Medicaid Estate Planning: Congress' Ersatz Solution for Long-Term Health Care

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The Medicaid program, established under Title XIX of the Social Security Act of 1965, is a jointly financed federal-state pro-


For the seminal review of the peculiar legislative history of the Medicaid program see ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA 19-48 (1974); see also Rand E. Rosenblatt, Dual Track Health Care—The Decline of the Medicaid Cure, 44 U. CIN. L. REV. 643 (1975) (reviewing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA (1974) and offering a modified political analysis). For an excellent synopsis of this history see Kenneth R. Wing, The Impact of Reagan-Era Politics on the Federal Medicaid Program, 33 CATH. U. L. REV. 1 (1983). As Professor Wing noted, “Medicaid has been frequently labeled as a ‘sleeper,’ hastily considered and not fully understood at the time it was passed.” Id. at 3 n.2. In 1965, because political eyes were focused on the much-heralded Medicare legislation, few people noticed the addition of the Medicaid program to the Medicare bill as part of a compromise to ensure passage. Id. Indeed, there were no committee meetings held and very little debate is recorded specifically discussing the provisions that created the Medicaid program. Id. Even more astonishing, no sponsor or author of record appears for the Medicaid provisions. Id. (citing S. Rep. No. 404, 89th Cong., 1st Sess. 289 (1965)). Yet, despite this inconspicuous origin, Medicaid has become one of the most prominent government programs. See STAFF OF HOUSE COMM. ON WAYS AND MEANS, 103d CONG., 2D SESS., 1994 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 795-97 (Comm. Print 1994) [hereinafter “1994 GREEN BOOK”] (projecting that Medicaid outlays will reach $96.2 billion in fiscal year 1995). For a comparable example of surprising growth see also Matthew 13:32.

The federal statute and regulations governing the Medicaid program are found at 42 U.S.C. § 1396a (1988 & Supp. V. 1993) and 42 C.F.R. §§ 430-36, 440-42, 447, 455-56 (1994). These federal rules and regulations provide to states some flexibility in the categories of individuals covered and the scope of services provided. See 42 U.S.C. § 1396a(a)(10) (1988 & Supp. V 1993) (directing the Secretary of the Department of Health and Human Services to promulgate regulations defining areas within which the states may regulate Medicaid policy); see also 42 C.F.R. §§ 435.110 to 435.340 (detailing the finer aspects of Medicaid policy within the domain of the states). Consistent with the federal guidelines, each state defines its own eligibility groups; determines the types and range of services it will provide; sets payment levels for those services; and establishes its own administrative and operating procedures. Id.; see also Dawson v. Myers, 622 F.2d 1304, 1307 (9th Cir. 1980) (noting that as long as it complies with the requirements imposed by the Secretary, a state has wide discretion in administering the Medicaid program), vacated on other grounds sub. nom, Beltran v. Myers, 451 U.S. 625, 625-26 (1981) (per curiam). These state rules typically are found within the state welfare code. See, e.g., N.Y. SOC. SERV. LAW § 363.
program designed to pay a portion of health care costs for needy persons of all ages. One of the most prominent features of Medicaid is that it pays


Under federal law, each state is required to designate a single state agency to administer the Medicaid program and determine finer aspects of coverage and eligibility issues. See 42 U.S.C. § 1396a(a)(5) (1988) (requiring each state to administer the program through a single state agency). In many states a single state agency sets policy and oversees the administration of the Medicaid program, while county or local government agencies handle day-to-day administration and application of the eligibility rules. Patricia Tobin, Medicaid Basics and a Review of Amendments to Medicaid Law Under OBRA '93, in PLANNING FOR AGING OR INCAPACITY 1994: LEGAL AND FINANCIAL ISSUES at 203, 207 (PLI Est. Plan. & Admin. Practice Course Handbook Series No. D4-231, 1994).


In addition to sharing funding responsibilities, both the state and federal governments develop appropriate rules and regulations for Medicaid eligibility. 42 C.F.R. §§ 430.0 to 430.104 (1994). Through statute, the federal government establishes “State plan” requirements that define the parameters within which the states may administer the program. 42 U.S.C. § 1396a(a) (1988 & Supp. V 1993). The Health Care Financing Administration (HCFA, pronounced “HICKFA” by cognoscenti), an agency within the Department of Health and Human Services, promulgates regulations interpreting these federal laws. These regulations generally are found at 42 C.F.R. §§ 430.0 to 456.725 (1994). In addition to, and sometimes in place of, promulgating regulations through the Federal Register, HCFA periodically issues transmittals which are reprinted in: Department of Health and Human Services, New Developments, MEDICARE & MEDICAID GUIDE, (CCH).

Several proposals in the current Congress portend to change Medicaid significantly into a program of block grants to the states. If any such proposal ultimately is enacted, and eligibility determinations fall under the aegis of the individual states, the issues discussed in this Comment simply will become issues for the states to address in their individual programs.

3. Although this Comment focuses on Medicaid planning by the elderly, long-term care financing is by no means an issue confined to that age group. Rather, chronically disabled persons of all ages receive long-term care Medicaid benefits. See UNITED STATES GEN. ACCOUNTING OFFICE, HOME CARE EXPERIENCES OF FAMILIES WITH CHRONICALLY
for the long-term health care of elderly people who cannot afford to pay for it themselves. In recent years, greater than sixty percent of all U.S. nursing home residents have relied on Medicaid to pay their entire bills. During 1992, state Medicaid programs spent in excess of $21 billion providing nursing home care to nearly 1.6 million qualified elderly Americans. This amount constituted more than one-fourth of all Medicaid

4. See infra text accompanying note 8 (stating that greater than one-fourth of all Medicaid expenditures go toward financing long-term health care for elderly persons).


6. 1994 Green Book, supra note 1, at 807. Between 1975 and 1992, Medicaid expenditures on long-term care increased at an average annual rate of 7.8%. Id. The table from which this data is derived uses the term “Skilled Nursing Facilities” (SNFs) for nursing homes in 1992. Id. Prior to 1992, the Medicaid program had bifurcated long-term care providers into separate categories: skilled nursing facilities and intermediate care facilities. Id. at n.1. Statistics on intermediate care facilities include facilities for the mentally retarded and other similar types of care facilities. See id. (indicating these components of expenditures on intermediate care facilities). Accordingly, it is appropriate to utilize the data on skilled nursing facilities for determining information about Medicaid expenditures on long-term health care for the elderly. See id. (utilizing this method of calculation to determine the average annual percent change in expenditures between 1975 and 1992).

