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# How To Fix Long-Term Care Financing

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## PREFACE

The Foundation for Government Accountability contracted with the Center for Long-Term Care Reform to conduct a study titled “Medicaid Long-Term Care: Ensuring Scarce Resources Reach the Neediest People.” This report is the result of that study. The author, Stephen A. Moses, is president of the Center for Long-Term Care Reform.

The Center for Long-Term Care Reform ([www.centerltc.com](http://www.centerltc.com)) is an independent, non-partisan research institute dedicated to ensuring quality long-term care for all Americans.

The Foundation for Government Accountability promotes better lives for individuals and families by equipping policymakers with principled strategies to replace failed health and welfare programs nationwide.

## ACKNOWLEDGEMENTS

The Milbank Foundation for Rehabilitation underwrote this project through a grant to the Foundation for Government Accountability.

*"The simplest answer is most often correct."*

-Occam's Razor

*"Give me a lever long enough and a fulcrum strong enough and single-handed I can move the world."*

-Archimedes

## Executive Summary: Medicaid Matters Most

Medicaid is in the news daily, particularly its expansion under the Affordable Care Act, or ObamaCare. But ObamaCare primarily affected acute care for young people. And while the young are three-fourths (75 percent) of Medicaid's recipients, they account for only slightly more than one-third (36 percent) of the program's expenditures. The aged, blind, and disabled, on the other hand, are just one-fourth of the recipients (24 percent) but account for nearly two-thirds (63 percent) of expenditures, mostly for the long-term services and supports that they require.<sup>1-2</sup> Given its disproportionately high impact on Medicaid costs, long-term care deserves much more attention than it currently receives from policymakers.

With that said, long-term care financing is complicated. Consider all the research studies, journal articles, and special commissions that have unsuccessfully grappled with it for decades. Recall the myriad variables, perplexing questions, noble goals, and stubborn obstacles standing in the way of progress. To name a few:

*Who should pay? Are families responsible for payment or is the government? Should planning be voluntary or compulsory? Why do people ignore long-term care risk and cost until it is too late to prepare? How can nursing home bias prevail when people prefer cheaper home care? Why is long-term care fraught with access and quality problems? How can taxpayers spend so much for long-term care but the sector remains starved for funding? Who will provide care when compensation is so low? What is going to happen when the age wave finally crests and crashes in the 2030s?*

Most policy analysts respond to these perplexities by wringing their hands. They conclude that the government must compel people to prepare for long-term care by paying higher taxes. But what if public financing caused the long-term care dysfunctions in the first place? What if the questions and problems we face have a simpler answer? Do Occam's razor and Archimedes' leverage principle apply to long-term care?

Medicaid is not just a factor in long-term care financing; it is the critical factor. Since its founding in 1965, Medicaid has evolved from a minor funding source to the primary funder of formal paid care. This near monopsony status has serious ramifications. Because it requires state programs to pay for nursing home care, Medicaid has an institutional bias. Because it pays notoriously low reimbursement rates, Medicaid causes caregiver shortages, access, and quality

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problems. Because it pays for care after it is needed, Medicaid enables the public's denial of long-term care risk and cost. Because it pays after the insurable event occurs, Medicaid crowds out private long-term care insurance. And because it increasingly pays for home care, Medicaid inhibits the private home care market. Name a deficiency of long-term care service delivery or financing and you will find Medicaid at the root of the problem.

Many policy analysts will agree with that assessment or at least some parts of it. They too blame Medicaid for numerous long-term care problems but for different reasons. Most analysts claim Medicaid requires impoverishment, that people must spend down their life's savings to qualify for long-term care benefits, and that wide swaths of the American public are devastated by catastrophic expenditures before they receive help from Medicaid.

What such analysts do not and cannot explain is, if Medicaid requires impoverishment, why do most people ignore such a calamitous risk? Why do they fail to plan, save, invest, or insure for long-term care and end up dependent on a means-tested welfare program to receive nursing home care they would rather avoid? Since they cannot explain this logical contradiction, most analysts evade it.

Therein is the fulcrum strong enough and the lever long enough to render a simple answer to the long-term care financing quandaries: Medicaid long-term care benefits do not require impoverishment. Virtually unlimited income does not obstruct eligibility if medical and long-term care expenses are high enough, as they usually are for people in need of formal, paid long-term care. Virtually unlimited assets are exempt in the form of home equity (between \$560,000 and \$840,000), one business, one auto, IRAs paying periodically, term life insurance, Medicaid-compliant annuities, life care contracts, prepaid burials, personal belongings, and home furnishings. In addition to these routine exemptions, the use of trusts, "spousal refusal," disinheritance, divorce, and numerous sophisticated "Medicaid planning" techniques make access to Medicaid long-term care benefits available to nearly anyone who chooses to take advantage of the program.

Once it is clear that Medicaid does not require impoverishment, the puzzles associated with long-term care financing disappear. If people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever need expensive paid long-term care, and, if they do, transfer most of the cost to Medicaid, then everything else follows logically. Most people do not plan for long-term care; instead, they end up on Medicaid by default when they need care, leaving Medicaid to pick up the cost and overburdening its scarce resources. Consequently, Medicaid has too little revenue to pay care providers adequately, causing caregiver shortages as well as access and quality problems. Consumers lack choice of services and providers that a freer market could ensure. The system struggles financially in the absence of private revenue from genuine asset spend down, home equity conversion, or long-term care insurance.

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*This report explains and substantiates the argument that easy access to Medicaid after care is needed has caused most of long-term care's problems.*

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That analysis requires fuller exposition and proof. This report explains and substantiates the argument that easy access to Medicaid after care is needed has caused most of long-term care's problems. This report demonstrates that access to Medicaid long-term care benefits does not require impoverishment and explains why most analysts wrongly claim that it does. It describes Medicaid's true role as the dominant factor in long-term care financing and traces

the history of how it became that way. It recounts how legislative and regulatory efforts to target Medicaid's limited resources to its originally intended needy recipients have failed repeatedly. It explains why such efforts ended in 2005, show no signs of recurring, and must begin anew to salvage long-term care financing. Finally, this report proposes simple solutions to improve Medicaid as a long-term care safety net for people in need while improving the access to and quality of long-term care for people of all economic levels.

# Introduction

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After decades of struggling unsuccessfully to find a better way to finance long-term care, researchers, industry experts, and public policymakers are beginning to agree on a general direction for reform. A consensus is forming around the idea of a mandatory, government-financed program to cover the back-end, catastrophic long-term care risk.<sup>3</sup>

This nascent consensus is based on analysis from a November 2015 Health Affairs article<sup>4</sup> which concluded that, among the front-end or back-end, voluntary or mandatory, capped or uncapped financing alternatives considered, “the mandatory options would be more successful than the voluntary versions” and “the comprehensive and back-end mandatory options would be most beneficial.” However, this growing consensus is badly mistaken; there is a better solution.

Those concerned about long-term care financing should identify and question the assumptions, data, and reasoning behind the above proposal. Unpacking these components, readers will find several common propositions underpinning them that warrant critical analyses. For example, does the fact that many people eventually turn to Medicaid for help with long-term care mean they have been forced to spend down into impoverishment by the welfare program’s allegedly draconian income and asset restrictions? Is it true that half of what people spend for long-term care comes out of their own pockets? Do too few people buy private long-term care insurance because the product costs too much and delivers too little? Does it follow from rising long-term care expenditures incurred by a rapidly aging population that the best way to pay for care is through a new, obligatory government program?

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America already has a number of centrally planned entitlement programs with high and still-growing unfunded liabilities. We should not contemplate adding another without first scrutinizing these and associated questions.

# I. Medicaid Does Not Require Impoverishment

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Advocates for a new, compulsory program to finance long-term care have made the mistake of assuming that Medicaid forces large numbers of Americans to impoverish themselves paying for long-term services and supports. But this assumption ignores how Medicaid actually operates today.

Although Medicaid was intended to serve only the truly needy, eligibility expansions and loopholes have turned the program into a middle-class entitlement. Indeed, some attorneys now spend their entire careers helping middle-class and even affluent Americans plan their estates in such a way as to qualify for Medicaid, as quotes in this report's supplemental bibliography substantiate.

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Although federal law restricts Medicaid long-term care eligibility to individuals with limited countable assets – usually around \$2,000 for an individual – numerous exemptions and loopholes have enabled people with significant resources to qualify for the program. Individuals with high incomes can deduct medical and long-term care expenditures or use Miller income diversion trusts to reach Medicaid's income eligibility guidelines.

While there is some variation in state Medicaid eligibility rules, DeNardi, French, and Jones concluded there was "little practical difference in Medicaid eligibility across the different states," largely due to medical and long-term care expense deductions.<sup>5</sup> For these reasons, Medicaid has become the dominant long-term care payer not only for the poor but for middle class and even affluent Americans as well.

## How Middle Class and Affluent Families Qualify for Medicaid Long-Term Care Services

Much of the long-term care financing literature focuses on aging Americans with low or median incomes and assets who decumulate their wealth rapidly before becoming eligible for Medicaid long-term care benefits.<sup>6</sup> The presumption is that such people are spending down their sparse resources on long-term care before relying on public assistance. But what can be said about people with higher incomes and assets?

### INCOME ELIGIBILITY

Half of all Medicare beneficiaries had annual incomes below \$26,200 in 2016.<sup>7</sup> Based on this income, these individuals could easily qualify for Medicaid's long-term care benefits if they have any uncompensated medical or long-term care costs.

But 45 percent of Medicare beneficiaries had annual incomes between \$26,200 and \$103,450. Though the public often does not think of people with higher incomes qualifying for public assistance, they can – and many do.

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The average cost of a semi-private nursing home bed in the United States was \$82,128 per year in 2016.<sup>8</sup> In most states, anyone with income below the cost of their long-term care satisfies the income qualification for Medicaid benefits. Even



someone with income of \$103,450 per year – at the 95th percentile – could meet Medicaid’s income eligibility limit by spending down that much income on nursing home care plus additional medical or other allowable income deductions.<sup>9</sup> In high cost areas, this scenario is not unrealistic and, in the remaining “income cap” states, affluent citizens can divert excess income into Miller income diversion trusts to qualify.<sup>10</sup>

Several scholars have recognized this reality. Research published in the *American Economic Review*, for example, found not only that retirees with high incomes can enroll in Medicaid but that when they do, the cost to taxpayers is greater than the cost for low-income individuals.<sup>11</sup>

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## ASSET ELIGIBILITY

Half of all Medicare beneficiaries had savings of \$74,450 or less in 2016.<sup>12</sup> This substantially exceeds the \$2,000 in countable assets that most states allow Medicaid recipients to retain. People with lower savings typically have less access to financial planning advice and it may be reasonable to assume that many spend down their sparse savings for care until they reach Medicaid asset eligibility levels.

But 45 percent of Medicare beneficiaries have savings between \$74,450 and \$1.4 million. Especially at this higher level, these seniors generally have greater access to professional financial advice on how to protect their wealth from long-term care expenditures.

If middle-class and affluent seniors do consult financial advisors about Medicaid eligibility, they will learn the many techniques of “Medicaid planning” described later. But by doing little more

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*Medicaid eligibility workers often suggest to applicants or their representatives that they purchase exempt assets . . . to avoid spending their remaining resources on private long-term care.*

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than speaking with a state Medicaid eligibility worker, they can learn of Medicaid’s virtually unlimited asset exemptions, including \$560,000 to \$840,000 in home equity and, without dollar limits, one income-producing business, including the capital and cash flow, IRAs generating periodic income, prepaid burial funds for the immediate family, one

automobile, home furnishings, personal belongings, and more. Medicaid eligibility workers often suggest to applicants or their representatives that they purchase exempt assets, especially prepaid burial plans, to avoid spending their remaining resources on private long-term care.<sup>13</sup>

## HOME EQUITY EXEMPTION

76 percent of Medicare beneficiaries owned home equity in 2016.<sup>14</sup> Their median equity was just \$70,950. Only five percent of enrollees had home equity of more than \$466,600 with just one percent owning equity worth \$873,150 or more. Given Medicaid’s high home equity exemption ranging from \$560,000 to \$840,000, depending on the state, it is unlikely that this limit disqualifies many people.

There is evidence that some individuals sell their homes to fund assisted living or a continuing care retirement community as an alternative to nursing home institutionalization

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*Medicaid diverts a substantial portion of over \$2 trillion of home equity from personal long-term care financing liability into a likely public expenditure.*

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funded by Medicaid.<sup>15</sup> Nevertheless, with three-quarters of approximately 47 million Medicare beneficiaries over age 65 owning homes with a median equity of \$70,950, Medicaid diverts a substantial portion of over \$2.5 trillion of home equity from personal long-term care financing liability into a likely public expenditure.

Barbara Stucki, author of a seminal 2005 blueprint to increase the use of reverse mortgages for long-term care expenses, more recently explained that there is “little evidence that older people liquidate home equity to pay for community based services” and that “Medicaid could realize savings if older homeowners liquidated home equity with a reverse mortgage for long-term services and supports in the community.”<sup>16-17</sup>

## Medicaid Planning

Researchers have found that many people structure savings and spending to prepare for the possibility that they may need to avail themselves of public assistance someday. Single, elderly households that anticipate long-term care needs, for example, often reduce their net worth while married households – who are subject to more generous eligibility rules – tend to convert countable resources into exempt assets, including home equity.<sup>18</sup>

Indeed, research on the adoption of Medicaid estate recovery programs highlights the impact of this planning. After the adoption of these programs, elderly individuals were 33 percent less likely to own their homes at death. Instead, they were more likely to transfer home equity into trusts in order to preserve their assets at death.<sup>19</sup>

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For many years, anecdotes and articles in the popular media discussing millionaires on Medicaid have abounded.<sup>20</sup> New York Medicaid eligibility supervisor Janice Eulau testified before Congress in 2011 that during her 36-year career in the field, she witnessed many individuals diverting significant resources in order to obtain Medicaid:

*It is not at all unusual to encounter individuals and couples with resources exceeding a half million dollars, some with over one million. There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care. Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves.<sup>21</sup>*

*(Congressional testimony of a New York Medicaid eligibility supervisor)*

The idea to which Ms. Eulau alluded – that people have a right to Medicaid long-term care benefits – pervades the elder law literature on how to qualify for Medicaid without spending down. For example, one popular estate planning text argues that attorneys should “emphasize to the older client, who may be reluctant to utilize Medicaid because of pride or possible stigma, that participation in Medicaid is not a gratuity but an entitlement like use of a public library or a public park.”<sup>22</sup> Another estate planning treatise suggests that a large share of middle-class families view Medicaid as “a legitimate entitlement that may be employed to preserve assets for spousal enjoyment and ultimate inheritance by the family.” Worse yet, the text argues that Congress has “knowingly or unknowingly strengthened the perception that opportunities for assistance under the Medicaid system are appropriate estate and financial planning tools” by refusing to close existing loopholes.<sup>23</sup>

**Below are just a few methods that individuals use to qualify for Medicaid long-term care benefits without spending their wealth for care.**

- Giving away countable assets at least five years before applying for Medicaid<sup>24</sup>
- Transferring countable assets into an irrevocable income-only trust<sup>25</sup>
- Adding an exempt home to a trust in order to protect it from estate recovery<sup>26</sup>
- Purchasing an income-producing business for full market value<sup>27</sup>
- Maximizing tax-deferred retirement plans, including IRAs, 401(k)s, and Keoghs<sup>28-29</sup>
- Purchasing Medicaid-friendly or Medicaid-compliant annuities<sup>30-31</sup>
- Converting countable assets into exempt assets<sup>32</sup>
- Setting up a Life Care Contract<sup>33-34</sup>
- Throwing parties or traveling the world<sup>35-36</sup>
- Buying more expensive homes, carefully ensuring that equity does not exceed state limits<sup>37</sup>
- Purchasing home furnishings, personal belongings, a new car, or a prepaid burial<sup>38</sup>
- Entering viatical settlements<sup>39</sup>
- Structuring gifts as disguised gifting<sup>40</sup>
- Disinheriting the Medicaid applicant<sup>41</sup>
- Employing the “spousal refusal” strategy<sup>42</sup>
- Allowing guardians to do Medicaid planning on behalf of their wards<sup>43</sup>
- Divorcing a spouse<sup>44</sup>
- Lying about untraceable assets<sup>45</sup>

## In response to a Congressional inquiry, states provided numerous examples of Medicaid planning practices.<sup>46-47</sup>

### NORTH DAKOTA

A couple with \$700,000 in liquid assets qualified for Medicaid long-term care benefits by purchasing a more expensive house, car, and an additional annuity while receiving \$8,000 per month of income from pensions, Social Security, annuity payments and oil lease money. Another couple had more than \$528,000 in assets, but qualified when the community spouse bought a new home, a new car, and two annuities worth \$240,000, and then applied for Medicaid to pay the institutionalized spouse's nursing home costs.

### WISCONSIN

An ill spouse transferred \$600,000 to the community spouse who refused to sign the Medicaid application, making the ill spouse eligible for Medicaid because "interspousal transfers are not considered divestment."

### NEW YORK

Using promissory notes, immediate annuities and spousal refusal, affluent long-term care Medicaid applicants qualify while retaining unlimited assets. This occurs even when the state has legal recourse, because "Medicaid does not have sufficient resources to pursue all these cases in court."

### RHODE ISLAND

A couple with \$400,000 in a bond account became eligible in one month by purchasing "a large single premium immediate annuity." A single man transferred \$100,000 to his son but dodged half of the penalty for transferring assets by using a promissory note to carry out a reverse half-a-loaf strategy.

### VIRGINIA

A man bought a \$900,000 annuity in his wife's name, which paid her \$89,000 per month, but "the Virginia Medicaid program could not count this income for purposes of determining the husband's Medicaid LTC eligibility."

As has been evidenced, "spending down" assets to qualify for Medicaid without expending those funds for long-term care or any other health-related expense is far easier and more commonplace than most economists and long-term care policy analysts willingly acknowledge.

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## II. Why Do Analysts Wrongly Claim Medicaid Long-Term Care Eligibility Requires Impoverishment?

If people with substantial assets and income can, and do, receive Medicaid-financed long-term care benefits, why do so many analysts say that Medicaid requires impoverishment? The answers lie in a confusion of key concepts and the use of ambiguous language to explain them.

**First, analysts wrongly claim Medicaid requires impoverishment because they equivocate on the meaning of “impoverishment.”** Medicaid long-term care eligibility requires inadequate cash flow, i.e. insufficient income, to cover all an individual’s medical and long-term care costs. But it does not require low income, low assets, or financial destitution. Even so, statements like these abound:

*If people with substantial assets and income can and do receive Medicaid-financed long-term care benefits, why do so many analysts say that Medicaid requires impoverishment?*

*Medicaid (the federal-state health care program for the poor) covers long-term care costs for individuals below certain income levels, but the deductible for Medicaid is nearly all of an individual’s income and assets. As a result, Medicaid is the long-term care coverage of last resort for those with no assets.<sup>48</sup>*

*Medicaid is a means-tested welfare program, and eligibility is limited to people who are poor or become poor after incurring high medical and long-term services and supports expenses, and who have very low levels of assets.<sup>49</sup>*

The right conclusion to reach about Medicaid’s role in long-term care financing is that it substantially ameliorates the risk and cost of long-term care, not that it impoverishes people. In

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the absence of Medicaid, if people truly had to bear the entire cost of long-term care, impoverishment would prevail, reverse mortgages would consume home equity to fund care, Medicaid long-term care expenditures would decline substantially, and many more people would plan, save, invest, and insure for long-term care risk and cost.

