursing home care. Abraham is seventy-five years old and Sarah is seventy-three years old. They have the following assets:

Investments	$150,000
Home	75,000
Automobile	2,000
TOTAL	$227,000

(1) Life Estate in Residence

Sarah and Abraham wish to protect their home which is an exempt asset if one of them were to go into a nursing home so long as the other continues to live in the home. However, if both were to go into a nursing home, or if the community spouse were to die, the home generally ceases to be an exempt asset. Therefore, on January 1, 1998, they transferred their home to their adult children reserving a joint life estate for themselves. The transfer of the remainder interest to the children is a disqualifying transfer and a penalty period will be assessed based on the following formula:

Fair market value of residence	$ 75,000
X (remainder interest fraction based on youngest life tenant's age)[204]	x .44429
	$ 33,321

Thus, the total uncompensated transfer amounts to $33,321 which when divided by the current average private pay rate of $2,869 results in a penalty period of 11.61 months. Sarah and Abraham have the right to live in the house, or the right to any rental income it might generate, for as long as they live. They are also responsible for paying the property taxes as the life tenants. When both of them to die, the house automatically becomes vested in the children as the remaindermen without any need for probate. The value of their life estate is also considered an exempt asset.[205] The property will also receive a step-up in tax basis upon the death of the last joint life tenant.[206]

(2) Outright Transfer of Assets

Sarah and Abraham decide to transfer some of their liquid assets to their children as well. They gift a total of $60,000 to their children on January 1, 1998. This results in a total of $93,321 which has been

204. N.D. ADMIN. CODE § 75-02-02.1-32(4)(c)(4) (1997).
205. *Id.* § 75-02-02.1-28(2) (1997).
206. I.R.C. §§ 1014, -2036 (1998).

transferred for less than fair market value. The resulting penalty period will be 32.53 months ($93,321 ÷ 2,869).

(3) Update Vehicle

Sarah and Abraham also decide to trade in their old vehicle and use $10,000 of their remaining investments to purchase a new vehicle for $12,000. Their remaining assets are:

Investments remaining	$ 80,000
Value of life estate in home	41,679
Automobile	12,000
TOTAL	$133,679

Should either one need nursing home care and application for benefits is made after the penalty period has expired, their assets are within Medicaid limits:

TOTAL ASSETS	$133,679
Less CSRA	-80,760
Less personal exemptions	-6,000
Less burial exemption	-3,000
Less life estate value	-41,679
Less exempt auto	-12,000
TOTAL	$9,760

b. Medicaid Case Study Number One of One Spouse in Nursing Home

Jacob and Rachel are husband and wife. Rachel lives in the couple's home on their farmstead, but Jacob has recently moved into a nursing home. Jacob is seventy years old and Rachel is sixty-eight years old. Jacob's income does not cover the cost of his nursing home care. They have the following assets:

Farm land and residence	$150,000
Investments	75,000
Automobile	2,000
TOTAL	$227,000

(1) Pre-Need Burial Purchases

Jacob and Rachel purchase plots, a headstone, caskets, vaults, and grave opening and closing services for both of them for a total of

$6,000. This amount will be excluded as their pre-paid burial arrangements.[207]

(2) Exempt Farm Land

Since Rachel continues to live in the couple's home which is located on land that is contiguous to all of their land, the entire value of their farm will be considered exempt even though she leases it to her son.[208]

For Medicaid purposes, they have the following countable assets:

TOTAL ASSETS	$227,000
Less exempt farm land	-150,000
Less CSRA	-80,760
Less burial items	-6,000
Less personal exemptions	-6,000
Less exempt auto	-2,000
COUNTABLE ASSETS	$17,760

Jacob would qualify for Medicaid benefits immediately since no disqualifying transfers were made and the couple's assets are within limits.

c. Medicaid Case Study Number Two of One Spouse in Nursing Home

Andrew and Carol are husband and wife. Andrew, who is seventy-three years old, lives in the couple's residence and Carol, who is seventy-two years old, resides in a nursing home. The net cost of Carol's care is $2,700 per month after applying her income to these expenses. Carol's income is not enough to cover the cost of her care. They have the following assets:

Investments	$200,000
Home	80,000
Car	5,000
TOTAL	$285,000

(1) Pre-Need Burial Items

Burial items are purchased for both Andrew and Carol for a total of $6,000.

---

207. N.D. ADMIN. CODE § 75-02-02.1-24(4)(d) (1997).
208. *Id.* § 75-02-02.1-24(4)(a).

(2) Update Automobile

Andrew trades in their current car and purchases a vehicle worth $20,000.

(3) Update and Repair Home

The home is sided, some appliances are updated, old carpet is replaced in several rooms, and a new roof is put on the house for a total of $20,000 spent on improvements to the residence. Their assets are affected as follows:

TOTAL ASSETS	$285,000
Less CSRA	-80,760
Less exempt burial items	-6,000
Less personal exemptions	-6,000
Less exempt auto	-20,000
Less exempt home	-80,000
Less home improvements	-20,000
TOTAL COUNTABLE ASSETS	$ 72,240

(4) Outright Transfer

Andrew and Carol transfer $37,078 outright to their daughter on January 1, 1998. To determine the optimal amount to be transferred while reserving enough assets to pay for care during the penalty period, the following formula is used:

Countable assets are plugged into the formula: (A + B)X = C, where,

(A) represents the monthly average private pay rate ("APPR") ($2,869)
(B) represents the actual net cost of care ($2,700)
(C) represents the amount of countable assets ($72,240)
(X) is multiplied by the APPR which results in the projected optimal transfer amount:

$$(\$2,869 + \$2,700)X = \$72,240$$
$$(\$5,569)X = \$72,240$$
$$\frac{(\$5,569)X}{5,569} = \frac{\$72,240}{5,569}$$
$$X = 12.97 \text{ months of penalty}$$

12.97 x 2,869 = $37,211 to be transferred leaving $35,029 to be retained to pay for Carol's care during the penalty period.