7. Id. at 808. In 1975, Medicaid provided nursing home care to approximately 1.31 million persons. Id. By 1981, this number increased to approximately 1.39 million recipients. Id. This represented an increase of approximately 70,000 recipients over a six-year period, for an average of nearly 11,500 additional long-term care recipients per year. Id. In 1989, approximately 1.45 million persons received Medicaid-financed long-term care. Id. This again amounted to an increase of approximately 70,000 new recipients, but this time over a seven-year period. Id. Thus, the number of long-term care recipients grew at a rate of approximately 10,000 per year. Id. In 1990, the number of recipients grew to 1.46 million, consistent with the previous annual growth rate of 10,000 long-term care recipients. Id. In 1991, however, the number of long-term care recipients grew to 1.5 million, representing a one-year increase of 40,000 recipients. Id. This trend grew exponentially in 1992 when 1.58 million individuals received long-term care benefits under the Medicaid program. Id. This one-year growth of 80,000 long-term care recipients was greater than the increase during the entire seven-year period between 1981 and 1989. See id. (noting increases in the number of long-term care recipients).
expenditures.  

One reason for the widespread reliance on Medicaid is the shortage of financing alternatives for nursing home care. Merely one percent of all first-time nursing home residents are covered by private long-term health care insurance. Moreover, Medicare, the federal health insurance program for the elderly and disabled, provides only short-term nursing home benefits. Consequently, many members of the elderly middle-class...
deplete their entire life savings by paying for nursing home care until they become impoverished and can qualify for Medicaid. This process commonly is referred to as “spending down” to Medicaid eligibility.

As elderly citizens become aware of these inauspicious effects of long-term nursing home care, many seek professional advice to protect their assets in the event they will need long-term care. This practice, known

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Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage 7 (1991) (alteration in original) (quoting Alexander Bove, The Medicaid Planning Handbook: A Guide to Protecting the Assets of Massachusetts Families (1990)); see also Linda Koco, What Planners Look For in LTC Policies, Nat’l Underwriters, Sept. 11, 1989, at 9 (stating that the purchase of long term care insurance probably is not an economically sound decision for those with non-exempt assets of less than $150,000, thus implicitly suggesting that those with assets above this amount are the middle class individuals that are “pinched” under the current system).


14. An essential distinction must be made between this use of the term “spend down” and an alternative use of the term describing the practice of divesting one’s resources on expenditures other than health care costs for the purpose of appearing impoverished and qualifying for Medicaid. See infra text accompanying notes 15-18 (describing the practice of “spend-down” through planned divestiture of assets). The former is a clearly legitimate practice. See infra text accompanying notes 25-28 (describing this type of spend-down and coverage of the “medically needy”). The latter is a highly controversial practice analyzed in-depth in this Comment. See infra text accompanying notes 15-18 (defining the practice of Medicaid Estate Planning); see also discussion infra part I (describing the financial requirements for Medicaid eligibility and past congressional attempts to limit Medicaid planning); part II (reviewing the recent congressional efforts, enacted in OBRA ’93, attempting to reduce Medicaid planning); part III.A (analyzing these most recent efforts); part III.B (discussing the conditions that cause many people to utilize Medicaid planning as a means to finance long-term care needs while still preserving reasonable levels of assets); and part IV (advocating the creation of a system integrating long-term care insurance and Medicaid as a means to both limit Medicaid fraud and provide the elderly with a dignified option for financing long-term care).

15. Concededly, elderly individuals approach the twilight of life anxious about a variety of issues, including “physical and mental decline, functional impairment and dependence on others, diminishing opportunities to pursue enjoyable and fulfilling activities, and inevitable loss of family members and friends.” Marshall B. Kapp, Options for Long-Term Care Financing: A Look to the Future, 42 Hastings L.J. 719, 719 (1991). Nonetheless, “[i]n the contemporary United States, financial impoverishment, with its attendant restrictions on lifestyle and its dampening of an elder’s ability to leave a significant financial inheritance to her heirs, is perhaps the most feared result of the aging process.” Id.

16. See Esther B. Fein, Welfare for Middle-Class Elderly?, N.Y. Times, Sept. 25, 1994, at 39 (stating that “[f]or the last several years, thousands of middle-income elderly people . . . have transferred their assets . . . to qualify for Medicaid”). An exceptionally poignant example of the events that lead to Medicaid planning and the ease with which it is some-
as Medicaid Estate Planning, is a process by which individuals shelter or divest their assets to qualify for Medicaid without first depleting their life savings.\textsuperscript{17} In recent years, more elderly individuals have taken advantage of this long-term care financing option.\textsuperscript{18}

In February 1992, an elderly man came into the local Medicaid eligibility office to make a Medicaid application on behalf of his female cousin, who was in a nursing home. His cousin was the beneficiary of an irrevocable family trust with a principal value of approximately $1.5 million. Although she was the trust beneficiary, the income generated from the trust was placed in a joint bank account, which she and her cousin jointly held. The balance in the account was approximately $279,000. A few days before coming to the Medicaid eligibility office, the man had made a withdrawal of $184,000, leaving $95,000 in the account. Seeing this fund balance, the eligibility worker informed the man that his cousin was not eligible for Medicaid. At that point, the man wrote himself another check on the account for $93,000, leaving a balance of $2,000. "Is she eligible now?" he said. "Yes, she is," the eligibility worker replied.


17. See BURWELL, supra note 12, at 11. Medicaid planning is not an intergenerational issue. \textit{Id.} at 13. Very few elderly are "looking for free rides at taxpayers' expense." \textit{Id.} at 12. In fact, the elderly rarely initiate these planning activities themselves. \textit{Id.} Rather, they usually are prompted by an applicant's children, attempting to maximize their inheritances. \textit{Id.} at 12-13. Cf. Kapp, supra note 15, at 719 (suggesting that it is actually the elderly themselves who are motivated by the unselfish desire to leave a significant financial inheritance to heirs). Thus, while taxpayers suffer from the effects of Medicaid Estate Planning through greater Medicaid expenditures, the financial beneficiaries of Medicaid planning are not usually the elderly themselves, but their future heirs. BURWELL, supra note 12, at 13.