Those are not reasons to eliminate or replace Medicaid but rather reasons to target the program to its originally intended recipients — the truly needy — and to increase both positive and negative incentives for the middle and upper classes to prepare for long-term care and avoid Medicaid dependency.

**Second, analysts wrongly claim Medicaid requires impoverishment because they equivocate on the meaning of “spend down.”** Real asset spend down comes from expending income and savings for care before applying for Medicaid benefits. Artificial spend down comes from divesting or sheltering wealth by legal or other means to qualify for Medicaid. An expansive legal literature on methods to qualify for Medicaid while preserving wealth began in 1981, immediately after the first restriction on asset transfers was imposed in the Omnibus Reconciliation Act of 1980. It continues today.<sup>50</sup> A 2012 article on preserving wealth through

Medicaid planning describes the strategy this way:

*Medicaid planning may be defined as the process of effectively accessing government resources to pay for long-term health care of a disabled person in the manner that is least financially disruptive to the wellbeing of the person's spouse and family. These government resources derive primarily from Medicaid.<sup>51</sup>*

The ability to access “government resources to pay for long term health care” in order to preserve the “wellbeing of the person’s spouse and family” sounds highly desirable. Who wouldn’t take advantage of such resources when faced with catastrophic long-term care expenses? In fact, why would anyone plan for long-term care expenses when such an option is available after expensive care is needed and the cost is no longer insurable privately? The reality is that public policy incentives like these discourage early and responsible planning for long-term care and result in excessive Medicaid dependency and cost.

Despite this reality, economists and health policy analysts who write about Medicaid and long-term care financing rarely mention that Medicaid eligibility can be achieved by means other than paying cash for long-term care services. A common error is to claim falsely that Medicaid asset spend down must be done by purchasing medical or long-term care services.

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Medicaid requires applicants to spend down their income on medical and long-term care costs to reach allowable income limits. But Medicaid

does not require applicants to spend down their assets on medical or long-term care services to reach allowable asset limits. Assets may be divested or spent down in exchange for any exempt product or service without reducing eligibility so long as fair market value is received in the exchange. Spending down one’s income may hurt financially, but spending down one’s assets can be financially painless.

Nevertheless, analysts often refer to asset spend down as though it refers to spending savings on long-term care. For example, an otherwise excellent article by a well-regarded economist on the influence of Medicaid estate recovery on wealth accumulation and decumulation states that “spend-down of assets occurs as individuals are required to contribute liquid resources toward the cost of their care until the typical state threshold of \$2,000 is reached.”<sup>52</sup>

### **Third, analysts wrongly claim Medicaid requires impoverishment because they equivocate on the meaning of “Medicaid planning.”**

Analysts seldom cite the extensive legal literature on Medicaid planning nor acknowledge the omnipresent information on Medicaid planning in the popular media and on the internet.<sup>53</sup>

*Analysts seldom cite the extensive legal literature on Medicaid planning nor acknowledge the omnipresent information on Medicaid planning in the popular media and on the internet.*

Instead, when writing about decumulating wealth to qualify for Medicaid, they usually assume and imply that the money is used to purchase long-term care rather than being divested, diverted, or sheltered to achieve eligibility. This ignores Medicaid’s lenient income and asset eligibility criteria that allow people with substantial resources to qualify for long-term



care benefits; it ignores the fact that Medicaid rules do not require that assets be spent down for long-term care services; and it evades the reality that information on ways to qualify for Medicaid without paying for care is universally available.

In the rare instance where analysts consider the possibility that people might qualify for Medicaid without spending down wealth, they tend to write only about “asset transfers” without considering other Medicaid planning methods and they often misrepresent the arguments of those seeking to preserve resources for the truly needy.<sup>54-56</sup>

Asset transfers are very expensive for taxpayers, crowding out resources for the most vulnerable. Transferring assets may have increased Medicaid spending by as much as \$1.5 billion in 2014 alone.<sup>57-58</sup> But focusing only on asset transfers ignores the more widely practiced techniques of Medicaid planning. Indeed, asset transfers are only the tip of the Medicaid planning iceberg.

Routine practices of eliminating countable assets by converting them into exempt assets, setting up caregiver agreements, employing Medicaid-friendly annuities, or making use of trusts, spousal refusal, or even divorce are far more common than asset transfers. Elder law specialists not only describe these techniques in the estate planning literature but frequently encourage their use.

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*By focusing only on asset transfers, analysts overlook the far more extensive and costly forms of Medicaid planning.*

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Unfortunately, analysts rarely consult and almost never cite this legal scholarship, despite its direct relation to the topic at hand. By focusing only on asset transfers, they overlook the far more extensive and costly

forms of Medicaid planning. (See the supplemental bibliography in Appendix I for numerous examples of Medicaid planning techniques that are not based on transferring assets.)

**Fourth, some analysts wrongly claim that Medicaid requires impoverishment because they equivocate on the meaning of “out-of-pocket” expenditures for long-term care by claiming they are higher than they really are.**

Some analysts say the out-of-pocket share of long-term care expenditures has skyrocketed to more than 50 percent.<sup>59</sup> But they arrive at that figure by including room and board expenses in residential care settings — costs that people would incur whether they need long-term care or not — and by excluding Medicare post-acute care expenditures from the total even though Medicare’s relatively generous nursing home and home care reimbursements are the only thing enabling Medicaid to pay long-term care providers less than the cost of providing the care to a majority of long-term care patients.<sup>60</sup>

In reality, the proportion of long-term care expenses paid by taxpayers has been rising and the proportion paid by families has been declining for half a century. When Medicaid first started paying for long-term care in the late 1960s, out-of-pocket expenditures were very high – upwards of half of all nursing home expenditures. Since then, Medicaid and Medicare spending have increased rapidly and dramatically. Out-of-pocket expenditures declined to around one-fourth of total long-term care expenditures. But even that low figure is misleadingly high because roughly half of it is not savings being spent down as often implied but Social Security and other income being “spent-through” by people already on Medicaid to offset Medicaid’s cost

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of care as federal law requires.<sup>61</sup> To this day, upwards of 85 to 90 percent of nursing home expenditures are accounted for without dipping into personal savings and only 8.9 percent of formal home health care costs were paid out of pocket.<sup>62</sup>

Nevertheless, analysts continue to argue that out-of-pocket long-term care expenditures are higher than they really are in order to justify new, government-funded long-term care financing programs.

**Fifth, analysts wrongly claim Medicaid requires impoverishment because they rely on data, much of it faulty, from HRS and AHEAD surveys.**

When economists and health policy analysts claim that older people approaching the need for long-term care retain few assets and spend down rapidly, they generally draw their evidence from survey data provided by the Health and Retirement Study (HRS) and its auxiliary, the Asset and Health Dynamics among the Oldest Old (AHEAD) study. These surveys have information on home values, automobile ownership, liquid assets, farms and other businesses, retirement accounts, and other assets.<sup>63</sup>

Noteworthy is the fact that each of these financial holdings are either expressly exempt under federal law or easily converted into an exempt asset for purposes of Medicaid long-term care eligibility. For example, between \$560,000 and \$840,000 of home equity is exempt from eligibility limits, depending on the state.

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Additional real estate such as vacation homes may easily be made exempt. As one Medicaid planning attorney explains in his newsletter, a spouse could take out a loan in the amount of the second home's equity to "reduce its effective value to \$0" and then spend the borrowed money on home improvements or invest it in other exempt resources.<sup>64</sup> Another estate planner explained that a couple with a second vacation home could simply rent its own home and claim the rental income as necessary for the spouse's maintenance needs, converting it into a non-countable resource.<sup>65</sup>

One automobile is exempt regardless of value so long as it is used at least occasionally for the benefit of the Medicaid recipient. Liquid wealth such as bank accounts or securities may be converted from countable to non-countable status by purchasing exempt assets. These strategies typically involve converting countable assets into home equity, a new car, household items, travel, funeral expenses, or burial plots.<sup>66</sup>

Farms and other businesses, including their capital and cash flow of unlimited value, are exempt without any dollar limit.<sup>67</sup>

Tax-deferred retirement accounts, including IRAs, Keoghs, and 401(k)s are exempt if the holder is receiving a regular payout.<sup>68</sup> Such payouts are required by the time an individual reaches 70.5 years old, though may begin as early as 59.5 years old.

**HRS/AHEAD Data are highly questionable.**

While the HRS and AHEAD surveys provide the most reliable longitudinal data currently available, they are far from foolproof. One expert found significant data quality issues in the surveys due to "measurement errors in the data, particularly those arising from item nonresponse and from



inaccurate respondent reports of the ownership and level of assets.”<sup>69</sup> He concluded that the survey data make it “difficult to reach consensus among research studies” because “each author must arbitrarily decide whether to exclude, censor, or impute particular observations.”<sup>70</sup> Other researchers have noted similar limitations, explaining that “information on people who are cognitively impaired and who die is derived from proxy respondents, often relatives, who may not know about specific long-term services and supports use or Medicaid eligibility.”<sup>71</sup> Given these facts, these surveys provide a dubious foundation on which to generalize about long-term care financing policy.

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Furthermore, there are many reasons why survey respondents and their representatives might fail to report income and assets to surveyors or even purposefully misrepresent the facts. People who have reconfigured their wealth to qualify for public welfare benefits may be ashamed of having done so or simply unaware that their heirs did this on their behalf. Seniors reporting on themselves may be cognitively impaired or intimidated by self-interested family members. Heirs who benefit from preserving parents’ estates may prefer to conceal the facts. Lawyers who do Medicaid planning are protected from disclosure by attorney/client privilege, while long-term

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care providers and Medicaid eligibility staff, who often know which wealthy locals are taking advantage of Medicaid, cannot disclose the information because of legally enforced confidentiality. Getting to the truth in such matters is extremely difficult.

Finally, the HRS/AHEAD surveys pose the wrong questions regarding wealth transfer and do not address the larger issue of Medicaid planning at all. They typically ask if the respondents gave financial help worth more than \$500 to

any children, not counting shared housing or food costs, within the preceding two years.<sup>72</sup> But there are several problems with this question. Transfers of assets relevant to qualifying for Medicaid long-term care benefits are not necessarily done to provide “financial help” to children. Looking back only two years is insufficient, as Medicaid has a look-back period of five years. Finally, focusing as narrowly as the question does on asset transfers ignores the much larger issue of other sophisticated Medicaid planning tactics.<sup>73</sup>

**Sixth, analysts wrongly claim Medicaid requires impoverishment because they do not ask the people who know the truth.**

Besides passing over the formal legal literature on Medicaid planning, long-term care scholars have paid little attention to the voluminous testimony of Medicaid staff, financial advisors, Medicaid planners, consumers and long-term care providers about the ease and impunity with which middle and upper-class individuals take advantage of Medicaid long-term care benefits. In the 1990s, The Gerontologist published several articles quoting these sources on that topic, but very little such information has found its way into the peer-reviewed literature since.<sup>74</sup> Despite this absence, popular media abound with such examples.

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Since 1998, for example, the Center for Long-Term Care Reform has published 144 articles about Medicaid planning.<sup>75</sup> Unfortunately, most academic scholars either do not read such material or they think they can ignore anything in it, however conclusive, that contradicts the conventional scholarly wisdom about long-term care financing. Unfortunately, such arrogance has significant consequences not only for taxpayers but ultimately for the truly needy. After all, every dollar spent on Medicaid benefits for middle-class and affluent seniors is a dollar that cannot be spent on the truly vulnerable.

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### III. What is Medicaid's Actual Role in the Long-Term Care Financing System and How Did It Get that Way?

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Medicaid has never forced large numbers of Americans to spend down into impoverishment. That misrepresentation should not be used to argue for large, new government programs. But Medicaid long-term care financing has had a major negative impact on America's overall long-term care financing system by shifting resources away from the truly needy and toward middle-class and affluent seniors. Numerous legislative initiatives designed to ensure Medicaid's scarce long-term care resources go first and foremost to the most vulnerable show how hard it has been to achieve that objective. In the following history of those initiatives, note how they flourished after economic recessions but regressed during subsequent recoveries.

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From Medicaid's inception in 1965 until 1980, federal law explicitly permitted asset transfers for the purpose of qualifying for long-term care benefits.<sup>76</sup> Anyone could give away everything and qualify for benefits immediately. An economic downturn in the late 1970s led to a recession in early and mid-1980.<sup>77</sup> By December 1980, Congress enacted the Boren-Long Amendment, which prohibited asset transfers "solely to qualify" for Medicaid for the first time, though the policy change failed to include exempt assets in the restriction.<sup>78-79</sup>

Stress on Medicaid budgets continued as the nation suffered another and longer economic recession in 1981 and 1982. The Tax Equity and Fiscal Responsibility Act of 1982 added exempt homes to the asset transfer prohibition but also went much further by allowing state Medicaid programs to (1) penalize uncompensated asset transfers made within two years of applying for Medicaid with an eligibility delay of up to two years, (2) impose liens on real property in order to (3) enable recovery of the cost of their care from recipients' estates.<sup>80</sup> Congress

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intended for this legislation to "assure that all of the resources available," including equity in a home, not otherwise needed to support a spouse or dependent children would be "used to defray the cost of supporting the individual in the institution" before turning to taxpayers.<sup>81</sup>

But as soon as Congress started to restrict asset transfers for the purpose of qualifying for Medicaid, lawyers began finding ways to circumvent the new eligibility constraints. The first known article on Medicaid planning was published in 1981.<sup>82</sup> Scores of law journal articles soon followed. A new legal specialty with Medicaid planning as its main source of billable hours quickly evolved. In 1987, 23 lawyers founded the National Academy of Elder Law Attorneys (NAELA) to represent their professional interests. Today, the NAELA has grown to a membership of 4,500 and functions as the Medicaid planners' trade association, frequently advocating for looser Medicaid eligibility rules and more public spending on long-term care.<sup>83</sup>

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A 2003 survey of NAELA lawyers in 30 states found that 40 percent of Medicaid planning clients transferred more

than \$75,000 of wealth and 63 percent involved estates of more than \$100,000.<sup>84</sup> Most clients transferred more than \$50,000 in order to qualify for Medicaid benefits.<sup>85</sup>

The rule of thumb for Medicaid planners' compensation is that fees to qualify someone for Medicaid long-term care benefits amount to roughly one month's cost of nursing home care as a private payer. According to one source, such fees "can range from \$2,500 for individuals with relatively simple estates to \$10,000 for individuals with significant assets."<sup>86</sup>

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Shortly after Congress restricted outright asset transfers, new techniques were developed to transfer assets into "Medicaid qualifying trusts" in order to avoid the new rules. Congress responded by limiting the use of these trusts in 1985.<sup>87</sup>

Undaunted, the Medicaid planning bar found many new ways to evade congressional intent. Congress responded again in 1988 for the first time requiring state Medicaid programs to penalize asset transfers done for the purpose of qualifying for Medicaid and expanding the look-back period from two years to thirty months, but leaving the maximum eligibility penalty at no more than thirty months.<sup>88</sup>

But Medicaid planners again found creative ways around the rules. For example, lawyers devised a new "pyramid divestment" strategy to take advantage of Medicaid regulations that allowed asset transfer penalties to run concurrently. They published charts showing how clients could give away as much as a million dollars in a single year by transferring smaller and

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*Lawyers devised a new "pyramid divestment" strategy to take advantage of Medicaid regulations that allowed asset transfer penalties to run concurrently. They published charts showing how clients could give away as much as a million dollars in a single year by transferring smaller and smaller amounts of assets over time and allowing the eligibility penalties to run concurrently.*

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smaller amounts of assets over time and allowing the eligibility penalties to run concurrently. By then, dozens of law journal articles were being published annually, advising practitioners on how to manipulate Medicaid eligibility.

In 1988, the Inspector General at the U.S. Department of Health and Human Services addressed the Medicaid planning phenomenon.<sup>89</sup> The Inspector General noted that Medicaid rules allowed "knowledgeable individuals to transfer

or shelter property from Medicaid resource limitations in a manner reminiscent of income tax avoidance." Interviews with state Medicaid staff indicated that resources could be better preserved for the truly needy by imposing stronger asset transfer restrictions, mandating estate recovery programs, and allowing greater use of liens during the estate recovery process.

As state Medicaid budgets were recovering from another recession in the early 1990s, Congress passed the Omnibus Budget Reconciliation Act of 1993, which implemented most of the Inspector General's recommendations.<sup>90</sup> That law extended the asset transfer restriction to three full years, required estate recoveries, prohibited pyramid divestment, and removed the 30-month cap on asset transfer penalties.

Unfortunately, most states did not fully implement this new package of eligibility controls; the federal government did not enforce the rules aggressively; and the media did not publicize the mandatory estate recovery provisions. Consequently, despite these significant changes, the public remained unaware of the new reasons to save, invest, or insure for long-term care and consumer behavior changed little.

By 1996, information on ways to qualify for Medicaid long-term care benefits without spending down was universally available to the public. In addition to formal, legal treatises and law journal articles on the topic, family members of ailing seniors could find Medicaid planning advice from best-selling books like Armond Budish's *Avoiding the Medicaid Trap*, popular magazines like *Family Circle*, and even radio talk shows.<sup>91-93</sup>

The gradual, unintended expansion of Medicaid from a safety net program protecting the poor to the main long-term care payer for virtually everyone had spiraled out of control by the mid-1990s. As a result, President Clinton and a Republican Congress tried a full-frontal attack on Medicaid planning in 1996.<sup>94</sup>

Congress enacted changes that made it a crime – punishable by prison time – to transfer assets for the purpose of qualifying for Medicaid. After significant negative publicity, Congress repealed the change in 1997 and replaced it with new rules that criminalized attorneys' Medicaid planning practices. That change was quickly ruled unconstitutional as Medicaid planning itself was no longer illegal.

After another recession in the early 2000s was followed by a slower recovery, Congress again acted to improve and preserve the integrity of Medicaid as a long-term care safety net for the poor. In the Deficit Reduction Act of 2005, Congress extended the look-back period for asset transfers to five years and closed several loopholes, including the then-popular "half-a-loaf" strategy whereby people could give away half of their assets, hide or spend down the rest, and qualify for Medicaid while avoiding a significant portion of the asset transfer penalty.<sup>95</sup> Unfortunately, the Medicaid planning bar quickly replaced these prohibited loopholes with new methods that rely on promissory notes, intra-family loans or annuities to create new but comparable loopholes.<sup>96</sup>

In 2005, Congress also placed the first cap ever on Medicaid's home equity exemption, allowing states to set the cap between \$500,000 to \$750,000. These caps, which increase annually with inflation, have now reached between \$560,000 and \$840,000. Although Medicaid still exempted several times the median value of seniors' homes, this did at least mean that owners of multi-million dollar mansions were excluded from Medicaid eligibility – unless they employed Medicaid planning strategies to reduce home equity and purchase other exempt assets or shelter funds in some other way.<sup>97</sup>

As happened with earlier changes, every loophole Congress closed in 2005 was replaced by new ones. After 36 years of trying to target Medicaid long-term care benefits to the needy while encouraging the middle class and affluent to pay privately — or at least reimburse Medicaid for their care — the Medicaid program remains today the principal payer of expensive long-term care for the vast majority of Americans, regardless of wealth.