Their assets are as follows:

TOTAL ASSETS	$285,000
Less CSRA	-80,760
Less exempt burial items	-6,000
Less personal exemptions	-6,000
Less exempt auto	-20,000
Less exempt home	-80,000
Less home improvements	-20,000
Less transfer	-37,211
Less Carol's care during penalty period	-35,019
TOTAL COUNTABLE ASSETS=	$ 10

d. Medicaid Case Study of Spouses Who Are Both in a Nursing Home

George and Theresa are husband and wife. Theresa and George are both eighty-five years old and both live in a nursing home. They have $40,000 of savings left. They each have $500 per month in income. Their net nursing home costs are $2,600 per month each.

(1) Pre-Need Burial Contracts

They purchase pre-need burial contracts of $3,000 a piece.

(2) Personal Exemptions

Separate checking accounts are kept for George and Theresa and $3,000 is deposited into each as their personal exemption amounts.

(3) Outright Transfer

They have $28,000 in remaining countable assets. Apply the transfer formula discussed above individually since George and Theresa will be treated as single individuals since they are both institutionalized:

($2,869 + $2,600)X = $14,000 (one-half of countable assets)
($5,469)X = $14,000
($5,469)X = $14,000
5,469 5,469
X = 2.56
2.56 x 2,869 = $7,345

Each transfers $7,345 to their son. Each will incur a penalty period of 2.56 months. They will have reserved a total of $13,310 which will pay for their care during the penalty periods.

Their assets are as follows:

TOTAL ASSETS	$40,000
Less burial exemptions	-6,000
Less personal exemptions	-6,000
Less transfer	-14,690
Less cost of care during penalty periods	-13,312
TOTAL COUNTABLE ASSETS	$ 2

Application for Medicaid benefits should be made after the penalty periods have expired.

e. Medicaid Case Study of Single Person Not in Nursing Home

Elizabeth is a seventy year-old widow who lives on her own and has no health problems. She has one adult son, John, who farms her land. John is married but it looks like he will be going through a divorce soon. Elizabeth's assets are as follows:

Farmland	$100,000
Investments	50,000
TOTAL	$150,000

(1) Life Estate

On January 1, 1998, Elizabeth transfers her farm land to her son reserving a life estate for herself. The remainder interest transferred to her son is a gift of $39,478 ($100,000 x .39478).

(2) Income Only Trust

On January 1, 1998, Elizabeth transfers her investments into an irrevocable trust which specifies that she is to be paid only the interest income from the trust for her lifetime and that she has no right to any of the principal. Upon her death, the principal shall be distributed to her son. This is a transfer of $50,000 since she has irrevocably given up her right to ever access this principal amount just as if she had transferred it outright to her son.

Elizabeth has made total disqualifying transfers of $89,478 which results in a penalty period of 31.18 months (89,478 ÷ 2,869). She will be ineligible to receive Medicaid nursing care benefits during that time period.

f. Medicaid Case Study of Single Person in Nursing Home

Eunice, a seventy-eight year-old widow, is in a nursing home. She has $40,000 invested in certificates of deposit ("CD's") plus a $5,000 automobile. The net cost of her care is $3,500 per month. Her grandson, Timothy, will be attending college in another state this fall and needs an automobile. She also has an eighteen year-old granddaughter who is permanently and totally disabled.

(1) Pre-Need Burial Contract

Eunice purchases a $3,000 pre-need burial contract for herself.

(2) Transfer Vehicle

Eunice trades in her vehicle and buys for a newer one worth $15,000 and transfers it to her grandson. The transfer is non-disqualifying.[209]

(3) Special Needs Trust

Eunice sets up a special needs trust for her disabled granddaughter with the remaining money she has in CD's. As long as the trust meets certain requirements, which are discussed in more detail in the section of this article that deals with trusts, the transfer will not be considered disqualifying.[210]

Eunice's assets are affected as follows:

TOTAL ASSETS	$45,000
Less exempt burial contract	-3,000
Less personal exemption	-3,000
Less exempt auto	-15,000
Less transfer to trust	-24,000
TOTAL COUNTABLE ASSETS	$ 0

V. CONCLUSION

The state of health care for the elderly, particularly nursing home care, is and will continue to be, in a state of flux as our lawmakers attempt to catch up with changing demographics as the number of elderly individuals in this country increases. The debate over how to

209. *Id.* § 75-02-02.1-33.1(2)(e)(1) (1997).
210. *Id.* § 75-02-02.1-31.1(4) (1997).

fund long term care will surely continue as well. Some will advocate that such care should be funded through payroll tax programs such as Medicare. Others will encourage protecting against such risks through long term care insurance and the passage of government provided incentives to purchase such insurance. Still others will push for governmentally funded universal health care which will include nursing care services. Whatever the solution may be in the future, there exist today planning opportunities for those who may need assistance in order to pay for the high cost of nursing home care.