18. The only empirical evidence of Medicaid Estate Planning comes from a study by the General Accounting Office reviewing a random sample of 403 Medicaid applications for nursing home benefits in Massachusetts. U.S. GENERAL ACCOUNTING OFFICE, MEDI-CAID ESTATE PLANNING, GAO/HRD-93-29R. GAO found that more than half of these applicants had either converted available assets into exempt assets, or had transferred assets to another person within the 30-months prior to their application. \textit{Id.}

Aside from this limited study, most evidence is purely anecdotal. See Hearings, supra note 16, at 338 (statement of Brian O. Burwell, Division Manager for SysteMetrics/MEDSTAT Systems). Nonetheless, this anecdotal evidence overwhelmingly indicates that Medicaid Estate Planning is widespread. \textit{Id.} Attorneys who have established entire practices on their expertise in this field frequently provide the elderly with free seminars on Medicaid Estate Planning. \textit{Id.} Major newspapers, magazines, books, and even home videos have examined this practice extensively. \textit{Id.; see, e.g., Fein, supra note 16, at 39 (noting that "[t]he practice has created a swelling corps of lawyers who help people to pauperize themselves legally [in order to qualify for Medicaid]"); ALEXANDER BOVE, THE MEDICAID PLANNING HANDBOOK: A GUIDE TO PROTECTING THE ASSETS OF MASSACHUSETTS FAMILIES (1990); Melinda Beck et al., Planning to Be Poor, NEWSWEEK, Nov. 30, 1992, at 66; Laura Sanders, The King Lear strategy, FORBES, Dec. 9, 1991, at 164; Jane Bryant Quinn, Do Only the Suckers Pay?, NEWSWEEK, Dec. 18, 1989, at 52; see also Hearings, supra note 16, at 362 (statement of Sheldon Goldberg, representative of the Ameri-
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. This Comment first details the sundry eligibility requirements for Medicaid recipients, focusing on the financial eligibility requirements under the "Medically Needy" category. It then reviews previous congressional initiatives designed to prevent individuals from qualifying for Medicaid fraudulently through a process of planned divestiture. Next, this Comment details the significant changes to these eligibility rules implemented as part of the Omnibus Budget Reconciliation Act of 1993. This detailed review is followed by an analysis of the extent to which the current system can be expected to forestall this form of Medicaid fraud, noting specific provisions that are flawed. Finally, this Comment concludes that, while the recent amendments close many loopholes in the law and make it more difficult for individuals to utilize Medicaid Estate Planning, the legislation fails to address the underlying problem prompting Medicaid planning — the lack of long-term care financing options. Indeed, this Comment argues that, by precluding expansion of integrated public-private partnerships for financing long-term care, the recent legislation tragically frustrates development of this most viable option for supplanting Medicaid planning with responsible, dignified alternatives for financing long-term health care.

I. FEDERAL REQUIREMENTS FOR MEDICAID ELIGIBILITY

A. Classifications of Medicaid Eligibility

Individuals may qualify for Medicaid under three general classifications. First, federal law requires that states cover all persons who are...
"categorically needy." Within this definition are recipients of Aid to Families with Dependent Children (AFDC) and most aged, blind, and disabled persons receiving assistance through the Supplemental Security Income (SSI) program.

Second, the "optionally categorically needy" category permits states to extend Medicaid coverage to needy individuals from a number of other

an individual qualifies as "disabled," states must use definitions established by the federal government. §§ 435.540 to 435.541. Finally, under the residency rules, states are required to provide Medicaid to all qualified residents of the state. § 435.403(a). Generally, the state of residence is the state in which the individual is residing with the intention to remain either permanently or for an indefinite period. § 435.403(i). Accordingly, institutionalized individuals may not be denied Medicaid based on the fact that residency was not established before institutionalization. § 435.403(i)(2).


21. 42 U.S.C. § 1396a(a) (1988 & Supp. V 1993); see also 42 C.F.R. §§ 435.121 to 435.138 (1994) (providing a complete description of the other types of individuals that may be categorically eligible, depending on other programs offered by the state).

The Supplemental Security Income system, established in the Social Security Act Amendments of 1972 to replace former cash assistance programs for the aged, blind, and disabled, provided higher income and resource eligibility standards. Social Security Act of 1972, Pub. L. No. 92-603, § 1611, 86 Stat. 1329, 1466. Concerned that mandating Medicaid coverage for the additional individuals that would then be eligible for Medicaid would discourage states from participating in the Medicaid program, Congress elected to allow states to continue utilizing the SSI standards that were in effect on January 1, 1972 for the purposes of Medicaid eligibility. § 209(b), 86 Stat. at 1381 (codified at 42 U.S.C. § 1396a(f) (1988)); see Savage v. Toan, 795 F.2d 643, 644-46 (8th Cir. 1986) (discussing the background and purpose of § 209(b)). States electing this option are known as "209(b) states" for the section of the Act which provided this option. See, e.g., Krauskopf, supra note 9, § 11.12, at 379-80 (discussing mandatory coverage of persons who qualify for Medicaid); Barbara J. Collins, Medicaid, in ELDER LAW INSTITUTE 1994: REPRESENTING THE ELDERLY CLIENT OF MODEST MEANS, at 99, 104 (PLI Est. Plan. & Admin. Practice Course Handbook Series No. D-235, 1994); 1994 GREEN BOOK, supra note 1, at 785. There are 12 Section 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia. Id. For an exceptionally clear presentation of issues and rules arising in 209(b) states, see ADVISING THE ELDERLY CLIENT §§ 29:6, 29:12 (Louis E. Mezzullo et al. eds., 1993).