## The Broken Rhythm of Reform

Historically, progress toward making Medicaid a better long-term care safety for the poor tends to occur after major economic downturns when state and federal governments face serious budgetary constraints. After most recessions since 1965, Congresses and presidents of widely divergent ideological persuasions backed legislation closing Medicaid long-term care eligibility loopholes and encouraging early and responsible long-term care planning. But as each recession was followed by a rapid economic recovery and fiscal pressure abated, Medicaid long-term care benefits always reverted to virtually universal availability for all economic classes. This pattern has changed since the start of the new millennium. After the recession from March 2001 to November 2001 following the internet bubble's implosion, economic recovery came more slowly than before. Likewise, it took much longer for legislation discouraging the excessive use of Medicaid long-term care benefits to be passed. The Deficit Reduction Act of 2005 was not signed into law until February of 2006, nearly five years after the start of the previous recession. Ultimately, economic recovery did come and, true to form, enforcement of DRA 2005 declined.

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The resulting boom ended when the housing bubble burst, causing the Great Recession of December 2007 to June 2009. Again, economic recovery has come very slowly and meagerly.<sup>98</sup> To date, eight years after the end of the last recession, we have seen neither a full economic recovery nor action to spend Medicaid's scarce resources more wisely by aiming them toward people most in need. In fact, as this report has observed, public policy analysts and advocates are moving in the opposite direction, towards proposing yet another government program funded by taxpayers to expand public financing of long-term care for all.

What might explain slower recoveries in recent years and less attention to the cost of Medicaid long-term care benefits? The Federal Reserve forced interest rates to almost zero during and since the Great Recession. The consequences of this policy have ramified through the economy in many ways. One way is that government has been able to finance deficit spending and the rapidly increasing national debt at considerably lower carrying costs than before when interest rates were much higher. By enabling politicians to spend more without facing the normal fiscal consequences, this new economic policy has attracted greater financial resources, including borrowed funds, into public financing of all kinds and simultaneously diverted private wealth into low-interest-rate-induced malinvestment. Consequently, political concern about burgeoning budgets and debt has abated and no significant effort to preserve Medicaid funds by targeting them to the poor has occurred.

The danger is that just as excessive public spending and private malinvestment in the early 2000s led to the housing bubble and its consequent mid-decade recession, so the current much larger credit bubble driven by excessive government borrowing and spending could lead to an even greater economic collapse. With the current national debt nearing \$20 trillion and total unfunded entitlement liabilities around \$106 trillion, a return to economically realistic market-based interest rates would render the federal government immediately insolvent.<sup>99</sup>

Further exacerbating the problem of long-term care financing is the fact that the long-anticipated age wave is finally cresting and will soon crash on the U.S. economy. Baby boomers began retiring and taking Social Security benefits at age 62 in 2008. At age 65 in 2011, they turned the Social Security and Medicare programs cash-flow negative. Boomers began taking Required Minimum Distributions (RMDs) from their tax-deferred retirement accounts in 2016, depleting the supply of private investment capital. They will reach the critical age (85 years plus) of rising long-term care needs in 2031, around the time Social Security and Medicare are expected to deplete their trust funds, forcing them to reduce benefits.

Of course, Medicaid is the main funder of long-term care, but according to the Center for Medicare and Medicaid Services Chief Actuary in a statement of consummate denial, “. . . Medicaid outlays and revenues are automatically in financial balance, there is no need to maintain a contingency reserve, and, unlike Medicare, the ‘financial status’ of the program is not in question from an actuarial perspective.”<sup>100</sup> In a sentence, conditions are coalescing for a potential economic cataclysm in or before the second-third of this century and public officials are almost entirely ignoring the risk.

## How Medicaid Damaged Long-Term Care Financing

If Medicaid is not the catastrophic poverty-maker its long-term care critics make it out to be, what is it? Simply put, it has become an entitlement for middle-class and affluent families. Individuals can ignore the risk of future long-term care expenses, avoid premiums for private insurance, and then protect home equity and other wealth for heirs if such care is ever actually needed, shifting the cost of long-term care to taxpayers. Given this reality, it is a wonder that people worry as much about future long-term care costs as they do.

By making nursing home care virtually free in the mid-1960s, Medicaid locked an institutional bias into the long-term care system, crowded out a privately financed market for home care, and trapped the World War II generation in sterile, welfare-financed nursing facilities.<sup>101</sup>

By reimbursing nursing homes less than the cost of providing the care, Medicaid guaranteed that America’s long-term care service delivery system would suffer from serious access and quality problems.<sup>102</sup>

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By underfunding most long-term care providers – leading to doubtful quality – Medicaid incentivized plaintiffs’ lawyers to launch giant tort liability lawsuits, extract massive financial penalties, and further undercut providers’ ability to offer quality care.

By making public financing of expensive long-term care available after the insurable event occurred, Medicaid discouraged early and responsible long-term care planning and crowded out the market for private long-term care insurance.<sup>103</sup>

By compelling impoverished citizens to spend down what little income and savings they possessed in order to qualify for long-term care benefits, Medicaid discouraged accumulation and growth of savings among the poor, reducing their incentives to improve their stations in life.<sup>104</sup>

By allowing affluent people to access subsidized long-term care benefits late in life, Medicaid encouraged accumulation and growth of savings among the rich who could pass their estates to their heirs whether they were stricken by high long-term care expenditures or not.<sup>105</sup>

Medicaid discriminated against the poor and favored the affluent by allowing people and families with extra “key” money to buy their way into the better nursing facilities, and by allowing planners to help affluent clients avoid the program’s reputedly poor care.

Medicaid is the cause of most of the dysfunction in America’s long-term care service delivery and financing system. But blame should not fall on a mythical Medicaid program imagined by advocates of a new compulsory government program. Rather, blame must fall on the real Medicaid program that has operated by funding long-term care after people require expensive care while allowing them both time and the means to preserve most of their wealth.

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# IV. A Better Way

Over the past half century, society has learned a lot about what produces prosperity and reduces poverty. Research has shown that the more governments are involved in managing economies, the less prosperity and the more poverty they produce. Economic freedom, on the other hand, is directly correlated with higher per capita income, as the following charts depict.<sup>106</sup>

Exhibit 1.6: Economic Freedom and Income Per Capita

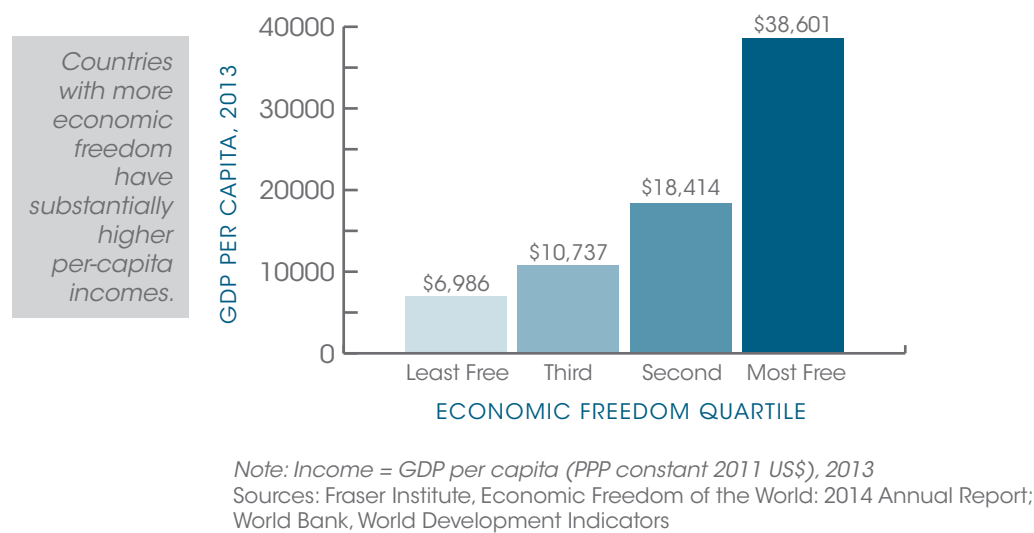
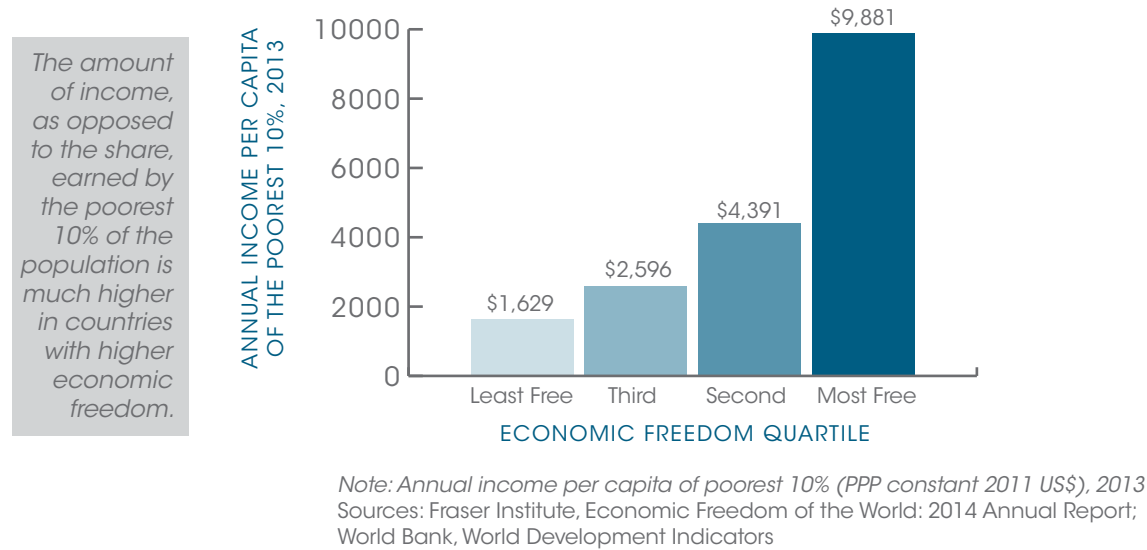


Exhibit 1.9: Economic Freedom and the Income Earned by the Poorest 10%



The U.S. poverty rate holds true to this pattern. It plummeted from 56 percent in 1900 to 13 percent in 1967, but has failed to decline further, resting at nearly 15 percent by 2014.<sup>107-108</sup> Trillions of dollars spent on Great Society programs, including Medicaid, have failed to reduce poverty.

America's problems with long-term care have not been caused by government forcing too many people into impoverishment but rather by the opposite: Medicaid has indemnified too many people against the risk and cost of long-term care, resulting in their complacency about long-term care planning and ultimately in their excessive dependency on inadequate government welfare financing. So how might Medicaid's role in long-term care financing be modified to improve its results and protect limited resources for the truly needy?

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*America's problems with long-term care have not been caused by government forcing too many people into impoverishment, but rather by the opposite.*

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# Recommendations

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Medicaid must return to its intended purpose as a long-term care safety net for the poor. Medicaid long-term care benefits can and should be improved for those in need but only if resources are repurposed from serving middle-class and affluent families. Instead, the long-term care system should incentivize those with the financial means to plan early and responsibly for the risk and cost of long-term care.

The steps needed to achieve these objectives are not complicated. Medicaid simply needs new rules that make access to long-term care benefits after care is already needed less easy for the affluent and rules that prevent the use of Medicaid as free inheritance insurance for heirs.

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*Medicaid simply needs new rules that make access to long-term care benefits after care is already needed less easy for the prosperous and rules that prevent the use of Medicaid as free inheritance insurance for heirs.*

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## HOME EQUITY EXEMPTION

To meet these objectives, Medicaid should stop exempting seniors' largest asset – home equity. Reverse mortgages allow people over the age of 62 to tap the equity in their homes while federal regulations guarantee borrowers and surviving spouses the right to remain in their homes without repaying their loan until they move out, sell the property or die. Once home equity is exhausted to pay privately for their care, home owners could become eligible for a Medicaid program with fewer recipients to support and as a result, more resources to provide better care in private homes, residential care facilities, and nursing homes.

The national economy would benefit from this change. If home equity were at risk to fund long-term care, more people would consider the future risk and cost of long-term care. Heirs currently

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*If home equity were at risk to fund long-term care, more people would consider the future risk and cost of long-term care.*

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indemnified by Medicaid would more seriously consider private long-term care insurance for their parents and for themselves. New jobs in the reverse mortgage and long-term care insurance industries would increase tax revenue. Administrative costs of Medicaid would decrease substantially. Private financing flowing into the long-term care service delivery system at full market

rates from home equity conversion would invigorate the private home care market and relieve the pressure on wages that impede hiring of and retention of high-quality nursing aides.

One added benefit of curtailing Medicaid's home equity exemption is that it would reduce the need to track exempt assets and recover from estates. If home equity, recipients' largest asset, were spent down prior to eligibility, most of the need for liens and estate recovery would be eliminated.

Unfortunately, eliminating Medicaid's home equity exemption would also create an even stronger incentive to shelter or divest a home's value. This would require extending the look-back period for asset transfers well beyond the current five-year period. As home ownership and transfers are publicly recorded, a look-back period of ten or even twenty years could be easily tracked and would effectively discourage home transfer gaming.

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## ELIGIBILITY LOOPHOLES

The booming Medicaid planning business depends on taking advantage of holes in Medicaid financial eligibility rules that invite abuse. One of the largest and most costly is the Medicaid-friendly annuity loophole that allows unlimited asset transfers immediately before eligibility for long-term care benefits begins.<sup>109</sup> Another is the “spousal refusal” strategy – allegedly authorized by federal law but a clear violation that is permitted by only some states – which the Centers for Medicare and Medicaid Services has not actively discouraged.<sup>110</sup>

Many other gaps in the rules protecting Medicaid from overuse need to be filled. Experts have proposed limiting transfers to a third party for the sole benefit of the community spouse, clarifying the use of court orders to increase community spouse resource allowances, and reducing the use of “intent to return” loopholes when it is unlikely that the individual will be able to leave institutional settings.<sup>111</sup> Experts have also recommended requiring states to impose liens as part of the estate recovery process, pooling income and assets in determining eligibility and requiring better eligibility verification in the application process.<sup>112</sup> Congress must close all of these and other loopholes.

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*The booming Medicaid planning business depends on taking advantage of holes in Medicaid financial eligibility rules that invite abuse.*

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## SYSTEMATIC STUDY

Scholars should consider a different research approach. The literature on how Medicaid impacts the poor is substantial. But too little is known about Medicaid’s effect on the middle and upper classes. Researchers should conduct a thorough and objective review of actual Medicaid long-term care cases. Such a project should at a minimum answer (1) how many Medicaid long-term care recipients own homes and with what values, (2) what their economic status was ten or twenty years before needing long-term care, when they still might have — with the right incentives and absent the existing disincentives — taken measures to prepare for long-term care and avoid Medicaid dependency, and (3) what happened to the wealth they

formerly possessed and to what extent it was expended for long-term care or used or transferred in some other way.

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*Answers to questions like these cannot be obtained by asking Medicaid recipients, family members or friends who may have a stake in hiding or misrepresenting the facts.*

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Answers to questions like these cannot be obtained by asking Medicaid recipients, family members, or friends who may have

a stake in hiding or misrepresenting the facts. Nor are the opinions of focus groups relevant. Instead, these questions require serious forensic study delving into public records such as those retained by county assessors’ offices on property ownership and by recorders’ offices on real property transfers. Decades ago, the federal AFDC and Medicaid programs had Quality Control review and re-review programs to test for eligibility errors; these programs found very high error rates. Unless and until similar reviews are conducted of Medicaid long-term care eligibility decisions, it is impossible to say with certainty how Medicaid affects the poor or the prosperous.

## EXPERIMENTATION

Measures that are needed to establish and preserve Medicaid as a long-term care safety net for the truly needy are controversial. But a future economic meltdown may compel such changes as Medicaid budgets become more strained and tax receipts drop. In the meantime, the best approach is to permit individual states to experiment with alternative methods of Medicaid long-term care eligibility determination. Block granting Medicaid would achieve that objective. Allowing states to receive federal support for their long-term care programs with fewer strings attached would also encourage them to try innovative approaches.<sup>113</sup> Congress could authorize special waiver programs to allow such experimentation.

Regardless of the approach or the specific methods employed, if Medicaid is to do a better job of caring for the poor, it will have to exercise tougher love for the prosperous.

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*Whatever the approach or the specific methods employed, if Medicaid is to do a better job of caring for the poor, it will have to exercise tougher love for the prosperous.*

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## How Much Could Taxpayers Save?

If Congress and the Trump Administration implemented the foregoing recommendations, how much could taxpayers save on Medicaid expenditures and what would the ramifications be for care access and quality?<sup>114</sup> To answer this question requires consideration of the disproportionality of Medicaid long-term care spending by enrollee type and eligibility status.

Total Medicaid spending for federal fiscal year 2015 was \$545.1 billion (three percent of the Gross Domestic Product), but these funds were not distributed evenly among enrollees.<sup>115-116</sup>

Medicaid's long-term care recipients consume an uneven share of total program expenditures. For example, people eligible for Medicaid and Medicare, or "dual eligibles", accounted for 36 percent of Medicaid spending in 2010 although they comprised only 14 percent of Medicaid recipients.<sup>117</sup> These dual eligibles are heavy users of long-term care which comprised 65 percent of their Medicaid expenditures.<sup>118</sup>

The aged, blind, and disabled - also heavy users of long-term care - are one-fourth of Medicaid recipients (24 percent) but account for nearly two-thirds of program costs (63 percent), whereas younger recipients, mostly poor women and children, are three-fourths of the recipients (75 percent) but only account for approximately one-third of the cost (36 percent).<sup>119-120</sup>

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*If Congress and the Trump Administration implemented the foregoing recommendations, how much could taxpayers save on Medicaid expenditures and what would the ramifications be for care access and quality?*

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Researchers and policymakers are trying to find ways to manage dual eligibles more cost-effectively, but no one has focused on how to prevent people from becoming dual eligibles in the first place. Because dual eligibles and the aged, blind, and disabled (ABD) consume a

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disproportionate share of Medicaid's total resources, every actual or potential dual eligible, ABD, or long-term care recipient diverted from Medicaid dependency will result in a highly leveraged savings to the Medicaid program. In other words, prevent Medicaid dependency for even a small number of these heavy long-term care users and the savings will be extraordinarily high.

Why do people become dual eligibles and how could they be diverted from that fate? As this report has explained, easy access to Medicaid long-term care eligibility after care is needed has discouraged early and responsible long-term care planning.