Finally, included within the categorically needy are those individuals who became ineligible for SSI because of the cost of living increases for eligibility enacted in the so-called "Pickle Amendment" in 1977. Unemployment Compensation Amendments of 1976, Pub. L. No. 94-566, § 503, 90 Stat. 2667, 2685-86 (1976); see Collins, supra at 104. For a more detailed review of this area of eligibility, see A Quick and Easy Method of Screening for Medicaid Eligibility Under the Pickle Amendment, 24 CLEARINGHOUSE REV. 1219 (1991).
specific groups.\textsuperscript{22} If a state chooses to extend benefits to one of these groups, the state must extend the benefits to all eligible individuals within that group.\textsuperscript{23} Furthermore, if a state provides this form of Medicaid coverage, it must provide the same benefits to these individuals as it grants to categorically needy persons.\textsuperscript{24}

Finally, states may choose to extend Medicaid to the "medically needy."\textsuperscript{25} These are individuals whose income, while too high to qualify them as categorically needy, is reduced by such large medical expenses that their available income effectively equals the income of categorically needy individuals.\textsuperscript{26} In other words, an individual who is not categorically needy may qualify for Medicaid if she\textsuperscript{27} can prove that, due to large medical expenditures, she has "spent-down" her resources to the level of the categorically needy.\textsuperscript{28}

Procedures for determining financial eligibility vary among these three categories. Tautologically, individuals who are categorically needy con-
clusively qualify for Medicaid by virtue of their eligibility for AFDC or SSI. Similarly, there are very straightforward and mechanical financial requirements for optionally categorically needy individuals. In contrast, applicants under the medically needy classification are not subjected to any previous means test. Therefore, complex financial eligibility rules exist for qualifying under the medically needy classification.

**B. Financial Requirements for the Medically Needy**

To determine the eligibility of an applicant under the medically needy category, states analyze the income and resources of the individual in light of federal standards. With respect to both income and resources, federal law provides that in determining Medicaid eligibility a state may count only those amounts that are available to an individual. Accord-

29. See 45 C.F.R. Part 233, Coverage and Conditions of Eligibility in Financial Assistance Programs (1994) (detailing the means test required for AFDC eligibility); 20 C.F.R. Part 416 Subparts K (Income) to L (Resources and Exclusions) (1994) (detailing the means test required for SSI eligibility); see also supra notes 19-21 and accompanying text (noting that categorically needy individuals are those receiving AFDC and SSI).

30. See supra notes 22-24 and accompanying text (describing the various circumstance under which an individual may qualify for Medicaid as "optionally categorically eligible").

31. Compare supra notes 20-21 and accompanying text (noting that categorically needy applicants have been previously subjected to a means test upon application for AFDC or SSI) and supra notes 22-24 and accompanying text (demonstrating that means testing for optionally categorically needy applicants is rather mechanical, as it directly relates to eligibility standards for SSI) with supra notes 26-28 and accompanying text (noting that applicants under the medically needy category are subjected to a specific means test as part of the Medicaid application procedure only).

32. See supra note 28 and accompanying text (discussing the means test for Medicaid eligibility for the medically needy).

33. Generally, all earned and unearned income, unless specifically exempted or disregarded, is counted to determine Medicaid eligibility. See 42 C.F.R. § 435.811(a) (1994) (requiring states to determine eligibility using a single income standard meeting the provisions). This income standard is indexed to account for different family sizes. § 435.811(b).

34. All liquid and non-liquid assets not specifically exempted may be included in the calculation of a Medicaid applicant's resources. See 42 C.F.R. § 435.840 (1994) (setting forth the requirements of the medically needy resource standard). The resource standards also account for differences in family size. § 435.840(d). As with most of the means tests within the Medicaid eligibility rules, this standard also may vary based on differences in the costs of shelter in urban and rural areas. See § 435.811(f).

35. For income, these standards are listed at 42 C.F.R. §§ 435.811 to 435.832 (1994). For resource levels, these standards can be found at 42 C.F.R. §§ 435.840 to 435.845 (1994). Under the most recent changes to the law, the terms "income" and "resources" are replaced by the term "assets." 42 U.S.C. § 1396p (1988 & Supp. V 1993); see infra note 88 and accompanying text (describing this change in the law).

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ingly, federal regulations require that “income and resources are considered available both when actually available and when the applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance.” 37

In defining the conditions under which an applicant maintains a legal interest in property, Congress has developed extensive rules governing the transfer, expenditure, divestiture, or conversion of income and resources to qualify for Medicaid. 38 Invariably, as states have implemented these provisions, the Medicaid Estate Planning industry has developed schemes to circumvent the law. 39 Consequently, Congress has continued to amend eligibility rules in an attempt to restrict the ability of elderly persons to shelter assets and qualify for Medicaid. 40

C. The Evolution of Efforts to Police Planned Divestiture

1. Early Legislation Regarding Asset Transfers

In the Omnibus Budget Reconciliation Act of 1980 (OBRA ‘80), 41 Congress made its first significant attempt to police asset transfers. 42

conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes nonexistent resources to recipients.” Heckler v. Turner, 470 U.S. 184, 200 (1985). For a more detailed historical review of the availability principle, see Elizabeth C. Kolshorn, The Effect of the Federal Availability Principle on State AFDC Asset-Transfer Rules, 89 COLUM. L. REV. 580, 583-85 (1989) (discussing federal eligibility standards and the availability principle).

37. 45 C.F.R. § 233.20(a)(3)(ii)(D) (1994); see Couch v. Director, Mo. State Div. of Family Serv., 795 S.W.2d 91, 94 (Mo. Ct. App. 1990) (upholding a decision that the res of a self-settled trust created to qualify an individual for Medicaid constitutes an “available” resource). But see Tidrow v. Director, Mo. State Div. of Family Serv., 688 S.W.2d 9, 12-14 (Mo. Ct. App. 1985) (holding that a discretionary trust, authorizing but not requiring the trustee to distribute sums to the beneficiary as the trustee deems necessary, is not considered available).

38. See infra notes 41-72 and accompanying text (discussing in detail the history of congressional efforts to police transfer, expenditure, divestiture, and conversion of assets to establish Medicaid eligibility).

39. See Brian Burwell, SysteMetrics, State Responses to Medicaid Estate Planning 1-2 (1993) (noting that, despite congressional efforts to restrict Medicaid planning, the practice has continued to grow, due in part to “a dramatic expansion in knowledge and techniques . . . on how to make the assets and income of prospective Medicaid applicants ‘unavailable’ during the Medicaid application process”); see also supra note 18 (noting the widespread presentation of free seminars instructing individuals how to shelter assets, newspaper and magazine articles discussing Medicaid planning, and even books and home videos instructing individuals how to shelter assets effectively).