People who come to need long-term care but have failed to plan for it ultimately end up with very limited income and assets. Whether they qualify for Medicaid genuinely by spending down their wealth for care or artificially by taking advantage of the program's generous exemptions, eligibility loopholes or Medicaid planning, such people automatically become dual eligibles when they turn 65 years of age and qualify for Medicare.

The greatest asset they retain, and often preserve for heirs by avoiding estate recovery, is their home equity. If home equity were at risk to pay for long-term care, it would take longer for homeowners to qualify and fewer people would end up as Medicaid recipients. As a result, Medicaid would have fewer dual eligibles to support for shorter periods of time.

Medicaid spent \$139 billion on 9.6 million dual eligibles in 2010.<sup>121</sup> Fifty-nine percent of dual eligible enrollees were 65 years of age or older and accounted for 60 percent of Medicaid spending on dual eligibles.<sup>122</sup> Thus 5.7 million dual eligibles over age 65 consumed \$83.4 billion

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for an average of \$14,632 per dual. Further, we know that 76 percent of Medicare beneficiaries owned home equity in 2016 and their median equity was \$70,950.<sup>123</sup> These figures are very conservative estimates of home equity conversion's potential to fund long-term care, because the percentage of homeowners and

their home equity may well have been much higher in previous years when they could have taken measures to protect their homes value by saving, investing, or insuring against long-term care risk.

If Medicaid no longer exempted home equity from long-term care risk and cost, those 76 percent of Medicare beneficiaries with median home equities of \$70,950, and especially those with equities above the median whom Medicaid currently protects up to \$560,000 to \$840,000 (greater than the 95th percentile), would be strongly incentivized to plan for long-term care. Alternatively, if they came to need expensive paid care and lacked other resources, they would need to take out reverse mortgages to fund the care and thus deplete their home equity, ultimately becoming dependent on Medicaid but only after spending down their real estate wealth.

What might the potential savings to Medicaid be? If one in five of the 5.7 million age-65-plus dual eligibles in 2010 had taken measures earlier to protect their home equity from long-term care spend down, the savings to Medicaid would have been \$16.7 billion (20 percent of the \$83.4 billion spent in that year).

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*If one in five of the 5.7 million age-65-plus dual eligibles in 2010 had taken measures earlier to protect their home equity from long-term care spend down, the savings to Medicaid would have been \$16.7 billion (20 percent of the \$83.4 billion spent in that year).*

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Is such a reduction in dual eligibles feasible? The actual reduction would probably be even greater. According to the National Council on the Aging,

*With an estimated amount of over \$72,000 available on average to older households from these loans, reverse mortgages can help impaired elders pay for several years of daily home care visits, over a decade of out-of-pocket expenses and respite for family caregivers or substantial home modifications.<sup>124</sup>*

That much money added to other income and assets and used for long-term care, especially private home and community-based services, could delay or prevent Medicaid eligibility for millions of Americans. The savings to Medicaid would easily exceed \$20 billion per year in combined state and federal expenditures, probably much more. Over time, Medicaid savings will increase rapidly beyond these initial estimates as more people plan to pay their own long-term care expenses by means of real asset spend down instead of Medicaid planning, home equity conversion, or private long-term care insurance, a product whose market will only expand if and when it becomes needed to protect home equity from long-term care expenses.



The potential benefits to America's long-term care service delivery and financing system from engaging home equity to fund care go far beyond Medicaid savings. Spending their own money, consumers will purchase care they prefer, aging in place instead of being drawn into institutional settings that Medicaid often requires. Paying private market rates for care, consumers will command red-carpet access to top quality care instead of relying on Medicaid's notoriously meager reimbursement rates. Medicaid itself, with fewer expensive dual eligibles to support, would have more resources to provide better care for people genuinely in need of the help. Drawing the enormous potential resource of home equity into the financing of long-term care would thus improve care access and quality for all people irrespective of their private-pay or Medicaid status.

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## Conclusion

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Medicaid long-term care eligibility does not require impoverishment, despite the conventional wisdom espoused by analysts who misunderstand and misrepresent the role Medicaid plays in the long-term care financing system. Ironically, Medicaid's counterproductive design actually created the dysfunctions that many analysts and policymakers seek to fix with new entitlement programs. These problems – created by government interference in the long-term care market – would retreat if the market were freer.

Significant changes to Medicaid long-term care eligibility policy as recommended here would improve the program as a safety net for the poor. Every dollar spent on Medicaid benefits for middle-class and affluent families is a dollar that cannot be devoted to the most vulnerable. Policymakers must act swiftly to end Medicaid's perverse incentives and refocus the program on the needy.

# Appendix I: Supplemental Bibliography

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## Supplemental Bibliography of Books, Elder Law Treatises and Law Journal Articles on Medicaid Planning Listed Chronologically with Dates of U.S. Economic Recessions and Passage of Major Legislation to Control Medicaid Planning

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*This annotated bibliography documents the argument in the report that progress to target Medicaid long-term care benefits to the neediest tended to occur during or shortly after economic recessions and receded during the subsequent economic recoveries—until recently.*

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This annotated bibliography documents the argument in the report that progress to target Medicaid long-term care benefits to the neediest tended to occur during or shortly after economic recessions and receded during the subsequent economic recoveries—until recently. Since 2000, intervention by the Federal Reserve to push interest rates artificially down has enabled more deficit spending and made controlling Medicaid long-term care expenditures less of a concern. This reduction in fiscal restraint reduced pressure to direct the program's scarce resources to the needy in the intervening years leaving Medicaid the dominant payer for long-term care and more financially vulnerable than ever as the age wave begins to crest.

**New legislation is shaded in green and recessions are shaded in red.**

**July 30, 1965: President Lyndon Johnson signed Medicaid into law providing “medical assistance on behalf of . . . aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.”**

*“Because of the attention focused on Medicare, Title XIX was passed by Congress with little public notice. This relative obscurity was lost when the cost of New York State’s Medicaid program (effective May 1, 1966) became known. Federal cost estimates for the entire Medicaid Program were shown to have been grossly underestimated.” (p. 63)*

*“Under Title XIX a state may also provide medical assistance to some of the ‘medically indigent.’ This group includes all persons whose income is high enough to meet daily living expenses, but not sufficient to meet medical bills.” (p. 64)*

*“Several different methods of limiting the federal contributions to state Medicaid programs were considered over the objections of liberal, mostly urban, Congressmen. After long debate, the method finally selected was to place limits on the annual incomes of the medically indigent for whom federal matching funds would be available.” (p. 83)*

**Columbia Journal of Law and Social Problems, “Medicaid: The Patchwork Crazy Quilt,” Columbia Journal of Law and Social Problems, 5 Colum. J.L. & Soc. Probs. 62 1969**

## December 1969 to November 1970: Recession

*"Typical relative responsibility requirements of public assistance programs are relaxed under the Medicaid program so that the only relatives with prior responsibility for payment of medical care costs are an individual's spouse and the parents of a child who is under 21, blind, or disabled. Liens may not be imposed against the property of any recipient while he is alive; recovery may be had only from the estates of recipients who were 65 [since lowered to 55] or over when they received medical assistance, and then only after the death of the spouse and if there is no surviving child aged under 21, or who is blind or disabled. The state agency is required to publicize the program so that potential applicants are aware of it and to keep persons eligible for the program informed about the changes in the program."* (p. 737)

*"The question [for states] of whether to participate was not a very meaningful one. Even if the high federal matching ratio was not sufficiently attractive, states were not likely to run the risk of losing federal funds for all of their public assistance medical care programs if they did not have a Medicaid program in effect by 1970. The question of whether to have a program thus became, in effect, when to begin one's program."* (p. 743)

*"Spending under Medicaid, which has continued to rise since 1968, is clearly greatly in excess of the expectations of Congress and of the states. A major factor contributing to this unexpectedly high expenditure has been the unusually high increase in medical care prices since 1965, an increase to which Medicaid and Medicare contributed by suddenly adding large sums of money to the demand for medical care without substantially increasing or efficiently organizing the supply of medical services available."* (p. 745)

*"Two services, in-patient hospital and nursing home care, take the bulk of Medicaid money."* (p. 747)

*"To evaluate Medicaid at the halfway mark to 1975, i.e., in terms of its ability to provide comprehensive medical care to substantially all needy and medically needy, would show not merely a failure but, perhaps, a disaster. It is fair to say that no major participant in medical care policy debates continues to claim that Medicaid can be the vehicle for comprehensive medical care to the poor; this is underscored by the Ways and Means Committee's abandonment of the 1975 goal, even after its postponement to 1977."* (p. 748)

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*"To evaluate Medicaid at the halfway mark to 1975, i.e., in terms of its ability to provide comprehensive medical care to substantially all needy and medically needy, would show not merely a failure but, perhaps, a disaster."* (p. 748)

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*"Those states which attempted to bring the poor into the mainstream by providing liberal eligibility standards, broad benefits, and adequate fees found themselves running into opposition at home and in Congress on both financial and ideological grounds."* (pps. 752-3)

*"The public assistance system is an inadequate vehicle for providing medical care equitably throughout the country. A system which merely provides additional funds and makes no attempt at major revisions in the service delivery system is bound to produce increased costs with gains not commensurate to those costs. Medicaid has resulted in incremental improvements and changes in the public assistance medical care system but at great cost. The ultimate result has been little satisfaction for the poor, for the public, or for professionals."* (p. 755)

**Sydney E. Bernard and Eugene Feingold, The Impact of Medicaid, Wisconsin Law Review, Wis. L. Rev. 726 1970**

## November 1973 to March 1975: Recession.

## January to July 1980: Recession.

"Prior to an amendment to the SSI program in 1980, applicants were expressly permitted to transfer resources that otherwise would have disqualified them from receiving any benefits. A number of decisions confirmed that states were not permitted to deny Medicaid eligibility to

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an applicant who had divested himself of resources for less than fair market value. The conflict between the federal rule and state rules, which were promulgated to prevent applicants from divesting themselves of all resources in order to qualify for assistance, gave rise to litigation which prompted Congress to make a legislative attempt to resolve this problem.

"In December of 1980, Senators Boren of Oklahoma, and Long of Louisiana, added an amendment to the Parental Kidnapping Prevention Act of 1980. The Boren-Long amendment prohibited the transfer of assets solely to qualify for benefits under the SSI statutes. The new requirement allowed states to specify a similar procedure for denying benefits. This procedure cannot be more restrictive than the procedure specified when an applicant or recipient has disposed of resources for less than fair market value. A critical aspect of the law, with which the states were most concerned, was left out. The new SSI rule was expressly not applicable to assets which were exempt when transferred, and this included the family home. Because of this exemption, courts were prohibiting states from applying their transfer rules to assets that were exempt when transferred." (pps. 372-73)

**Timothy N. Carlucci, The Asset Transfer Dilemma: Disposal of Resources and Qualification for Medicaid Assistance, *Drake Law Review*, 36 *Drake L. Rev.* 369 1986-1987**

**December 5, 1980: President Jimmy Carter signed the Omnibus Reconciliation Act of 1980, imposing the first restriction on asset transfers done in order to qualify for Medicaid.**

**Spring 1981:** First law journal article on Medicaid planning published:

*"Careful planning even under adverse state law will still be able to achieve the goal of excluding an applicant's resources for purposes of determining Medicaid eligibility."*

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**William G. Talis, "Medicaid as an Estate Planning Tool," *Massachusetts Law Review*, Spring 1981, p. 94**

Also: "The article also describes ways clients might reduce exposure to health costs through (1) creation of various trust devices, (2) conveyance of remainder interests in property, (3) conversion of property into assets exempted from eligibility tests for Medicaid, and (4) outright transfers of property. If a client can be rendered eligible for Medicaid, medical expenses will be paid in full and estate assets will be conserved. Moreover, while the Department of Public Welfare may seek recovery for payments made on behalf of elderly recipients from their estates, careful planning can lawfully defeat the Department's ability to obtain indemnification." (*Ibid.*, p. 90)

## July 1981 to November 1982: Recession

**September 3, 1982: President Reagan signed the Tax Equity and Financial Responsibility Act authorizing state Medicaid programs to penalize asset transfers, place liens on real property, and recover benefits from the estates of deceased recipients.**

*"It is substantially easier to obtain placement of a patient in a well-regarded nursing home if the patient is or appears to be able to pay privately for six months to a year, than if a patient is unable to do so. Therefore, the goal of financial planning may be to leave the potential patient with adequate funds to pay privately for at least six months."*

**Charles M. Delbaum, "Financial Planning for Nursing Home Care: Medicaid Eligibility Considerations," *Ohio State Bar Association Report*, Volume 57, Number 14, April 2, 1984, p. 373**

*"With long-range planning, the cooperation of relatives, some good health, and maybe a little luck, couples will be in a position to negotiate between the rock and a hard place that Congress has placed in the Medicaid path."*

**Gill Deford, "Medicaid Liens, Recoveries, and Transfer of Assets after TEFRA," *Clearinghouse Review*, June 1984, p. 139**

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*"With long-range planning, the cooperation of relatives, some good health, and maybe a little luck, couples will be in a position to negotiate between the rock and a hard place that Congress has placed in the Medicaid path."*

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*"By helping clients plan before the occurrence of disability, by advising clients to make permissible transfers of assets, and by making them aware of relevant administrative regulations on deeming, lawyers can aid in preserving funds to the greatest extent possible."*

**William E. Oriol, *The Complex Cube of Long-Term Care*, American Health Planning Association, Washington, D.C., 1985, p. 216**

**April 7, 1986: President Reagan signed the Consolidated Omnibus Budget Reconciliation Act of 1985 restricting the use of Medicaid Qualifying Trusts.**

*"Many people assume that a family's resources must be virtually exhausted before any help will be available through the Medicaid program. In fact, people in Washington who need nursing home care can benefit from Medicaid without devastating their families."*

**Peter Greenfield and Barbara A. Isenhour, "Medicaid for Nursing Home Care: Some Estate Planning Considerations," *Washington State Bar News*, Volume 40, Number 6, June 1986, p. 29**

*"...many individuals find it desirable to shelter their income and assets in order to remain eligible for public assistance. A trust is often recommended to achieve such a shelter.... Trust mechanisms have been and will continue to be an important aspect of planning for Medicaid eligibility."*

**C. Wesley Martin, "Medicaid Qualifying Trusts," *Connecticut Probate Law Journal*, Vol. 3, Fall 1987, pps. 185, 208**



*"In regard to assets owned by the welfare recipient, the estate planner needs to be familiar with the number of exemptions and exclusions available under the various federal and state public benefit programs which will shelter assets or income and continue the eligibility of the recipient.... Converting assets into exempt assets is a primary goal in planning the estate of the public benefit recipient."*

**James D. Palmer, Jr., "Estate Planning for Public Welfare Recipients," *Probate and Property*, Vol. 2, No. 2, March/April 1988, p. 44**

**July 1, 1988: President Ronald Reagan signed the Medicare Catastrophic Coverage Act of 1988 making asset transfer penalties mandatory and expanding the look-back period to 30 months.**

*"So is there any practical way to juggle assets to qualify for Medicaid before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmakers' best efforts...Here are the best options: Hide money in exempt assets...Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses...Pass assets to children through a spouse...Transfer a home while retaining a life estate...Change wills and title to property...Write a durable power of attorney...Set up a Medicaid Trust...Get a divorce...."*

**Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34**

Also: "By paying off a mortgage, they can magically change assets like cash, which would be lost to a nursing home, into assets that can't be touched.... Since there's no limit on the value of a house [later capped at equity of \$500,000 to \$750,000 plus inflation by DRA '05] that they can buy, they may be able to hide most or all of their assets with this one simple technique. This is a giant loophole, which they should feel free to take advantage of." (*Ibid.*, p. 38)

Also: "If the person is married, household goods, a car and personal effects are protected without regard to their value! For example, oriental rugs or paintings that appreciate in value may be worthwhile investments that add beauty and hide assets at the same time." (*Ibid.*, p. 39) Also: "Here's another loophole that a nursing-home resident may want to consider. He or she could buy a brand-new—and expensive—ring right before going into a nursing home. After all, the law doesn't limit this exclusion to rings purchased at the time of a wedding or engagement." (*Ibid.*)

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*"...a common misconception among applicants is that excess resources must be spent only on doctors, hospitals, nurses, medication, and nursing homes. Nowhere in the law is this indicated. Quite literally, an applicant could spend all of his or her assets on something 'frivolous,' such as a 90th birthday celebration of Ziegfield Follies proportion and this should not be cause for denial of Medicaid, because the applicant received 'value' for his or her money."*

**Ira S. Schneider and Ezra Huber, Financial Planning for Long-Term Care, Human Sciences Press, Inc., New York, 1989, p. 142**

### **July 1990 to March 1991: Recession**

*"It's common...for people to have undocumented and untraceable assets, such as cash and bearer bonds. If these items were to be surreptitiously transferred, their existence would probably not become known to the authorities. No doubt it is improper to tell clients to make such transfers, but the temptation to hint at them, or to scrupulously avoid finding out if the client has a safe deposit box or undocumented assets, however reprehensible, is strong."*

**Peter J. Strauss, Robert Wolf, and Dana Shilling, Aging and the Law, Commerce Clearing House, Inc., Chicago, 1990, p. 16**

*"It's common...for people to have undocumented and untraceable assets, such as cash and bearer bonds. If these items were to be surreptitiously transferred, their existence would probably not become known to the authorities. No doubt it is improper to tell clients to make such transfers, but the temptation to hint at them, or to scrupulously avoid finding out if the client has a safe deposit box or undocumented assets, however reprehensible, is strong."*

*"While there are rules against giving away most assets, there are no prohibitions against simply spending money...options might include travel to visit relatives or see the world, or one last tour of Reno's finest establishments."*

**Michael Gilfix and Mark Woolpert, "Medi-Cal Asset Preservation and Your Clients or Estate Planning is Not Enough!: A California Elder Law Institute Continuing Legal Education Seminar," Gilfix Management Group, Palo Alto, California, 1990, p. 42**

*"Whenever an aging person requires a period of nursing home care, all of that person's assets are at risk of loss. Unless one of the safe harbors*

*or loopholes contained in MCCA is exploited, however, chances are that last-minute planning will not succeed and that the home will be lost. Many clients therefore should be persuaded to transfer their homes earlier than they would otherwise have wished."*

**Brian E. Barreira, "Despite Medicaid Transfer Restrictions, the Home May Be Kept in the Family," Estate Planning, Vol. 17, No. 2, March/April 1990, p. 107**

*"Just as there is no illegality or fraud involved in taking maximum legitimate tax deductions, there is not illegality or fraud in maximizing governmental benefits. For example, giving away property to qualify for Medicaid benefits easily can be analogized to making gifts in contemplation of death to reduce estate tax. Neither is an ethical question necessarily raised by taking steps, short of illegality, to maximize benefits. The comprehensive literature on the subject rarely raises the issue of the appropriateness of this type of planning."*

**Robin Herman, "Planning for Incompetency and the Aging Client: Professional Responsibility Issues," *Tax Management Estates, Gifts and Trusts Journal*, Vol. 15, No. 4, July 12, 1990, p. 152**

*"The most common problem put to the elderlaw practitioner is how to keep an older person's assets within the family and yet allow the person to qualify for Medicaid."*

**John J. Regan, "Financial Planning for Health Care in Older Age: Implications for the Delivery of Health Services," *Law, Medicine and Health Care*, Vol. 18, No. 3, Fall 1990, pps. 275-6**

*Also: "It is important to emphasize to the older client, who may be reluctant to utilize Medicaid because of pride or possible stigma, that participation in Medicaid is not a gratuity but an entitlement like use of a public library or a public park."*

**John J. Regan, *Tax, Estate & Financial Planning for the Elderly*, Matthew Bender, New York, 1991, 1993 update, p. 2-44**

*Also: "If a couple has a second vacation home, consider having the couple rent that home and then claim the rental income as necessary for maintaining the community spouse's minimum monthly maintenance needs allowance. If the vacation home is considered necessary for this purpose, it is no longer a countable resource." (Ibid., p. 10-68)*

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*"It is important to emphasize to the older client, who may be reluctant to utilize Medicaid because of pride or possible stigma, that participation in Medicaid is not a gratuity but an entitlement like use of a public library or a public park."*

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*"Once Medicaid eligibility is established, the community spouse may acquire unlimited assets in her own name. Such assets might be received by gift, inheritance, or by selling the home and, thereby, converting an exempt asset into a non-exempt asset (cash) with impunity."*

**Michael Gilfix, "Elder Law in the 90's: No Shortage of Issues," *Trusts & Estates*, Vol. 129, No. 4, April 1990, p. 45**

*"There continue to be a number of ways that a single person can structure his or her ownership of assets so that assets can be shifted to other people on relatively short notice to achieve Medicaid eligibility."*

**Young, James H., "Medicaid Eligibility," *Maine Bar Journal*, Vol. 5, No. 4, July 1990, pps. 226-7**

*Also: "Extreme though the strategy may be, for some couples divorce may be preferable to depleting the estate...particularly if the nursing home resident spouse is beyond comprehending the circumstances." (Ibid., p. 227)*



*"This article discusses the criteria for, and planning to achieve, eligibility for Medicaid, as the alternative to private pay longterm care, and approaches to maintaining an individual's assets for family use while Medicaid-eligible.... Disinheriting the Medicaid applicant is a simple and effective option for the estate plan of an applicant's spouse, parent or child...."*

**Ruth R. Longenecker, "Planning for Medicaid Eligibility," *Tax Management Estates, Gifts, and Trusts Journal*, Vol. 15, No. 4, July 12, 1990, pps. 131, 138**

*"A key element in Medicaid planning is to render property unreachable by the state either during the client's lifetime or after the client's death."*

**Brian E. Barreira, "Using Reserved Special Powers of Appointment in Medicaid Planning," *The ElderLaw Report*, Vol. 2, No. 3, October 1990, p. 1**

*"A trust may be created to insulate personal injury proceeds so that the fund is not available for consideration by the public agency providing for an injured person's support. For example, under the Medicaid statute, such a trust would not disqualify a party from the right to receive that program's benefits."*

**Clifton B. Kruse, Jr., "Trust Protection of Personal Injury Recoveries from Public Creditors," *The Colorado Lawyer*, Vol. 19, No. 11, November 1990, p. 2187**

*"The Transfer of Assets procedure to prevent spousal impoverishment has been clearly endorsed as public policy in the United States, based on both federal and state law. Individuals and families should not hesitate to draw upon this public policy to prevent hardship and to serve the wishes of those involved."*

**Cheryl C. Mitchell and F.H. Mitchell, Jr., *Paying for Long Term In-Home and Nursing Home Care*, Mitchell Publishing, Spokane, Washington, 1991, p. 109**

*"It is true, almost to the point of being a cliché, that benefit programs, whether public or private, are bonanzas for lawyers."*

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**Lawrence A. Frolik and Alison P. Barnes, "An Aging Population: A Challenge to the Law," *The Hastings Law Journal*, Vol. 42, No. 3, March 1991, p. 715**

*"A potential planning technique would be for the community spouse to reallocate his or her assets into forms that pay less income. For example, money market funds could be used to buy zero coupon bonds, gold, or growth stocks, all of which pay no income at all. The community spouse could then legitimately argue that he or she requires a larger allocation of income up to the Monthly Maintenance Needs Allowance."*

**Gregory Wilcox, "Another Strategy to Increase the CSRA," *The ElderLaw Report*, Vol. II, No. 8, March 1991, p. 12**

*"Transferring a principal residence to a trust may be desirable for Medicaid or estate tax planning. This article shows how a trust can be used without sacrificing the tax benefits from the sale of a principal residence."*

**John J. Bowe, "Sale of a House in Trust for Medicaid Planning," *Taxation for Lawyers*, Vol. 19, No. 5, March/April 1991, p. 276**

*"One way to transfer assets prior to institutionalization and still retain the use of the assets is to transfer the assets to a trust. An increasing number of people are using discretionary trusts to insulate non-exempt assets from Medicaid eligibility requirements."*

**Brent A. Mitchell, "Medicaid Planning for the Elderly: Using Supplemental Discretionary Trusts to Pay the Costs of Long-Term Care," *Washburn Law Journal*, Vol. 31, No. 1, Fall 1991, p. 94**

*"An alternative to resource gifting and conversion is the purchase of an annuity...the Medicaid estate can usually be reduced by the amount of countable assets used to purchase an annuity."*

**Jonathan M. Forster, "Favorable Investment Vehicles for Public Benefits Planning (Part 1: Resource Planning and the Annuity)," *Elder Law Advisory*, No. 7, October 1991, p. 2**

*"Recent judicial and administrative agency glosses on the federal regulation on the treatment of trusts appear to have created a legal planning tool which removes virtually all restrictions upon familial wealth retention.... Planned impoverishment has been collapsed into a last minute pit stop at an attorney's office to erect a trust shield around assets."*

**Michael Bagge, "The Eye of the Needle: Trust Planning, Medicaid and the Ersatz Poor," *New York State Bar Journal*, Vol. 40, No. 2, February 1992, p. 16**

*"A new amendment to the Social Security Act allows an exemption for the family business, farm or ranch from countable assets for Medicaid eligibility. The advocate should take maximum advantage of this exemption to achieve immediate or very rapid eligibility for clients in need of Medicaid assistance. A considerable amount of resources can be excluded including the value of land and buildings, equipment, livestock, inventory, vehicles, and liquid resources used in the business. The attorney should also counsel his clients on the best method of transferring the business, farm or ranch to avoid the imposition of liens and recovery from the estate for amounts spent for Medicaid."*

*"The new amendment to the Social Security Act (Pub. L. No. 101-239, 103 Stat. 2465, amending 42 U.S.C. 1382b(a)(3)) allows for the exemption of all income-producing property used in a trade or business.... In other words, there is now an unlimited exemption for such property.... Property used in a trade or business is excluded regardless of its value or rate of return...."*

**Robert E. Hales and Rebecca L. Shandrick, "Advanced Planning for the Family Business," 1992 *Symposium Manual*, National Academy of Elder Law Attorneys, Tucson, Arizona, 1992, p. 15**

*"The new amendment to the Social Security Act (Pub. L. No. 101-239, 103 Stat. 2465, amending 42 U.S.C. 1382b(a)(3)) allows for the exemption of all income-producing property used in a trade or business.... In other words, there is now an unlimited exemption for such property.... Property used in a trade or business is excluded regardless of its value or rate of return.... Critical provisions for advocates to note are that liquid resources used in the trade or business may be excluded from countable resources, and that no limit is placed on such resources (POMS SI 01130.501C.5). Thus, advocates may exclude large amounts of cash in business operating accounts, trust accounts, and the like, that are necessary for use in the business.... Ultimately, Medicaid recipients will want to transfer their property to avoid the imposition of a lien and recovery from the estate for Medicaid expenditures. Since business, farms, and ranches in current use are exempt property, they can theoretically be transferred without penalty. No restrictions are placed on the transfer of this exempt property, unlike the transfer of a home (42 U.S.C. 1396(c))."*

**Rebecca L. Shandrick, "The Family Business: An Exempt Resource for Medicaid Eligibility," *The ElderLaw Report*, Vol. 4, No. 3, October 1992, pps. 1-4, emphasis in the original**

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*"We have committed an act of piracy—we have broken into the Fort Knox of Government benefits and uncovered the best legal strategies available to you for claiming your share of the gold from the Government's treasure chest.... We'll explain how you can 'strike gold' in the Social Security [including SSI], Medicare, and Medicaid programs.... With this book we are handing you the treasure map, deciphered from a mine of unintelligible government rules and regulations."*

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**Amy Budish and Armond D. Budish, *Golden Opportunities: Hundreds of Money-Making, Money-Saving Gems for Anyone over Fifty*, Henry Holt and Company, New York, 1993, p. xiii**

*"...it is clear that a substantial portion of the middle class views Medicaid as a legitimate entitlement that may be employed to preserve assets for spousal enjoyment and ultimate inheritance by the family. Congress, in liberalizing the rules applicable when one spouse enters a nursing home and the other remains in the community and the rules relating to assets transfers, and in failing to close apparent loopholes, has knowingly or unknowingly strengthened the perception that opportunities for assistance under the Medicaid system are appropriate estate and financial planning tools."*

**John E. Donaldson, "Medicaid Program," Chapter 29 in Louis A. Mezzullo and Mark Woolpert, editors, *Advising the Elderly Client*, Clark Boardman Callaghan, New York, 1993, p. 95**

*"In some states a limited form of life estate retaining lifetime rights of use and occupancy to a family residence transferred to the next generation will protect the property from being considered available for purposes of Medicaid eligibility."*

**Bryan M. Dench, "Medicaid Planning with Retained Life Interests," *The ElderLaw Report*, Vol. 4, No. 6, January 1993, pps. 1-3**

*"Another asset preservation strategy is for a community spouse to 'just say no' to paying for the other spouse's nursing home care. Say Mrs. Jones holds more money than the state allows for her husband to qualify for Medicaid coverage. If it can be shown that she simply refuses to spend her money on her husband's care, Medicaid coverage will be allowed for Mr. Jones if other easily met requirements are satisfied. This approach has been particularly successful in New York."*

**Michael Gilfix, "Elders and Nursing Home Expenses: Preserving Client Assets," *Trial*, Vol. 29, No. 6, June 1993, p.38**

**August 10, 1993: President Bill Clinton signed the Omnibus Budget Reconciliation Act of 1993 making estate recovery mandatory, expanding the look back period to five years, eliminating the cap on asset transfer penalties, and prohibiting "pyramid divestment."**

*"Old Tactics That Are Still Good: Give Assets Away. Giving assets away [three years in advance] is still the simplest and easiest way to deal with the problem, although it leaves the elderly client totally dependent upon the good faith of their children or others. Spend Assets on Exempt Items. Another tactic is to spend the assets on property that won't count for Medicaid purposes... [such as] a home...a new car...household goods...funeral expenses...and... a burial plot...A client can also reduce his net worth by spending money on travel, which many elderly people enjoy. Pay Children for Their Help. Be sure that any payments to children for their services are pursuant to a written agreement, so it's clear that they are not just gifts. Give Assets to the Other Spouse, a Minor Child, or a Child Who is Disabled. [Such gifts] will not be penalized. The Other Spouse Can Petition for an Increased Asset Allowance. The other spouse can argue that additional assets are needed to generate income... [thereby sheltering in one example an additional] \$200,000. The Other Spouse Can Refuse to Support the Applicant.... In New York, this tactic can be successful even if the spouse's refusal is completely artificial; it is used in that state frequently. Divorce.... The idea is for the spouse to be given a larger portion of the couple's assets, with little or no support awarded to the applicant. Sign a Durable Power of Attorney. All clients should sign a durable power of attorney so that if they become incapacitated, someone else can shelter their assets."*

**Lawyers Weekly, September 27, 1993**

*"With a CRT [charitable remainder trust], together with a wealth replacement trust (if needed), the clients can have their cake and eat it too. They can sell their assets, take big income tax deductions, avoid the capital gains, achieve a higher standard of living, avoid or eliminate much of their estate tax problem, and preserve their children's inheritance."*

**Lawrence Davidow, *ElderLaw Report*, November 1993, p. 4**

*"Now we have more complicated plans, but we have plans. We are going to bill more. OBRA '93 was bad for our clients, but good for us.... Numerically, most of the techniques we use are still there.... It is worth trying anything once; then network and tell each other what we got away with.... Most of my clients get eligible quickly just from thoughtful spending."*

**Robert Fleming, *NAELA Institute* speech, November 21, 1993**

*"Most of our clients can still use Medicaid.... Take \$45,000 and buy a 45 percent interest in kids' house. This makes the resources unavailable. It works in Colorado."*

**Baird Brown, *NAELA Institute* speech, November 21, 1993**



"Most of the basic planning options that seem to exist today will survive; but many of the more unique, aggressive tactics may or may not survive [p. 1] .... WE STILL BELIEVE THAT ALMOST ANYONE CAN BECOME MEDICAID ELIGIBLE FOR LONG-TERM CARE BENEFITS EVEN IN CRISIS.... [p. 11] [Emphasis in original.] It is still possible to transfer non-exempt assets (countable) into exempt assets (non-countable) for purposes of obtaining eligibility. The catch will be planning around the estate recovery program.... [p. 14] For instance, the conversion of cash into an interest in a third person's residence is a way to shelter cash assets as part of the spend-down amount. The interest in the residence would then be transferred into a limited partnership. This limited partnership interest is not real property and is, therefore, not subject to having a lien placed against it.... [p. 16] Carve up the real property interest into non-probate property to avoid estate recovery. This is the life estate interest. Consider having a parent purchase for value, based on actuarial tables, a life estate interest in an adult child's residence that would create an asset that would not have to be liquidated. This seems to avoid estate recovery." [p. 29]

**Baird Brown and Robert Fleming, "Planning Options that OBRA '93 Does Not Affect," *National Academy of Elder Law Attorneys 1993 Elder Law Institute Proceedings*, Section #12, NAELA, Tucson, 1993**

"Our goal is to take countable assets (those that have to be spent to zero), and make them either non-countable, and therefore protected, or inaccessible, which means that Medicaid can't get them."

**Harley Gordon, *how to Protect Your Life Savings from Catastrophic Illness and Nursing Homes*, Financial Strategies Press, Boston, 1994, p. 66**

"While many practitioners may believe that the Medicaid qualifications rules limit benefit eligibility to only the very poor, significant planning opportunities exist which can be utilized to qualify an individual for Medicaid benefits who otherwise has the financial resources to pay the cost of long-term care.... The trade or business exception has favorable implications for farmers and ranchers. Under the amendment, the entire farm and ranch real estate, livestock, buildings, and equipment can potentially be excluded from the Medicaid applicant's available resources. Additionally, liquid resources used in the trade or business may be excluded from countable resources without limit.... For farm and ranch families, the Medicaid planning strategy may consist of transferring the farm to the children in full with the children then renting the farm back to the parents. The parents would then act as tenants under a lease with the children.... Practitioners have several planning options with respect to pension plans. One method might be to have the client purchase an annuity. The purchase of an annuity is not an asset transfer but rather a purchase for value. Thus, an annuity purchase should only be a prohibited asset transfer to the extent it is for less than fair market value.... The appropriate Medicaid planning strategy for a client who is the holder of closely held stock in a family owned corporation may be to work the potential Medicaid applicant into a minority position by making a series of gifts during life outside of the applicable look-back period until the applicant is in a minority position. Then, the strategist should argue that the applicant is no longer able to sell the stock and therefore should be immediately eligible for Medicaid benefits. This strategy allows the practitioner to preserve the

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*"While many practitioners may believe that the Medicaid qualifications rules limit benefit eligibility to only the very poor, significant planning opportunities exist which can be utilized to qualify an individual for Medicaid benefits who otherwise has the financial resources to pay the cost of long-term care...."*

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asset in question for the applicant and the applicant's family.... Another planning technique involves using the Medicaid appeals process to divert as much income as possible from the institutionalized spouse to the community spouse in order to bring the community spouse up to a specified minimum level of monthly income."

**Roger A. McEowen, "Estate Planning for Farm and Ranch Families Facing Long-Term Health Care," *Nebraska Law Review*, Vol. 73, No. 1, 1994, pps. 104-141**

"For clients facing the possibility of future long-term healthcare, estate planning advice concerning the preservation of their assets during their own lifetimes is of far greater importance than advice about the conventional after-death estate planning issues of wills, trusts, probate, and death taxes."

**Dwight F. Bickel, "Medicaid Eligibility Planning After the 1993 OBRA Amendments," *The Practical Lawyer*, Vol. 40, No. 1, January 1994, p. 22**

Also: "Until we see what types of statutes are enacted by the states, and how those statutes are construed in the courts, prudence dictates that you give a written warning to every client who wants Medicaid eligibility planning advice: although the strategies recommended will, in your opinion, be effective there are ambiguities in the present law and because of those ambiguities the extent to which the protected assets may be subjected to estate recovery proceedings after the client's demise cannot be guaranteed." (*Ibid.*, p. 32)

"Medicaid is a middle-class entitlement, just like the deduction for mortgage interest and IRAs."

*"Medicaid is a middle-class entitlement, just like the deduction for mortgage interest and IRAs."*

**Mark Heffner, former Rhode Island state legislator and RI Coordinator of NAELA in Providence, *RI Journal*, February 22, 1994**

"It is, I believe, safe to say that the Medicaid authorities are simply not ready for the complexities of, GRITs, GRATs, and GRUTs. They have not yet even been able to develop a basic set of rules on annuities!"

**Alexander Bove, *Elder Law Report*, September 1994**

"This Comment examines the Medicaid eligibility rules that allow many people to shelter thousands of dollars' worth of assets in order to qualify for taxpayer-financed long-term health care benefits, while requiring others to deplete their entire life savings to receive the same assistance." (p. 1223)

**Shawn Patrick Regan, "Medicaid Estate Planning: Congress' Ersatz Solution for Long-Term Health Care," *Catholic University Law Review*, 44 Cath. U. L. Rev. 1217, 1227 (1995)**

"Many older Americans have used so-called Medicaid planning to avoid the high cost of long-term care. This involves giving away their assets or placing them in Medicaid trusts so they can qualify for benefits if they enter a nursing home.... The Medicaid spend-down technique involves transferring ownership of all assets in excess of Medicaid limits from the person who needs nursing home care to persons other than the spouse, usually the adult children. Then Medicaid takes over the responsibility for all the nursing home expenses. If this strategy is followed, the assets stay in the family and the health care costs are taken over by the government."