40. See discussion infra part I.C (reviewing past congressional efforts in this regard).


42. § 5(b), 94 Stat. at 3568. The relevant provisions specifically denied SSI benefits to individuals who transferred assets for less than fair market value to qualify, and gave states
The specific provisions, known as the Boren-Long amendment, gave states the option of denying Medicaid to persons who transferred "countable" assets for less than fair market value within the previous twenty-four months. Depending on the uncompensated value transferred, states could render applicants ineligible for up to twenty-four months.

Subsequent to OBRA '80, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82), Congress expanded the scope of the transfer provisions by permitting states to consider transfers of any "excluded" assets within the previous twenty-four months, as well as transfers of "countable" assets during that time period, in determining Medicaid eligibility. In addition, Congress granted states the option, under certain conditions, to impose liens on the homes of institutionalized individuals as a means of eventually recovering Medicaid expenditures made on their behalf.

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43. See Lewis v. Hegstrom, 767 F.2d 1371, 1373 (9th Cir. 1985) (referring to these provisions as the Boren-Long amendment); see also Burwell, supra note 12, at 11 (same).

44. This term refers to assets which are "counted" in the financial eligibility determination, in contrast to those which are "excluded." See 20 C.F.R. § 416.1210 (1994) (listing items to be excluded in making a resource determination). For example, "excluded" assets include a reasonable amount of personal property, life insurance up to a certain face value, an auto below a certain value, burial space, a limited amount of funds set aside for burial, and one's home so long as it remains one's primary place of residence. Id.

45. The legislation specifically provided:

In determining the resources of an individual (and his eligible spouse, if any) there shall be included . . . any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.


46. § 5(b), 94 Stat. at 3568. The legislation did allow states to provide for periods of ineligibility to last for more than 24 months where the value of the resources disposed exceeded $12,000 and the period was directly related to the uncompensated value. Id.


48. See supra note 44 (distinguishing between "excluded" and "countable" assets).

49. See § 132(b), 96 Stat. at 372 (amending the rules on transfer of the applicant's home).
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behalf. TEFRA '82 expressly prohibited states from foreclosing these liens, however, if a spouse, dependent child, or other primary caregiver still lived in the home.

Congress further amended these asset transfer rules in the Medicare Catastrophic Coverage Act of 1988 (MECCA '88). First, MECCA '88 mandated that all states adopt the transfer restrictions made optional under prior measures. Second, it extended the "look-back" period for asset transfers from twenty-four to thirty months, so that any transfers made within the thirty months preceding application would be considered available resources for Medicaid eligibility determinations. Third, it exempted non-institutionalized Medicaid applicants from the transfer rules. Finally, MECCA '88 required that all countable assets held by the applicant and his or her spouse be totaled and divided equally between them for the purpose of determining the applicant's available as-

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50. § 1917(a)(2), 96 Stat. at 370-71 (amending Title XIX to provide for limited liens). The Committee report clearly articulated the purpose of this measure:

The amendment intends to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the spouse or dependent children, will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance the government's legitimate desire to recover its Medicaid costs against the individual's need to have the home available in the event discharge from the institution becomes feasible.

1982 Amendments: Committee Reports and Supplementary Material, DEPARTMENT OF HEALTH AND HUMAN SERVICES NEWS RELEASE, MEDICARE AND MEDICAID GUIDE, NEW DEVELOPMENTS (CCH) ¶ 24,559 (1982).

51. § 132(b), 96 Stat. at 370-71 (limiting the imposition of liens on one's home if certain persons legally reside therein).


54. § 303(b), 102 Stat. at 761.

55. Id. (applying the provision's rules to "institutionalized" individuals only). Apparently, this provision was based on the assumption that Medicaid benefits for the non-institutionalized elderly are less valuable than nursing home benefits and, therefore, there is much less incentive to transfer assets to qualify. But see 42 U.S.C. § 1396p(c)(1)(C)(ii) (Supp. V 1993) (allowing states to apply the transfer rules to "other long-term care services for which medical assistance is otherwise available under the State plan").
Accordingly, transfers between spouses were exempted, up to certain defined amounts, from the transfer rules.\textsuperscript{57} In the Omnibus Budget Reconciliation Act of 1989 (OBRA '89),\textsuperscript{58} Congress enacted a technical correction to MECCA '88 by restricting asset transfers by an applicant's spouse.\textsuperscript{59} This change closed a major loophole that had allowed an applicant to transfer assets to his or her spouse, who then transferred the assets to someone else without penalty.\textsuperscript{60}

\textsuperscript{56} § 303(a), 102 Stat. at 756; see 42 U.S.C. § 1396r-5(f) (1988). This provision is known as the "spousal impoverishment" rule and was designed to ensure that the applicant's spouse remains financially secure. See KRAUSKOPF, supra note 9, § 11.30, at 395 (noting that non-institutionalized spouses generally are allowed to retain resources sufficient for their own welfare without affecting the Medicaid eligibility of the applicant).

For an informative review of the highly complex rules regarding this area known as "spousal impoverishment," see id. §§ 11.30 - 11.34 (describing several special cases where these rules are implicated and the subtle differences in those cases); see also ADVISING THE ELDERLY CLIENT, supra note 21, §§ 29:79-29:93 (reviewing spousal impoverishment issues comprehensively); Jeanne Finberg & Roger Schwartz, Implementation of the Medicaid Provisions of the Medicare Catastrophic Coverage Act, 23 CLEARINGHOUSE REV. 370, 373-75 (1989) (providing a concise summary of the spousal impoverishment provisions enacted in MECCA '88).

\textsuperscript{57} Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 303(a), 102 Stat. 683, 759. The spousal impoverishment rules were designed to protect the spouse of nursing home residents from being forced into poverty to qualify the institutionalized spouse for Medicaid. Patrick H. Donahue, Medicaid Eligibility for Nursing Home Care: Understanding the New Eligibility Rules, J. KAN. B.A., May 1990, at 26, 26 n.2. Under these rules, the state measures the couple's resources upon institutionalization and bifurcates all non-exempt resources between the spouses. Generally, the institutionalized spouse then need only spend down his half of the resources to qualify for Medicaid. Collins, supra note 21, at 119. In some cases, however, the non-institutionalized or "community" spouse may retain more or less than one-half of the resources, depending on the "community spouse resource allowance" (CSRA). Id. The CSRA is equal to the greater of:

1. the lesser of one-half the total resources of the couple, or $60,000 as adjusted annually for inflation (the 1994 maximum was $72,660); and
2. $12,000 as adjusted annually for inflation, or more, if a greater minimum amount is set by the state (the 1994 minimum was $14,532).