**Sid Mittra, "The Techniques of Medicaid Planning," *Financial Planning*, Vol. 25, No. 4, April 1995, p. 114**



*"A transfer of the home with reserved special powers of appointment can provide the best of all possible worlds. It can completely protect the home from the reach of Medicaid after the applicable waiting period while allowing the power holder to retain control of the property and preserve all desirable tax benefits with no exposure to estate recovery."*

**Alexander Bove, Elder Law Report, February 1996, p. 3**

*"Despite more restrictive rules governing eligibility for Medicaid enacted in OBRA '93, a number of planning strategies are still available. This article examines transferring the residence and sheltering assets through annuities and special needs trusts."*

**James D. Palmer, Jr., "New Planning Approaches to Cope with Stricter Medicaid Rules," Estate Planning, Vol. 23, No. 2, February 1996, p. 1**

*August 21, 1996: President Bill Clinton signed the Health Insurance Portability and Accountability Act making it a crime to transfer assets for less than fair market value for the purpose of qualifying for Medicaid.*

*"Viatical settlements may provide an opportunity for families that include a senior in need of long-term care, to meet financial obligations without disqualifying the senior for Medicaid benefits.... Viatication affords a policyholder the means by which to convert a 'non-exempt' asset (i.e., a life insurance policy) to an 'exempt' asset for purposes of Medicaid regulation.... Possible uses of viatical settlement proceeds to create an 'exempt' asset include: (a) paying off a home mortgage; (b) making major home repairs or improvements; (c) paying off outstanding medical bills; (d) prepaying tax obligations, including real estate taxes; (3) purchasing or replacing a car; (f) creating a burial fund or making prepayments for funeral costs; and (g) purchasing a long-term care policy for a spouse. These alternative uses permit viators to put viatical proceeds to good use and still retain their Medicaid eligibility or the Medicaid eligibility of their spouses.... For example, as part of a Medicaid planning strategy, a prospective viator may sell the life insurance policy in question to other family members (e.g., children), possibly for an amount equal to the gift tax value of the policy.... Then, the children, at some point in the future, may viaticate the policy and realize a greater value."*

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*"Viatical settlements may provide an opportunity for families that include a senior in need of long-term care, to meet financial obligations without disqualifying the senior for Medicaid benefits.... Viatication affords a policyholder the means by which to convert a 'non-exempt' asset (i.e., a life insurance policy) to an 'exempt' asset for purposes of Medicaid regulation...."*

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**NAELA Conference 1996 proceedings, Session 11, pps. 18-19, 21-23**

*"The chart at the end of these materials labeled 'The Home in Medicaid Planning'...contains a matrix with 10 rows and 8 columns. Each row contains a method of protecting the family home from Medicaid estate recovery. Each column contains a Medicaid or tax issue which must be considered when selecting a method of protecting the family home."*

**NAELA Conference 1996 Proceedings, Session 7, p. 1**

*"As a practical matter, if your wife needs nursing home care in the future you may want to privately pay the nursing home (three months up front) for purposes of expediting your wife's placement in a nursing home, unless she is eligible for Medicare benefits. Once your wife is in the nursing home and eligible for Medicaid, you should immediately proceed to file for Medicaid Nursing Home Care.... Since your assets are in excess of the CSRA [\$652,550] at the time your wife files a Medicaid application for nursing home care, then it is critical that you submit a 'Spousal Refusal' to contribute your assets to pay for her care, or else she will be denied Medicaid.... We are available to assist you in the preparation and filing of Medicaid applications and the coordination of Medicaid coverage, including monthly budgeting.... If you receive a denial of benefits our firm is available to assist you with regard to any Medicare claims and appeals should your wife requires such care, you can obtain Medicaid eligibility for her by transferring assets into your name and your utilization of spousal refusal.... Another alternative would be for you to purchase an annuity with the assets in excess of the CSRA.... This approach will allow your wife to qualify for nursing home care without a transfer penalty and without spousal refusal.... Your wife can transfer her assets into a trust for your sole benefit. This transfer would not subject her to a Medicaid period of ineligibility.... the CSRA should be enhanced to \$200,000 from \$76,740.... If the consultation exceeds the one-half hour, then you will be charged based upon my hourly rate of \$275 and my legal assistant's rate is \$100."*

**NAELA Conference 1996 Proceedings, Session 9, pps. 34-38, 46**

*"The PAN [private annuity] and the SCIN [Self-Canceling Installment Note] are clearly effective but highly underutilized tools in the Medicaid planning area. As practitioners become more familiar with their tax, legal, and Medicaid planning benefits, their popularity will undoubtedly increase to the point where Congress will again change the laws."*

**NAELA Conference 1996 Proceedings, Session 14: "Making Resources Disappear-The Magic of Private Annuities and Self-Canceling Installment Notes," p. 12**

*"By using a LCC [Life Care Contract], the applicant is outside the purview of the disqualifying transfer section of Title 42 because the contract anticipates a transfer for value and not a gift. Therefore, to the extent that the elder's assets are transferred pursuant to this contract, the elder will incur no period of ineligibility.... The LCC is a transfer for value and can either be structured as a lump sum transaction where the entire property is transferred at one time, or can be structured to payout on a month to month basis.... Using this one payment method, an elder can transfer a large number of assets and shortly thereafter qualify for Medicaid if the caregiver can prove that the medical condition causing the disability was totally unanticipated (massive stroke) .... IT DOESN'T MATTER IF MOM HAS A MASSIVE STROKE AND IS A CANDIDATE FOR LONG TERM CARE SIX MONTHS LATER...."*

**NAELA Conference 1996 Proceedings, Session 6: "Uses, Terms and Provisions of Lifecare Contracts for Elders," pps. 1-2, 4, 11**

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"Depending on the state and a couple's savings, the amount of the Community Spouse Resource Allowance (CSRA) will be affected by the amount of assets held by the couple on the date of institutionalization of the nursing home spouse. Some states permit the community spouse to keep all of the couple's assets up to the cap of \$76,740 (or another lower figure). Most limit the CSRA to one-half of the couple's assets up to the cap. In either case, the more the couple is holding at the date of institutionalization (the 'snapshot'), the more the community spouse may keep.... The assets falling into the snapshot may be maximized if the nursing home placement is anticipated in advance. For instance, the couple can refrain from paying bills for several months (provided they can keep their creditors at bay). Or they can pay all of their expenses with credit cards, paying off the outstanding balance after institutionalization of the ill spouse. Or they can borrow money so that more is in their bank account on the date of institutionalization. What matters is what assets being available, not the couple's net worth. If a couple has \$60,000 in savings, the community spouse will be permitted to keep \$30,000. If through use of credit cards and holding off on paying bills they have \$70,000 on the date of institutionalization, the community spouse will be allowed to keep \$35,000. He or she can pay off the credit cards and settle the bills after institutionalization, giving her \$5,000 more in savings when the nursing home spouse qualifies for Medicaid.... Of course you may encounter resistance to these strategies; many clients in the generation now facing the need for nursing home care abhor going into debt for any purpose."

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**"Medicaid planning is still practiced by competent people of all socio-economic classes in all fifty states.... In this article, we argue that guardians should be permitted to perform Medicaid planning for their wards.... [T]he term 'Medicaid Planning' is used in this article to mean the process of lawfully rearranging an individual's assets so that the individual qualifies for Medicaid under the law while the assets are sheltered for use by a spouse, children or others...."**

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**"Practice Tips," *ElderLaw Report*, December 1996, p. 8**

"Many of our clients own a second piece of real property—a summer home, a mountain cabin, an investment. It is typically viewed as an impediment to Medi-Cal eligibility when one spouse enters a nursing home. Assume that a couple's second (non-exempt) residence is worth \$225,000 and that other cash assets are relatively modest, perhaps only \$80,000. Rather than sell this property, as Medi-Cal would likely advise, protect it. In tallying their assets, the appraised value, not the fair market value, determines the value of the real property asset for Medi-Cal purposes. Assume further that the appraised value is \$40,000, entirely likely in light of [California] Proposition 13. The community spouse, the spouse living at home, could take out a loan in the amount of \$40,000 and, for purposes of Medi-Cal, reduce its effective value to \$0. The borrowed money could then be used to add on to the residence, buy needed items, invest in other exempt resources, or be protected by an increased Community Spouse Resource Allowance (CSRA) order."

**Michael Gilfix, "Practice Tip: Protect Non-Residential Real Property and Medi-Cal," *Gilfix ElderLaw News Alert*, Vol. VII, No. 1, February 1997, p. 3**

Also: "Payment for personal services can be part of a 'spend-down' when a Medi-Cal application may be submitted in one's future. Depending on the amount of services rendered, this could justify \$1,000 or perhaps \$2,000 per month when care and support are very substantial.... [F]unds used for the payment of services might otherwise have to be invested in payment for nursing home services at the private rate." (*Ibid.*, p. 12)

"Cemeteries may do a good or bad job of maintaining grave sites. And they may do a good job today, but drop the ball years from now. A new service is being offered to provide assurance that sites will be maintained for the next 25 years. Depending on the plan purchased, the one-time fee ranges from \$3,800 to \$13,500. The company offering the plan, Westland Perpetual Trust, Inc., reports that payment of the fee has been permitted as a legitimate Medicaid spend down. The service is offered nationwide."

### **Elder Law Report, May 1997, p. 12**

"Medicaid planning is still practiced by competent people of all socio-economic classes in all fifty states.... In this article, we argue that guardians should be permitted to perform Medicaid planning for their wards.... [T]he term 'Medicaid Planning' is used in this article to mean the process of lawfully rearranging an individual's assets so that the individual qualifies for Medicaid under the law while the assets are sheltered for use by a spouse, children or others.... These techniques...include: divesting assets generally, transferring assets between spouses, transferring assets to trusts, converting assets, and divorcing a spouse.... [T]he couple may avoid a claim by the state to recover the Medicaid payments by transferring all spousal assets to the sole ownership of the community spouse after the institutionalized spouse's application for benefits has been approved.... Another sheltering strategy is to convert available, countable assets into non-countable exempt assets. For example, money in checking or savings accounts may be used, without creating a period of ineligibility, to purchase or improve a home, pay off a mortgage, buy a cemetery lot, pre-pay funeral services, pre-pay residence-related taxes and insurance, or even pay outstanding bills, including legal fees.... Divorce is one of the more extreme Medicaid planning strategies. A successful divorce, in which both parties are represented by independent counsel, and containing an agreement in which most or all of the couple's assets are given to the community spouse, can result in almost immediate Medicaid eligibility for an institutionalized spouse.... The mere fact that Congress and the states have enacted statutes and regulations expressly permitting and endorsing Medicaid planning is clearly an expression of the public policy to allow such planning."

**Hal Fliegelman and Debora C. Fliegelman, "Giving Guardians the Power to do Medicaid Planning," *Wake Forest Law Review*, Vol. 32, No. 2, Summer 1997, pps. 341-2, 359, 362-4, 373**

**August 5, 1997: President Bill Clinton signed the Balanced Budget Act (Throw Granny's Lawyer in Jail Law) repealing the criminalization of asset transfer to qualify for Medicaid, but making it a crime to recommend asset transfers for the purpose of qualifying for Medicaid in exchange for a fee.**

"The real goal, though, is to work with your parents on an asset-shifting plan that will allow them to have Medicaid pick up the tab for their long-term care if need be. We're not talking here about the increasingly dodgy moves people make to shield their assets from the government, but legitimate estate-planning steps.... The most common means of transferring assets—the 'half a loaf' method—is designed to exploit this principle without breaking any rules, explains Boston attorney Harry Margolis.... Planners also suggest shrinking the total assets your parents



have to begin with. One way to do this is by turning assets that aren't exempt from Medicaid into those that are. Money in the bank or a certificate of deposit could be spent on a prepaid funeral or a more extravagant engagement ring, for example; both are exempt assets.... If your parents live in a state that doesn't limit income for Medicaid recipients or their spouses, fixed annuities are another useful tool. Whichever of these solutions you choose to implement, planners say, it's important to pay privately for a good six months if you can swing it."

**SmartMoney, October 1997, pps. 134-136**

"Q: Can my parents give away a part of their life savings and still qualify for Medicaid? A: Yes. The law lets people give a portion of their savings to children or others to protect those funds from being tabulated as assets. Giving away money can help your parents reduce their funds to a level that makes them eligible for Medicaid. Q: How else can my parents protect part of their life savings? A: Here are three of the most popular planning strategies. ...1. Put money into exemptions [i.e. home improvements, a new car, etc.]. ...2. Create specialized trusts. Medicaid permits the creation of a variety of specialized trusts that preserve assets. Your parents might transfer their home to an irrevocable Medicaid trust, which allows them to live at home for life, obtain Medicaid coverage if they must enter a nursing home, pass the residence to heirs at death, and avoid capital-gains taxes. ...3. Purchase an immediate Medicaid annuity or promissory note. Let's return to the example of your parents with \$100,000 in assets when dad enters a nursing home. Your mom takes \$50,000 of that and buys (in her name) an immediate Medicaid-qualified annuity from an insurance company. ...Dad qualifies for Medicaid immediately, and Mom remains financially secure because she keeps all the income. She may even save and accumulate the annuity payments without jeopardizing her husband's Medicaid coverage."

**Armond Budish writing in Family Circle, November 1, 1997, p. 46**

"A potential Medi-Cal [Medicaid's name in California] applicant with cash or other liquid resources can always think about purchasing a residence. Since the residence is an exempt resource and will not count in determining eligibility, this is something of a safe harbor. It can also prevent the individual with lifestyle options that he might have deemed out of reach."

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**Michael Gilfix, "Medicaid NH Evictions: Not in California," Gilfix Elderlaw Newsalert, February/March 1998, p. 5**

"Annuities are excellent Medicaid planning tools for healthy spouses seeking coverage of long-term nursing home care for an ill spouse. In most instances, annuities should not be purchased until an ill spouse enters a nursing home. Annuities benefit lower-income community spouses less since an increased income stream may prevent the spouse from receiving additional assets above the standard resources available."

**Harry Margolis and Eric R. Oalican, "White Paper on the Use of Annuities in Long-Term Care Planning," unpublished paper received from the authors on July 17, 1998, p. 5**

*"An income-only trust provides the settlor with income from trust principal during her lifetime and is an excellent property management vehicle in the event of the settlor's incapacity. Moreover, if properly drafted, the principal of an irrevocable income-only trust is not considered an available resource of the settlor with respect to her Medicaid eligibility."*

**Bernard A. Krooks, "OBRA '93 – A 60-Month Lookback: The Continued Viability of Income-Only Trusts,"** *NAELA Quarterly*, Vol. 11, No. 3, Fall 1998, p. 17

*"The cornerstone of estate tax and long-term care planning is gifting. There are generally two reasons individuals desire to make gifts. The first is to remove assets from their taxable estates, and the second is to remove 'countable' assets from their names to plan for long-term care eligibility under the Medicaid program. The primary motive for gifting in either estate tax or long-term care planning is to maximize the amount of assets that are available to pass on to the transferor's heirs... This article will...concentrate on gifts used in planning for Medicaid eligibility. This article is intended to guide the lawyer in advising clients how to make gifts to ensure those gifts will not be contested and, therefore, deemed to be available for Medicaid qualification purposes. This article will also discuss the types of gifts frequently used in long-term care planning and will include recommendations as to how to document and structure gifts to ensure the client's intended results are met... Clients often choose to make a 'disguised' gift.*

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*The disguised gift is intended to keep the assets in one 'pot,' to be distributed among the intended donees after the donor's death... The reason for the use of the disguised gift is for the donor to ensure that the gifted funds will be available if the donor needs them in the future. Then, an unrequired but voluntary retransfer could be made. Care must be taken to ensure the transferred assets are not deemed to be an available resource which may affect the individual's eligibility for Medicaid benefits. Reserving too many 'controls' or retained interests in a gifted asset or premature disposition or use of the gifted asset by the donee after it has been transferred may cause the gift to be ineffective. Care must also be taken to avoid a transfer that is deemed fraudulent... The more control the transferor retains over the gifted asset, the more likely the government agency administering the Medicaid program will treat the asset as an available resource."*

**Baird Brown, "The Art of Gifting,"** *NAELA Quarterly*, Vol. 11, No. 3, Fall 1998, pps. 21-23

*"Until the need for Medicaid planning is eliminated, this service will remain an absolute necessity for the millions who face the financial devastation of paying for long term care. The perhaps all too human urge to get the most benefit at the least cost, such as tax avoidance, has resulted in a demand for lawyers whose practice includes a detailed knowledge of the Medicaid eligibility rules and how best to plan for eligibility." (p. 42)*

**Jason A. Frank, Esq., "The Necessity of Medicaid Planning,"** *University of Baltimore Law Forum*, 30 U. Balt. L.F. 29 1999-2000



*"The law, therefore, allows an institutionalized spouse to qualify for Medicaid benefits even though he or she may have a spouse that chooses to keep assets over the CSRA [Community Spouse Resource Allowance]. The spouse retains the assets, in any amount, and then refuses to make them available for the institutionalized spouse's costs of long-term care. In turn, the state seeks an assignment of the institutionalized spouse's support rights." (p. 26)*

**Scott M. Solkoff, "Spousal Refusal: Preserving, Family Savings by "Just Saying No" to Long-Term Care Impoverishment," *Marquette Elder's Advisor*, Volume 2, Issue 3 Winter Article 4, 2001**

*"In an attempt to qualify for government assistance to pay for medical costs, some elderly couples have resorted to extreme measures. One such measure has been for the elderly couple to obtain a divorce, and in the process transfer the majority of the couples assets from the ill spouse to the healthy one. This scheme allows the impoverished spouse to qualify for Medicaid assistance for that spouse's long-term care. In this note, Michael Farley discusses the implications of this measure and ultimately recommends eliminating this divorce loophole. Because of the number of alternatives that are available for elderly couples to obtain Medicaid assistance for costly medical expenses like nursing home care, permitting elderly couples to go through the emotional trauma and other significant drawbacks of divorce just to qualify for Medicaid is cruel and unreasonable. (p. 27)*

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*"In an attempt to qualify for government assistance to pay for medical costs, some elderly couples have resorted to extreme measures. One such measure has been for the elderly couple to obtain a divorce, and in the process transfer the majority of the couples assets from the ill spouse to the healthy one. This scheme allows the impoverished spouse to qualify for Medicaid assistance for that spouse's long-term care."*

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**Michael Farley, When "I Do" Becomes "I Don't": Eliminating the Divorce Loophole to Medicaid Eligibility, 28 *The Elder Law Journal* VOLUME 9, June 21, 2001**

### **March 2001 to November 2001: Recession**

*"True, Medicaid planning remains a core element in any elder law practice and is probably the leading source of clients and revenues for almost all elder law attorneys." (pps. 3-4)*

*"Of course, elder law is not a fringe practice. For thousands of attorneys, elder law represents the core of their practice." (p. 13)*

*"The practice of elder law, however, is not yet fully formed, because there are many parts of it that could either expand or contract, such as nursing home and assisted-living litigation. Will elder law attorneys perceive suing nursing homes and assisted-living facilities for negligent care as part of their practice, or will it be captured by personal injury attorneys?" (p. 14)*

**Lawrence A. Frolik, "The Developing Field of Elder Law Redux: Ten Years After," *The Elder Law Journal*, 10 *Elder L.J.* 1 2002**

*"Unfortunately, members of the Medicaid planning bar have sometimes been their own worst enemies. For example, at the May 1996 Symposium of the National Academy of Elder Law Attorneys, two prominent NAELA members (one a former President of the organization) gave a presentation on Medicaid planning. Using the format of a skit in which other NAELA members played the roles of the family, the presenters took the audience through a session in which an elderly couple, whose net worth exceeded \$750,000, was counseled on how to arrange their affairs to attain Medicaid eligibility. Among the assets in the couple's portfolio was a vacation home. The skit became fodder for critics of Medicaid eligibility planning and indeed was widely criticized by other NAELA members."* (p. 135)

**Timothy L. Takacs and David L. McGuffey, "Medicaid Planning: Can It Be Justified? Legal and Ethical Implications of Medicaid Planning," *William Mitchell Law Review*, 29 Wm. Mitchell L. Rev. 111 2002-2003**

*"The process of 'Medicaid planning,' or arranging assets and income for an individual or couple in order to achieve earlier Medicaid eligibility for nursing home benefits and protect assets for other uses than nursing home payments, is an important legal service that is identified with the broader field of elder law. However, specific techniques for obtaining Medicaid eligibility are seldom openly discussed in the literature. Two reasons seem readily apparent. First, practitioners may reasonably view their techniques as trade secrets, and may tailor information shared with colleagues to assure incompleteness as an economic protection for their individual practices. Secondly, some commentators have aggressively criticized Medicaid planning as a misuse of Medicaid funds."* (pps. 267-8)

**Alison Barnes, "An Assessment of Medicaid Planning," *Houston Journal of Health, Law & Policy*, 3 Hous. J. Health L. & Pol'y 265 2002-2003.**

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*"Unfortunately, members of the Medicaid planning bar have sometimes been their own worst enemies. For example, at the May 1996 Symposium of the National Academy of Elder Law Attorneys, two prominent NAELA members (one a former President of the organization) gave a presentation on Medicaid planning. Using the format of a skit in which other NAELA members played the roles of the family, the presenters took the audience through a session in which an elderly couple, whose net worth exceeded \$750,000, was counseled on how to arrange their affairs to attain Medicaid eligibility. Among the assets in the couple's portfolio was a vacation home. The skit became fodder for critics of Medicaid eligibility planning and indeed was widely criticized by other NAELA members."*

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*"Increasingly, middle-class and upper middle-class elderly Americans voluntarily impoverish themselves in order to obtain the government benefit known as Medicaid. 'Medicaid planning,' as this widely discussed estate planning technique is known, has several variations and is highly controversial. Footnote 2"*

*"Footnote 2 Searches of Westlaw and Lexis produce hundreds of relevant documents. The Practising Law Institute, the American Law Institute, and various state bar associations have published dozens of 'how to' publications in this area. E.g., MASSACHUSETTS CONTINUING LEGAL EDUCATION, INC., ESTATE PLANNING FOR THE AGING OR INCAPACITATED CLIENT IN MASSACHUSETTS: PROTECTING LEGAL RIGHTS, PRESERVING RESOURCES, AND PROVIDING HEALTH CARE, (2002). Likewise, lawyers, scholars and students have written reams about the topic. For a sampling of the leading treatments, see ERIC M. CARLSON, LONG-TERM CARE ADVOCACY (Matthew Bender & Co. 1999); Cynthia M. Brubaker, Medicaid Eligibility: Planning for the Elderly Client, 26 U. BALT. L.F. 15 (1995); Joel C. Dobris, Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance, 24 REAL PROP. PROB. & TR. J. 1 (1989); Hal Fliegelman & Debora C. Fliegelman, Giving Guardians the Power to Do Medicaid Planning, 32 WAKE FOREST L. REV. 341 (1997); Jason A. Frank, The Necessity of Medicaid Planning, 30 U. BALT. L.F. 29 (1999); A. Frank Johns, Legal Ethics Applied to Initial Client-Lawyer Engagements in Which Lawyers Develop Special Needs Pooled Trusts, 29 WM. MITCHELL L. REV. 47 (2001); Harry S. Margolis, A Proposal for Reform of Medicaid Rules Governing Coverage of Nursing Home Care, 9 STAN. L. & POL'Y REV. 303 (1998); Jan Ellen Rein, Misinformation and Self-Deception in Recent Long-Term Care Policy, 12 J.L. & POL. 195 (1996); Joseph A. Rosenberg, Supplemental Needs Trusts for People with Disabilities: The Development of a Private Trust in the Public Interest, 10 B.U. PUB. INT. L.J. 91 (2000); Michael Wytychak III, Payment of Nursing Home Bills Through the Medicaid Program, 36 IDAHO L. REV. 243 (2000); Michael Farley, Note, When "I Do" Becomes "I Don't": Eliminating the Divorce Loophole to Medicaid Eligibility, 9 ELDER L.J. 27 (2001); Kenneth Hubbard, Note, The Medicaid Cost Crisis: Are There Solutions to the Financial Problems Facing Middle-Class Americans Who Require Long-Term Health Care?, 43 CLEV. ST. L. REV. 627 (1995); Kristin A. Reich, Note, Long-Term Care Financing Crisis-Recent Federal and State Efforts to Deter Asset Transfers as a Means to Gain Medicaid Eligibility, 74 N.D. L. REV. 383 (1998); see also Ralph J. Moore, Jr. & Ron M. Landsman, Planning for Disability, 816 Tax Mgmt. (BNA) (2000) [hereinafter Planning for Disability], and the sources cited therein at C-4 to C-8."*

**John A. Miller, "Voluntary Impoverishment to Obtain Government Benefits," *Cornell Journal of Law and Public Policy*, 13 *Cornell J. L. & Pub. Pol'y* 81 2003-2004**

*"In the 2004 case of *In re Keri*, the New Jersey Supreme Court unanimously decided that making gifts of assets as part of a Medicaid eligibility spend-down plan is presumptively an appropriate estate planning strategy for an incapacitated person who has a court appointed guardian, even in situations where the guardian is the child of the incapacitated person and would be transferring ownership of some of the assets to himself." (p. 197)*

*"Elder law attorneys are regularly consulted by clients who are distraught at the idea that they may need to spend all of their savings on long-term care and leave no legacy for their children. In fact, clients in their seventies who are in relatively good health sometimes begin divesting themselves of their assets for this very reason. More often, people don't address this issue unless and until it becomes necessary. At that point of necessity, when the individual is presented with the opportunity to become eligible for a government program that will pay for their nursing home care, and armed with the knowledge that their care will be the same whether paid for by Medicaid or paid for by them, clients frequently choose Medicaid. This*

choice is often made because they feel that they have contributed to this program through their tax dollars, and they see it as another form of health care that should be partially paid for by the government.” (p. 199)

“In re John XX, the court authorized a guardian to transfer \$640,000 to adult children of the incapacitated person in advance of the Medicaid application. In In re Guardianship of F.E.H., the court approved inter-spousal transfer of the marital home in connection with Medicaid eligibility planning, and In re Daniels authorized the transfer of the Medicaid applicant’s real estate to his daughter.” (p. 208)

**Linda S. Ershow-Levenberg, “Court Approval of Medicaid Spend-Down Planning by Guardians,” Marquette Elder’s Advisor, 6 Marq. Elder’s Advisor 197 2004-2005**

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*“Today, Medicaid is a valuable resource for the nation’s middle class seniors and is no longer viewed only as a ‘safety net’ for the poor. Medicaid planning allows the elderly to qualify for Medicaid benefits by reorganizing their assets. This process places assets outside the boundaries of Medicaid regulations, and often out of the legal grasp of the applicant, while allowing the elderly to receive medical attention funded by Medicaid.”*

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**Bryn A. Poland, “Don’t Plan on Aging: The Kansas Supreme Court Reaffirms Its Hostility Toward Medicaid Planning, [Brewer v. Schalansky, 102 P.3d 1145 (Kan. 2004)],” Washburn Law Journal, 45 Washburn L.J. 491 2005-2006**

**February 8, 2006: President George W. Bush signed the Deficit Reduction Act placing the first cap ever on Medicaid’s home equity exemption, limiting the half-a-loaf loophole, amending the annuity rules, and unencumbering the Long-Term Care Partnership Program.**

“Can an elderly husband really refuse to support his wife in a nursing home by shifting the financial burden to Medicaid? Yes, says the U.S. Court of Appeals for the Second Circuit, by employing a Medicaid-planning strategy called ‘spousal refusal.’

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*Due to the high cost of nursing home care, elderly people and their families have increasingly turned to Medicaid-planning strategies to qualify for Medicaid benefits and ease their financial burden.' Medicaid planning involves taking measures to preserve one's assets in order to gain Medicaid eligibility by meeting the program's financial criteria. One such Medicaid-planning strategy is spousal refusal, under which a healthy spouse refuses to financially support a spouse in need of nursing home care. Spousal refusal has been in existence since 1988, following Congress' attempt to fix the Medicaid system to prevent spousal impoverishment, which is when a healthy spouse ends up poor after paying for an ailing partner's care. (p. 487)*

**Andrew D. Wone, "Don't Want to Pay for Your Institutionalized Spouse? The Role of Spousal Refusal and Medicaid in Funding Long-Term Care, *The Elder Law Journal*, Volume 14, 14 Elder L.J. 485 2006**

*"Now that the annuity rules have been greatly clarified, the annuity industry will likely accept this gift from Congress and develop annuity products which comply with DRA." (p. 17)*

**Stan Miller and D. Scott Schrader, Guest columnist: Rebecca H. Winburn, "Advanced Planning Strategies: Medicaid Planning After the Deficit Reduction Act of 2005," *Journal of Practical Estate Planning*, April - May 2006, 8 J. Pract. Est. Plan. 15 2006-2007**

### **December 2007 to June 2009: The Great Recession**

*"For example, an estate planning attorney may meet with clients who ask about the possibility of using the Medicaid program to preserve assets for a healthy spouse in the event the other spouse must enter a nursing home. It would be a breach of ethics to simply point out that only indigent individuals obtain Medicaid, advising the couple to simply invest wisely and 'pay their way' until the funds are depleted. Medicaid rules allow a healthy spouse to preserve at least some of the family assets while accessing Medicaid funds for the ill spouse." (p. 177)*

**Patricia F. Sitchler, "Cutting Edge VS. Over the Edge: Ethics and Malpractice Issues for Medicaid Planning," *Estate Planning and Community Property Law Journal*, 2 Est. Plan. & Cmty. Prop. L.J. 175 2009-2010**



"Many commentators, as well as taxpayers generally, have criticized the practice of 'Medicaid estate planning, [when] individuals shelter or divest their assets to qualify for Medicaid without first depleting their life savings.' At first blush, it may appear that sheltering or divesting one's assets to qualify for Medicaid is immoral, and several authors seem to share this sentiment. However, Medicaid estate planning is not only rational, 'but it is also consistent with notions of morality and fairness. Akin to tax planning,' Medicaid estate planning is as justifiable as any other legal advice an attorney may give to a client to obtain favorable governmental treatment,' despite recent measures taken by Congress that might suggest otherwise.' The public perception seems to be that tax planning is perfectly acceptable,' whereas Medicaid estate planning is morally questionable.' This Comment attempts to rebut rash assessments as to the propriety of Medicaid estate planning, as it is a necessary and moral response to the stifling costs of elder care. Ultimately, this Comment proposes solutions to reduce the costs of long-term health care for an aging population. Ethical considerations suggest, if anything, that punishing the elderly for seeking medical care and criminalizing legal advice are real social concerns today-not Medicaid estate planning." (pps. 815-817)

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**"The policy reasons set out by former President Bush for the passage of the DRA as it relates to Medicaid are clear: Medicaid's mission is to help the needy, the sickest and poorest members of society, without waste, fraud, or abuse."**

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**Chadwick Bothe** *The Stigma of Survival: Medicaid Estate Planning*, *South Texas Law Review*, 51 S.Tex. L. Rev. 815 2009-2010.

"President George W. Bush, in a statement made when he signed the DRA, explained:

*The bill tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits. Along with Governors of both parties, we are sending a clear message: Medicaid will always provide help for those in need, but we will never tolerate waste, fraud, or abuse.*

"The policy reasons set out by former President Bush for the passage of the DRA as it relates to Medicaid are clear: Medicaid's mission is to help the needy, the sickest and poorest members of society, without waste, fraud, or abuse." (pps. 347-8)

"Before the DRA, there was a huge gap between what Medicaid law allowed and Medicaid policy, as expressed by President Bush. The DRA was passed to bring Medicaid law closer to Medicaid policy.'" (p. 350)

**Catherine M. Reif**, "A Penny Saved Can Be a Penalty Earned: Nursing Homes, Medicaid Planning, the Deficit Reduction Act of 2005, and the Problem of Transferring Assets," *NYU Review of Law & Social Change*, 34 N.Y.U. Rev. L. & Soc. Change 339 2010

"In order to continue caring for an elderly relative, an increasing number of caregivers are asking elder-law attorneys to draw up agreements in which the caregiver helps the elder for a certain number of hours each week in exchange for an hourly wage. These caregiving agreements benefit both parties by relieving financial strain on caregivers and by keeping elderly relatives out of nursing homes. . . . State Medicaid agencies claim these agreements are often a front for elders to gift assets to their children, impoverish themselves, and qualify for the state to pay for long-term care in a nursing home." (p. 1272)

**Sheena J. Knox**, "Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?," 45 *Suffolk U. L. Rev.* 1271 2011-2012



*"While Medicaid was arguably created as a 'safety net' program with the sole purpose of providing health care for the poorest members of society, it is common for Medicaid to pay for LTC services for elderly individuals from a variety of economic backgrounds."* **(p. 358)**

*"It is not uncommon for couples and individuals to engage in a practice often referred to as 'Medicaid Planning,' which one commentary defines as 'the legal fiction of 'rearranging assets' to make someone poor on paper so that he or she may qualify for Medicaid.' It is well established that such 'Medicaid Planning' is legal and that it is professionally ethical, or acceptable, for attorneys and financial planners to assist clients in such planning. Nonetheless, the Medicaid planning and spend down processes are quite complex, potentially highly financially disruptive, and may lead to inequitable results. Moreover, although legal, Medicaid planning is often perceived as 'gaming the system.'"* **(p. 359)**

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*"It is not uncommon for couples and individuals to engage in a practice often referred to as 'Medicaid Planning,' which one commentary defines as 'the legal fiction of 'rearranging assets' to make someone poor on paper so that he or she may qualify for Medicaid.' It is well established that such 'Medicaid Planning' is legal and that it is professionally ethical, or acceptable, for attorneys and financial planners to assist clients in such planning."*

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**Andrew M. Hyer, Elizabeth L. Hannah, Ross E. Burkhart, and Sarah E. Toevs, "Paying for Long-Term Care in the Gem State: A Survey of the Federal and State Laws Influencing How Long Term Care Services for Idaho's Growing Aged and Disabled Populations Are and Will Be Funded," *Idaho Law Review*, 48 Idaho L. Rev. i 2011-2012**

*"As discussed more fully in Section IX purchasing an annuity for the community spouse with excess resources can immediately establish eligibility of the institutional spouse irrespective of the amount of excess resources."* **(p. 169)**

*"As discussed in Section IX, the transfer of asset rules do not foreclose all planning opportunities. It is ironic that more planning opportunities remain for persons of substantial means than for those persons of lesser means. This is an irony quite familiar to those who do tax planning."* **(p. 170)**

*"While not required, transferring title of exempt resources solely into the name of the community spouse can avoid ineligibility for the nursing home spouse in the event the resources are sold, as well as protect the assets from Medicaid estate recovery."* **(p. 183)**

*"Based on the foregoing analysis we can now set out various planning options to reduce excess resources in the most advantageous manner possible. We begin by looking at the options available to single persons and then consider the additional options available to married persons."* **(p. 188)**

*"Gifting and Waiting Out the Look-Back Period or the Ineligibility Period"* **(p. 188)**

*"Purchasing Exempt Resources"* **(p. 190)**

*"Consuming Excess Resources"* **(p. 190)**

*"Transfer the Home to Certain Children or Siblings"* **(p. 191)**

*"Establish Trusts for Disabled Persons Less Than 65 or For a Disabled Child of Any Age"* **(p. 191)**

*"Disinheritance or Third Party Special Needs Trusts" (p. 192)*

*"Transfer Exempt Assets from the Institutional spouse to the Community Spouse" (p. 193)*

*"Revise the Community Spouse's Estate Plan" (p. 193)*

*"Purchase an Annuity for the Community Spouse" (p. 194)*

*"Requesting an Excess Resource Allowance" (p. 195)*

*"Divorce, Legal Separation, or Non-Binding Unions" (p. 195)*

*"Using Washington State as an example, this article has attempted to provide a road map for practitioners seeking to guide their clients through the long term care planning process. Most of the legal requirements and planning techniques described here have application in other states as well. There are nuances of difference and, of course, the applicable authorities differ from state to state. Still the fundamentals are reasonably universal since Medicaid's basic architecture arises under federal law." (p. 196)*

**Sean R. Bleck, Barbara Isenhour, and John A. Miller, "Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care," *MSU Journal of Medicine and Law*, 17 Mich. St. U. J. Med. & L. 153 2012**

*"Imagine working your entire life and planning to leave your assets to your loved ones only to have those assets completely depleted by the cost of long-term care. This is not an unrealistic scenario and is faced by people young and old. So-called 'Medicaid planning' is one means people use to legally divest themselves of their assets, which accomplishes the dual purpose of creating Medicaid eligibility and protecting their assets so they may be distributed to loved ones." (p. 251)*

*"Although each state provides its own laws governing guardian duties and powers, a court may authorize guardians to engage in estate planning and Medicaid planning on behalf of their wards." (p. 253)*

*"This Note argues that guardians should have a duty to petition the court for approval of a Medicaid spend-down when the ward requires indefinite nursing home care." (p. 253)*

**Angelina M. Pargoff, "Estate Planning-A Race to the Poorhouse: Should Guardians Have a Duty to Impoverish Their Wards for Asset Protection Purposes Thereby Preserving Assets for Heirs?, *Western New England Law Review*, 34 W. New Eng. L. Rev. 251 2012.**

*"Qualifying a nursing home resident for Medicaid is often criticized as resulting in substandard care. Where planning for Medicaid eligibility would result in a degraded quality of life or restricted options in placement, there is a valid ethical objection to planning that would impoverish the client." (p. 141)*

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*"Qualifying a nursing home resident for Medicaid is often criticized as resulting in substandard care. Where planning for Medicaid eligibility would result in a degraded quality of life or restricted options in placement, there is a valid ethical objection to planning that would impoverish the client."*

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*"Despite the legal mandate of equal access to quality care, there are situations where a particular long-term care candidate who must rely only on Medicaid will have a difficult time securing a preferred placement. However, with the assistance of an attorney those cases are rare." (p. 141)*

*"It is just, mete and proper for the Elder Law attorney to protect a client's estate against the cost of long-term care by shifting the cost to the Medicaid program, provided that the client's care will not be adversely affected." (p. 150)*

**John B. Payne, "Ethical and Public Policy Considerations Related to Medicaid Planning," *Pennsylvania Bar Association Quarterly*, October 2013, 84 Pa. B. Ass'n Q. 139 2013**

*"Attorneys advising clients well in advance of their need for long-term care often recommend funding irrevocable trusts to hold assets that eventually would be passed down to children or others, but would provide income for the grantors; as long as transfers to such trusts were made beyond the look back, aging clients could maintain their lifestyles while providing, ultimately, for their families." (p. 96)*