\textsuperscript{59} § 6411(e), 103 Stat. at 2271.

\textsuperscript{60} MECCA '88 had implemented broad and complex provisions allowing an applicant to transfer, without impacting Medicaid eligibility, resources to his or her spouse sufficient for the spouse's maintenance in the community. See Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 754, 759; see also supra note 56 (discussing the spousal impoverishment provisions of MECCA '88). The original transfer rules enacted as part of OBRA '80 were applicable only to transfers made by the applicant. See supra text accompanying notes 43-46 (describing the Boren-Long Amendments). Thus, the MECCA '88 changes permitted the simple scheme by which an applicant "laundered" transfers through a spouse. See § 6411, 103 Stat. at 2271 (closing this loophole by adding to the law the language "or whose spouse," after the language "an institutionalized individual . . . who").
2. Early Legislation Regarding Trusts

While divesting or transferring assets is the simplest Medicaid planning strategy, for some individuals such a complete alienation of assets is intolerable. As a result, trusts have grown in popularity as a means of retaining control of assets while attempting to shelter them from Medicaid eligibility determinations. Responding to the use of trusts as a Medicaid planning tool, Congress enacted, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA ‘85), provisions designed to include trust assets in Medicaid eligibility determinations. Specifically, COBRA ‘85 provided that any non-testamentary trust or trust-like device established by an individual or her spouse under which the individual may be the beneficiary of the trust, and where the trustee has discretion regarding distribution, would be considered available to the Medicaid applicant regardless of the actual trust provisions. Congress termed this type of trust a “Medicaid Qualifying Trust” (MQT).

Certainly, COBRA ‘85 made it more challenging to utilize trusts for Medicaid planning by counting as available funds any amount of trust income or principle over which a trustee maintained the discretion to distribute. Rather than limit the practice of Medicaid Estate Planning,
however, the legislation merely stimulated more carefully constructed trust instruments to allow individuals to retain assets and still qualify for Medicaid.\(^6\) One common practice was to create a "convertible" or "trigger" trust.\(^7\) These instruments circumvented the MQT provisions by incorporating language that, upon the applicant's entry into a nursing home, immediately terminated both the trustee's discretion to make distributions to the applicant and the applicant's ability to revoke the trust.\(^8\) Another instrument that effectively evaded the MQT rules was the "donor" trust, under which an individual transfers assets to another person who then establishes a trust for the benefit of the donor.\(^9\) Because the applicant does not establish this type of trust herself, the trust does not fall within the precise language of the MQT provisions.\(^10\) Finally, "supplemental needs trusts," which could be used only for an individual's non-essential support, also were effective in circumventing the law.\(^11\)


\(^6\) In that COBRA '85 erected more technical rules for eligibility, its greatest legacy may be the subsequent proliferation of a multi-faceted Medicaid planning industry helping individuals shelter assets. See supra note 18 (noting the widespread coverage of Medicaid planning issues in newspapers and magazines, and citing the availability of books, home videos, and even computer software designed to assist an individual or lawyer in divesting resources to establish Medicaid eligibility). Certainly it is not coincidental that the National Academy of Elder Law Attorneys, which was formed in 1987, now has over 2,100 members. Hearings, supra note 16, at 335 (1993) (statement of Brian O. Burwell, Division Manager, SysteMetrics/MEDSTAT Systems). Moreover, because congressional Medicaid policy changes failed to control the development of Medicaid planning, some states began enacting further restrictions of their own to limit planning opportunities. See Burwell, supra note 39, at 17-19.

\(^7\) See Burwell, supra note 39, at 17 (discussing "trigger" trusts and New York legislation enacted to limit the use of such trusts by deeming them void as against public policy).

\(^8\) Id.

\(^9\) See id. at 18-19 (discussing donor trusts and Connecticut statutes designed to treat donor trusts "as if they had been established by the Medicaid applicant himself").

\(^10\) See § 9506(a), 100 Stat. at 210 (noting that the rules applied only to trusts established by an applicant or her spouse).

II. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

In the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress reacted to the sophisticated instruments used to circumvent the MQT rules by revising many of the financial Medicaid eligibility requirements for the medically needy category. In this most recent effort to combat Medicaid Planning, Congress amended many of the rules regarding resources and availability as applied to both the establishment of trusts (or similar legal devices) and the outright transfer of assets. This legislation: expanded the definition of assets; extended the look-back period for asset transfers; exempted certain asset transfers; comprehensively restructured the treatment of trusts; increased the potential penalty for attempted asset sheltering; and expanded the government's right of recovery from a recipient's estate. To this extent, OBRA '93 constitutes the most significant step to date toward eliminating opportunities for the middle class to avail themselves of Medicaid

76. See § 1396p(c).
77. § 1396p(c)(3) (including in assets property held in joint tenancy or similarly); see also discussion infra part II.A.1 (noting the replacement of the terms "income" and "resources" with the term "assets").
78. § 1396p(c)(1)(B)(i) (extending period to 36 months); see also discussion infra part II.A.2 (discussing extension of the look-back period).
79. § 1396p(c)(2)(B)(i)-(iv) (excluding transfers for benefit of spouse or children); see also discussion infra part II.A.2.a (detailing the exemptions provided in OBRA '93 for certain asset transfers).
80. § 1396p(d); see also discussion infra part II.A.3 (describing congressional repeal of the MQT provisions enacted in COBRA '85, and their replacement with language exempting certain trusts and prohibiting the use of certain other trusts previously used to circumvent the law).
81. § 1396p(c)(1)(A),(D),(E); see also discussion infra part II.B (describing how OBRA '93 both "uncaps" the penalty period of ineligibility for fraudulent transfers and ensures consistent state application of the penalty periods).
82. § 1396p(b); see discussion infra part II.C (noting that OBRA '93 mandates that all states implement programs to recover Medicaid expenditures from the estates of recipients).
through a process of planned impoverishment. Nonetheless, opportunities for Medicaid planning still remain.

A. The Means Test: Determining Whether an Applicant Is Medically Needy

1. Measuring Assets

Prior to OBRA '93, a state's first step in determining Medicaid eligibility for the medically needy involved measuring the applicant's income and resources separately. The law previously distinguished between income and resources, with only resources subjected to transfer rules. This structure often disregarded financial interests that could not be pigeon-holed as either income or resources. In OBRA '93, however, Congress significantly altered the way in which income and resources are defined.

The current law replaces these two terms with the sole term "assets," which includes all income and resources of the individual or her spouse. In addition to this technical change, Congress clearly broadened the analysis of financial factors by providing that the term assets encompasses all income or resources to which the individual or the spouse is entitled but does not receive because of an action by: (1) the individual or spouse; (2) a person, court, or administrative body with legal authority to act on behalf of the individual or spouse; or (3) any person, court, or administrative body acting at the direction or request of the individual or spouse.

83. See Jane Bryant Quinn, Paring Loopholes that Let the Well-Off into Medicaid, WASH. POST, Oct. 3, 1993, at H3 (quoting elder law attorney Armond Budish as saying that 10 loopholes in the eligibility rules were closed by OBRA '93); see also Schlesinger & Scheiner, supra note 74, at 74 (noting that "[t]he new provisions will have a dramatic impact").

84. But see discussion infra part III.A (noting several of the most significant ways in which OBRA '93 is deficient).


86. § 1396p(e)(1) (Supp. V 1993). In addition to including both income and resources, the term assets also includes "non-resources" such as the wedding ring discussed supra note 87. See ADVISING THE ELDERLY CLIENT, supra note 21, at 114 (describing such assets as "nonresources").


89. § 1396p(e)(1)(B).
spouse. This broad definition of assets makes it substantially more difficult for individuals to qualify for Medicaid by divesting themselves of their income through outright inter-vivos transfers and through the establishment of trusts or similar arrangements.

2. **Transfer of Assets for Less than Fair Market Value**

At first glance, it appears that the easiest way for an individual to meet the Medicaid asset requirements and qualify as medically needy would be to divest herself of assets through outright transfers to others. The mere transfer of assets to another, however, may not produce Medicaid eligibility. To the contrary, such a transfer could result in a period of Medicaid ineligibility. Under federal law, disposal of any asset for less than fair market value constitutes an uncompensated transfer to the extent that the value of the asset exceeds the amount realized. OBRA '93 expanded this rule in two very significant ways. First, the new law expanded the asset transfer rules to include the disposal of assets held jointly by the applicant and another. Second, OBRA '93 extended the

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91. § 1396p(e)(1)(C).

92. This practice of divestment alternatively is known as “asset spend-down” or “Medicaid Estate Planning.” See supra note 16 (commenting on the pervasiveness of planned divestiture and detailing an egregious example of fraudulent planning); see also supra note 14 and accompanying text (noting that “spend-down” is used also to describe the legitimate practice of spending so much of one’s assets on medical care that one qualifies for Medicaid under the medically needy category).

93. See discussion supra note 46 and accompanying text (noting the origin of administering a period of Medicaid ineligibility for such uncompensated transfers of assets); see also infra part II.B (describing in detail the recent modifications to the method of calculating the ineligibility period).


95. See infra notes 96-97 and accompanying text (detailing the significance of these changes).

96. § 1396p(c)(3) (Supp. V 1993). Prior to OBRA '93 the treatment of jointly held assets depended upon each state’s respective laws regarding the property rights of owners of jointly held assets. See Burwell, supra note 12, at 16 (noting the differences in state treatment of jointly held assets). In some states, all persons with joint title are equal owners. Id. Therefore, it was assumed that the applicant owned a proportionate share of the property, and any act by a non-applicant owner with his or her share was disregarded. Id. However, other states treated the full amount of any jointly held assets as belonging to the applicant for Medicaid purposes. Id. Such a rule was established in Florida, where the state supreme court created the “Streimer rule”, holding that the actions of one co-owner could not be considered in determining the Medicaid eligibility of another. Id. at 17. Several other states, however, responded to the situation by enacting their own regulations extending transfer rules to these types of transfers. See Burwell, supra note 39, at 11 (noting that, in Wisconsin, the Health Care Cost Containment Task Force recommended legislation treating withdrawals from joint bank accounts as prohibited transfers); see also id. at 10-11 (describing similar efforts in Michigan, Arizona, and Virginia). In OBRA '93, Congress incorporated this approach, and clarified that creation of any joint ownership rights would be considered a transfer of the asset. 42 U.S.C. § 1396p(c)(3) (Supp V. 1993).
“look-back” period for fraudulent asset transfers.\(^9\) Previously, any transfer of assets made within the thirty months prior to application for Medicaid would render an applicant ineligible.\(^8\) OBRA '93, however, extended this “look-back” period to thirty-six months.\(^9\)

The clearest effect of this change is that, where assets are held with another person in joint tenancy, tenancy in common, or other similar arrangements, any action by the applicant or another that reduces or eliminates the applicant's ownership or control of the asset is considered to be a transfer of the asset. \(\text{id.}\) Not as obvious, but equally important, under the new law some transactions that typically may not be thought of as asset transfers may fall within this provision. \(\text{See Krauskopf, supra note 9, § 11.41, at 407-08 (discussing this effect).}\) For example, the mere addition of another's name to a bank account may constitute an uncompensated transfer of assets to the extent that there is no reciprocal transfer of property of comparable value. \(\text{id. at 407.}\)

\(^9\) See infra notes 98-99 and accompanying text (explaining the extent of this change).

\(^8\) The rationale for the 30-month period was that, because most individuals cannot accurately anticipate when they will need long-term care and usually do not initiate Medicaid planning until placement in a nursing home is imminent, such a period would be ample to trace most transfers and would not be administratively burdensome or cost-prohibitive. \(\text{See Burwell, supra note 12, at 15; see also Leon Trotsky, Diary in Exile 106 (Elena Zarudnaya trans., 1958) (observing that “[o]ld age is the most unexpected of all the things that happen to a man”).}\) Indeed, although a recent Gallup Organization poll indicated that 76% of the population did not expect to need long-term care, in fact 43% of the individuals who celebrated a 65th birthday in 1990 will need long-term nursing home care during their lifetime. \(\text{Long Term Care Insurance: Debunking The Myths, BACKGROUND (American Health Care Association, Washington, DC) at 1 (on file with The Catholic University Law Review) (citing Public Attitudes on Long Term Care: “The EBRI Poll”, The Gallup Org., Inc. at 15 (1993)).}\) Hence, long-term care will be needed by nearly twice as many people as expect to need such care.