**William J. Brisk and Rebecca M. Flewelling, *Trusts Used in Medicaid Planning: The Doherty Challenge To Irrevocable Income Only Trusts and Its Aftermath*, 96 Mass. L. Rev. 95 2014-2015**

*"This Article posits that, unless the law is changed, divorce may well become standard Medicaid planning practice in many circumstances. This will be especially true for middle and upper middle class married couples because they have the most to gain from divorce in this context." (p. 44)*

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***"Thus, for example, if a person gives away one million dollars six years before applying for Medicaid, that gift will not be considered***

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*"Thus, for example, if a person gives away one million dollars six years before applying for Medicaid, that gift will not be considered in determining eligibility." (p. 54)*

*"Also, as discussed below, there are strategies for avoiding estate recovery. It is in states that are most aggressive in pursuing estate recovery that divorce may become the paramount strategy. (p. 57)*

"In our earlier work on this topic, my co-authors and I described many Medicaid planning strategies.' These include gifts beyond the five-year look-back period, disinheritance of the institutionalized person; the use of special needs trusts for the institutional spouse; annuitization of retirement accounts and savings (often for the benefit of the community spouse); spend down on the home or other exempt assets (called asset repositioning); caregiver agreements with family members; certain transfers of the home to a spouse, child or sibling; use of exempt assets (i.e., the home) to pay for the nursing home during a penalty period arising from gratuitous transfers; and, finally, divorce or marriage avoidance. Some of these are only designed to obtain Medicaid eligibility while preserving wealth during the recipient's lifetime. Others, most prominently gifts and annuities, are designed to avoid estate recovery as well. The liberal income rules and the restrictive resource rules make the purchase of an annuity for the community spouse with excess resources an important planning tool for middle class couples. Indeed, the annuity purchase option is the chief planning alternative to divorce in many cases." (p. 66)

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**John A. Miller, "Medicaid Spend Down, Estate Recovery and Divorce: Doctrine, Planning and Policy," 23 Elder L.J. 41 2015-2016**

"This Article suggests that the United States also maintains a secret welfare state. The secret welfare state exists because of lawyers' ubiquitous use of questionable practices in representing clients before benefit-granting government agencies, which enable thousands of individuals to collect public benefits who may not qualify for them." (p. 1847)

"The funding for SSDI and Medicaid is limited. In assisting relatively advantaged individuals to obtain SSDI, Medicaid, and other public benefits programs, lawyers may be jeopardizing these programs' sustainability and the welfare of those who depend upon them. (p. 1847)

"This Article concludes by calling for additional research on the role of lawyers in the American welfare state. In particular, it may be possible that the legal profession's central role in the distribution of public benefits is an obstacle to a fairer and more transparent social safety net." (p. 1849)

"Studies estimate that anywhere from 5 percent to 54 percent of current Medicaid beneficiaries have engaged in Medicaid planning. Even if the lower estimates are accurate, as Medicaid planning is generally used by more affluent individuals, it predominantly benefits the nonpoor." (p. 1855)

"Footnote 88: While fee information for Medicaid planning is not as readily available, according to the American Counsel [sic] on Aging, attorneys' fees can range from \$2500 for individuals with relatively simple estates to \$10,000 for individuals with significant assets. See Am. Council on Aging, Medicaid Planners: Pros & Cons of Public and Private Assistance, MEDICAID PLANNING ASSISTANCE, <http://www.medicaidplanningassistance.org/types-of-medicaidplanners#elderlaw-attorney> (last visited Mar. 27, 2016) [<http://perma.cc/EJ5L-2RWR>]. Nonlawyers who provide Medicaid planning services generally charge less." (p. 1857)

*"The American welfare state is sustaining relatively advantaged individuals and their lawyers as well as the truly needy. In the long-term, the United States would be well served by a more transparent public benefits regime."* (p. 1864)

**Milan Markovic, "Lawyers and the Secret Welfare State, Fordham Law Review, 84 Fordham L. Rev. 1845 2015-2016**

*"However, despite the potentially steep costs of long-term care, few elderly individuals actually purchase LTC. This decision is rational for most elderly people. First, LTCI insures a risk that may never occur, as the*

*majority of elderly Americans only need a year or less of long-term care. Second, Medicaid provides a publicly subsidized alternative to LTCI."* (p. 371)

*"Further discouraging the sale of LTCI is the reality that the elderly already own LTCI in the form of Medicaid."* (p. 377)

*"Eligibility for Medicaid differs from state to state, but Medicaid eligibility essentially requires that older persons impoverish themselves by spending substantially all of their assets and income on their cost of care."* (p. 378)

**Lawrence A. Frolik, "Private Long-Term Care Insurance: Not the Solution to the High Cost Of Long-Term Care for the Elderly," The Elder Law Journal, 23 Elder L.J. 371 2015-2016**

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*"The American welfare state is sustaining relatively advantaged individuals and their lawyers as well as the truly needy. In the long-term, the United States would be well served by a more transparent public benefits regime."*

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# Appendix II: Examples of Medicaid Planning Techniques; Home Equity Potential; Estate Recovery and Medicaid-Compliant Annuities

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## EXAMPLES OF MEDICAID PLANNING TECHNIQUES

LTC Bullet: Medicaid Loopholes by State, Thursday, July 24, 2003

LTC Bullet: Transfer Your Home to Get Medicaid?, Thursday, February 10, 2005

LTC Bullet: Rural Hijinks—Buy Cattle, Hide \$737,960, Get Medicaid, Thursday, December 15, 2005

LTC Bullet: Spousal Refusal: Who Wins? Who Loses?, Tuesday, April 18, 2006

LTC Bullet: Who Still Gets Medicaid LTC Without Spending Down?, Thursday, April 20, 2006

LTC Bullet: Medicaid Planning Update, Tuesday, June 3, 2008

LTC Bullet: Freddy Krueger and Medicaid Planning, Wednesday, October 28, 2009

LTC Bullet: Connecticut Expands Medicaid LTC Largesse, Wednesday, July 7, 2010

LTC Bullet: Medicaid Planning Up, LTCI Down, Tuesday, August 31, 2010

LTC Bullet: Spousal Refusal Robs Taxpayers and the Poor, Tuesday, December 14, 2010

LTC Bullet: Medicaid LTC Eligibility, Friday, February 17, 2012

LTC Bullet: Medicaid Planning for Long-Term Care, Friday, February 24, 2012

LTC Bullet: States Decry Medicaid LTC Loopholes, Friday, January 11, 2013

LTC Bullet #1,000: Medicaid Planning: Thousand Bullets Retrospective, Friday, May 24, 2013

LTC Bullet: Medicaid Planning—The Rest of the Story, Friday, February 7, 2014: Also applies to the annuity problem.

LTC Bullet: Medicaid Planning Writ Large, Friday, April 10, 2015 on provider taxes.

## EXAMPLES OF HOME EQUITY POTENTIAL

LTC Bullet: Reverse Mortgages Could Fund LTC Services and LTCI Premiums, Thursday, August 8, 2002

LTC Bullet: What Goes Around Comes Around, Thursday, August 14, 2003

LTC Bullet: Use Your Home to Stay . . . Off Medicaid!, Tuesday, February 8, 2005

LTC Bullet: Transfer Your Home to Get Medicaid?, Thursday, February 10, 2005

LTC Bullet: On Using Home Equity for LTC, Tuesday, March 21, 2006

LTC Bullet: NYT Editorial Favors HEC for LTC, Monday, April 24, 2006

LTC Bullet: Reversing Your Mortgage for Elder Care, Monday, February 4, 2008

LTC Bullet: The LTC Housing Sieve, Tuesday, July 22, 2008



LTC Bullet: Retirement Security, Reverse Mortgages, and LTC, Wednesday, March 24, 2010

LTC Bullet: LTCI + RMs = HCBS?, Tuesday, May 17, 2011

LTC Bullet: Home Equity, Long-Term Care, and Retirement Income Security, Friday, April 27, 2012

LTC Bullet: What the HECM is Happening with Reverse Mortgages?

## **ON ESTATE RECOVERY (MER)**

LTC Bullet: Medicaid Estate Recovery, Wednesday November 8, 2000

LTC Bullet: Medicaid Estate Planning Unmasked, Thursday, March 1, 2001; find Gerontologist article on which this Bullet is based in files for current project and here: <http://gerontologist.oxfordjournals.org/content/41/1/34.full.pdf>

LTC Bullet: Medicaid Estate Recoveries Clarified by HCFA, Wednesday March 7, 2001

LTC Bullet: Divorce, Medicaid Style, Friday November 9, 2001

LTC Bullet: "Nursing Home Care Virtually Free For Life", Tuesday, May 7, 2002

LTC Bullet: The Critical Role of Medicaid Estate Recoveries, Friday, September 30, 2005

LTC Bullet: Medicaid Estate Recover. . . up, Thursday, July 5, 2007: LTC Comment: Medicaid estate recovery could be a major source of non-tax revenue for the ailing LTC safety net for the poor, but AARP would tie the program in bureaucratic knots.

LTC Bullet: How Estate Recovery Protects the Poor AND the Affluent, Wednesday, July 1, 2009

LTC Bullet: How Medicaid LTC Sprung a Leak, Monday, September 14, 2009: On MER

LTC Bullet: Center Tackles Medicaid Estate Recoveries, Friday, April 26, 2013

LTC Bullet: The Role of Estate Recoveries in LTC Financing, Friday, June 7, 2013

LTC Bullet: Free LTC Loan With No Pay Back Required, Friday, August 22, 2014

LTC Bullet: Holding CMS's Feet to the Fire, Friday, February 6, 2015

LTC Bullet: Real ID vs. Estate Recoveries: A Decade of Divergence, Friday, February 26, 2016

## **ON MEDICAID-COMPLIANT ANNUITIES**

LTC Bullet: Annuity Blues, Friday, November 15, 2013

LTC Bullet: Medicaid Planning—The Rest of the Story, Friday, February 7, 2014: Also applies to the Medicaid planning problem.

LTC Bullet: How to End Medicaid Annuity Abuse, Friday, February 28, 2014: my study proposal.

LTC Bullet: Medically Underwritten Annuities for LTC, Friday, May 15, 2015; the good LTC annuities

LTC Bullet: Medicaid Annuity Abuse: A Case Study, Friday, June 5, 2015

LTC Bullet: LTC Annuities: To Get or Avoid Medicaid?, Friday, June 19, 2015

## Endnotes

1. Kaiser Family Foundation, StateHealthFacts.org, "Distribution of Medicaid Enrollees by Enrollment Group," cited May 8, 2017; <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/>.
2. Kaiser Family Foundation, StateHealthFacts.org, "Medicaid Spending by Enrollment Group," cited May 8, 2017; <http://kff.org/medicaid/state-indicator/medicaid-spending-by-enrollment-group/>.
3. Three reports published in February 2016 by Leading Age, the Bipartisan Policy Center and the ad hoc Long-Term Care Financing Collaborative offered variations of this plan. All three relied on research conducted by the Urban Institute (UI) and the actuarial firm Milliman as described in a November 2015 Health Affairs article titled "Financing Long-Term Services and Supports: Options Reflect Trade- Offs for Older Americans and Federal Spending," by Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson.

Leading Age. Leading Age Pathways Report: Perspectives on the Challenges of Financing Long-Term Services and Supports. Washington (DC): 2016 Feb. Available from: [http://annualmeeting.leadingage.org/uploadedFiles/Content/Members/Member\\_Services/Pathways/Pathways\\_Report\\_February\\_2016.pdf](http://annualmeeting.leadingage.org/uploadedFiles/Content/Members/Member_Services/Pathways/Pathways_Report_February_2016.pdf)

Bipartisan Policy Center. Initial Recommendations to Improve the Financing of Long-Term Care. Washington (DC): 2016 Feb. Available from: <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/12/BPC-Health-Long-Term-Care-Financing-Recommendations.pdf>

Long-Term Care Financing Collaborative. A Consensus Framework for Long-Term Care Financing Reform. Washington (DC): 2016 Feb. Available from: <http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTCFC-FINAL-REPORT-Feb-2016.pdf>

4. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson, "Financing Long-Term Services and Supports: Options Reflect Trade- Offs for Older Americans and Federal Spending," Health Affairs, 2015; <http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full.html>
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90. President Bill Clinton signed the Omnibus Budget Reconciliation Act of 1993 on August 10, 1993 making estate recovery mandatory, expanding the look back period to five years, eliminating the cap of asset transfer penalties, and prohibiting "pyramid divestment."
91. Find numerous examples in the Supplemental Bibliography.
92. Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989.
93. *Family Circle*, November 1, 1997
94. President Bill Clinton signed the Health Insurance Portability and Accountability Act ("Throw Granny in Jail Law") on August 21, 1996 making it a crime to transfer assets for less than fair market value for the purpose of qualifying for Medicaid.
95. President George W. Bush signed the Deficit Reduction Act on February 8, 2006 placing the first cap ever on Medicaid's home equity exemption, limiting the half-a-loaf loophole, amending the annuity rules, and unencumbering the Long-Term Care Partnership Program.

96. The “reverse half-a-loaf” strategy works as follows. The applicant gives away half his or her disqualifying assets thus creating an eligibility penalty equal to the amount of assets transferred for less than fair market value divided by the average cost of a nursing home. With the other half of the assets, the applicant creates an annuity in his or her own name and uses the proceeds of the annuity to pay for care during the duration of the penalty period. When the penalty period expires, the annuity runs out, and the applicant is eligible for Medicaid long-term care benefits having protected half the original assets from Medicaid’s spend down requirement. Loans, often to family members, can be used for the same purpose. The Medicaid applicant gives away half the assets, loans the remainder, pays for care during the penalty period with the proceeds of the loan and hence achieves Medicaid long-term care eligibility in half the time at half the cost.
97. U.S. Census Bureau, “2013 Housing Profile: United States,” American Housing Survey Factsheets, AHS/13-1, issued May 2015, Table 2. Financial Characteristics-Owner-Occupied Housing Units: 2013, p. 2
98. According to the Wall Street Journal, we are experiencing “the weakest pace of any expansion since at least 1949.” Eric Morath and Jeffrey Sparshott, “U.S. GDP Grew a Disappointing 1.2% in Second Quarter,” Wall Street Journal, July 29, 2016; <http://www.wsj.com/articles/u-s-economy-grew-at-a-disappointing-1-2-in-2nd-quarter-1469795649>.  
  
“Even seven years after the recession ended, the current stretch of economic gains has yielded less growth than much shorter business cycles.” Eric Morath, “Seven Years Later, Recovery Remains the Weakest of the Post-World War II Era,” Wall Street Journal, July 29, 2016; <http://blogs.wsj.com/economics/2016/07/29/seven-years-later-recovery-remains-the-weakest-of-the-post-world-war-ii-era/>
99. The “National Debt Clock” (<http://www.usdebtclock.org/>) places U.S. national debt at \$19.9 trillion and unfunded liabilities at \$106.0 trillion (cited May 2, 2017).
100. Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, “Report to Congress: 2016 Actuarial Report on the Financial Outlook for Medicaid,” Office of the Actuary, Centers for Medicare & Medicaid Services, United States Department of Health & Human Services, Sylvia Mathews Burwell, Secretary of Health and Human Services, 2016, p. 3; <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/mcicaidReport2013.pdf>. This identical quote was in the 2013 version of the “Actuarial Report” and was critiqued in S. Moses, “LTC Bullet: Does Medicaid Solvency Matter?,” Friday, October 31, 2014; <http://www.centerltc.com/bullets/archives2014/1062.htm>
101. One Medicaid planner promised and advertised nursing home care “virtually free for life.” Read about his program in S. Moses, “LTC Bullet: ‘Nursing Home Care Virtually Free For Life,’ May 7, 2002; <http://www.centerltc.com/bullets/archives2002/361.htm>
102. “Unreimbursed allowable Medicaid costs for 2015 are projected to exceed \$7.0 billion. Expressed as a shortfall in reimbursement per Medicaid patient day, the estimated average Medicaid shortfall for 2015 is projected to be \$22.46, 1 which is a 6.0 percent increase over the preceding year’s projected shortfall of \$21.20.” ELJAY, LLC & Hansen Hunter & Company, PC, “A Report on Shortfalls in Medicaid Funding for Nursing Center Care,” American Health Care Association, Washington, D.C., April 2016, p. 1; [https://www.ahcancal.org/research\\_data/funding/Documents/2015%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf](https://www.ahcancal.org/research_data/funding/Documents/2015%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf)
103. “Private insurance could be made more attractive to consumers by . . . taking steps to remove or lessen what is sometimes termed Medicaid crowd-out—the dampening effect that the availability of Medicaid’s LTC benefits has on sales of private LTC insurance policies.” The United States Congress, Congressional Budget Office, “Financing Long-Term Care for the Elderly,” April 2004, p. xiii; <https://www.cbo.gov/sites/default/files/108th-congress-2003-2004/reports/04-26-longtermcare.pdf>  
  
“Given the current structure of Medicaid, we estimate that even if (contrary to fact) comprehensive private insurance policies were available at actuarially fair prices, about two-thirds of the wealth distribution still would not want to buy this insurance. This suggests that fundamental Medicaid reform is necessary for the private insurance market to expand considerably.” (p. 1084) and “At actuarially fair prices, simple expected utility theory says that in our model all individuals would purchase insurance in the absence of Medicaid.” (p. 1095) Jeffrey R. Brown and Amy Finkelstein, “The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market,” American Economic Review, 98:3, 2008:1083–1102; <http://www.aeaweb.org/articles.php?doi=10.1257/aer.98.3.1083>
104. “We demonstrate theoretically that social insurance programs with means tests based on assets discourage saving my households with low expected lifetime income.” R. Glenn Hubbard, Jonathan Skinner, and Stephen P. Zeldes, “Precautionary Saving and Social Insurance,” The Journal of Political Economy, Vol. 103, No. 2, April 1995; <https://www0.gsb.columbia.edu/mygsb/faculty/research/pubfiles/476/precautionary.pdf>
105. “For many elderly people the risk of living long and requiring expensive medical care is a more important driver of old age saving than the desire to leave bequests. Social insurance programs such as Medicaid rationalize the low asset holdings of the poorest. These government programs, however, also benefit the rich because they insure them against their worst nightmares about their very old age: either not being able to afford the medical care that they need, or being left destitute by huge medical bills.” Mariacristina De Nardi, Eric French, and John Bailey Jones, “Why Do the Elderly Save? The Role of Medical Expenses,” NBER Working Paper No. 15149, July 2009, p. 2; <http://www.nber.org/papers/w15149.pdf>
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108. “In 2014, the official poverty rate was 14.8 percent. There were 46.7 million people in poverty. Neither the poverty rate nor the number of people in poverty were statistically different from the 2013 estimates.” Carmen DeNavas-Walt and Bernadette D. Proctor, “Income and Poverty in the United States: 2014,” United States Census Bureau, Report Number: P60-252, September 2015, p. 12; <http://www.census.gov/library/publications/2015/demo/p60-252.html>

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