\(^9\) 42 U.S.C. § 1396p(c)(1)(B) (Supp. V. 1993). The practical utility of extending the look-back period was a point of disagreement at the Committee hearing regarding these provisions. \(\text{See generally Hearings, supra note 16, at 423 (including several different opinions on extending the look-back period).}\) A representative of the American Health Care Association urged Congress to extend the period to 60 months. \(\text{id. at 389 (statement of Steven Chies, representative of the American Health Care Association).}\) The President of the American Association of Homes for the Aging even suggested extending the period to 5 years. \(\text{id. at 370 (statement of Sheldon L. Goldberg, President, American Association of Homes for the Aging).}\) But, a representative of the National Senior Citizens Law Center strongly opposed any extension, arguing that extending the look-back period would be administratively infeasible and would place a tremendous burden on applicants in terms of record-keeping and recollection. \(\text{id. at 357 (statement of Vincent Russo, President, National Academy of Elder Law Attorneys).}\) Moreover, Mr. Russo noted that requiring seniors, a significant number of whom are debilitated by Parkinsons, Alzheimers, or Senile Dementia, to provide detailed records for financial transactions occurring 3, 4, or 5 years ago “is unrealistic and unreasonable, a trap guaranteeing Medicaid denial. . . . for those in need.” \(\text{id. at 358.}\)
a. Exceptions to the Transfer Rules

Despite the expanded definition of available assets and the extended look-back period, the current law still provides that certain transfers will not affect Medicaid eligibility.\(^{100}\) For example, transfers not made for the purpose of qualifying for Medicaid will not result in ineligibility.\(^{101}\) Specifically, an individual must affirmatively prove that she either intended to dispose of the resources for fair market value or other valuable consideration,\(^{102}\) or that she transferred the assets for a purpose other than to qualify for Medicaid.\(^{103}\) In addition, the current law allows an individual to correct an uncompensated transfer by retrieving all of the assets transferred.\(^{104}\)

100. § 1396p(c)(2) (1988 & Supp. V 1993); see infra notes 101-15 and accompanying text (discussing these exempt transfers).

101. § 1396p(c)(2)(C) (Supp. V 1993). Under guidelines released by the Health Care Financing Administration, asset transfers for less than fair market value made within the look-back period are rebuttably presumed to have been made for the purpose of establishing Medicaid eligibility. HCFA Pub. No. 45-3 (State Medicaid Manual) § 3250.3.

102. § 1396p(c)(2)(C)(i). Under this exception, a transfer will not be considered in determining Medicaid eligibility if the applicant shows that the individual intended to dispose of the assets either at fair market value or for other valuable consideration. Id. This exception prevents the imposition of undue penalties on individuals entering into arm's-length transactions in which they meant to receive full value for the asset transferred.

103. § 1396p(c)(2)(C)(ii). For example, where an individual in good health makes estate planning transfers solely for the beneficial tax consequences and subsequently suffers from ill-health and applies for Medicaid, this exemption may apply. See Advising the Elderly Client, supra note 21, at 114 (posing this hypothetical as a case where the exemption may be appropriate).

104. § 1396p(c)(2)(C)(iii). Some commentators have noted that this provision is problematic because it does not address the partial return of transferred assets. See Jonathan M. Forster, OBRA 1993 and its Impact on Medicaid Planning, in Advising the Elderly Client, OBRA '93 Alert 3, 3 (Louis A. Mezzullo et al. eds., 1993) (stating that "[t]his new rule may create some harsh results when transferred assets cannot be fully retrieved"); see also Collins, supra note 21, at 128 (noting many questions that remain unanswered about correcting transfers). It may be that Congress recognized that rules regarding partial returns would be difficult to employ, as the commentators suggest and, therefore, chose not to allow for partial corrections. This choice is evidenced by the affirmative statement that "all" assets must returned. § 1396p(c)(2)(B)(iii); see Harry S. Margolis, Now It's the Law: Revised Medicaid Eligibility Rules Take Effect, The ElderLaw Rep., Aug. 1993, at 1, 2 (noting that corrective transfers are allowed only if all transferred assets are returned to the transferor).

Notwithstanding any efforts to resolve these questions, it seems that corrective transfers will remain rare because upon return to the applicant the transferred asset becomes an available asset and will disqualify the recipient from Medicaid. See discussion supra part II.A.1 (regarding measurement of assets in determining Medicaid eligibility); see also Margolis, supra, at 2 (noting that Massachusetts previously allowed corrective transfers and then reversed its policy).
The rules regarding transfer of assets also continue to provide specific exceptions for the transfer of a home.105 The transfer of an individual's home will not constitute an uncompensated transfer so long as the transfer is made to: (1) a spouse;106 (2) a child of the applicant who is blind, disabled, or under twenty-one years of age;107 (3) a child who has resided there for at least two years immediately prior to the applicant's institutionalization and who provided care for the applicant;108 or (4) a sibling with an equity interest who had resided therein for at least one year prior to the applicant's institutionalization.109

The current law also continues to provide exceptions for certain asset transfers involving an applicant's spouse.110 Any transfers to or from the applicant's spouse still are not considered uncompensated transfers, provided they are for the sole benefit of the spouse.111 Likewise, the current law also continues to exempt transfers to an applicant's blind or disabled children.112 In addition, OBRA '93 exempts transfers to trusts established solely for the benefit of one's blind or disabled children,113 or to trusts established solely for the benefit of disabled individuals over sixty-

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107. § 1396p(c)(2)(A)(ii).
108. § 1396p(c)(2)(A)(iv).
110. See supra note 60 (noting the broad provisions enacted in MECCA '88, allowing an applicant to transfer resources and income to his or her spouse without affecting the applicant's Medicaid eligibility).
111. § 1396p(c)(2)(B)(i)-(ii).
112. § 1396p(c)(2)(B)(iii).
113. Id. Some critics have argued that in limiting this exception to only trusts established "solely for the benefit of" these specified individuals, Congress has created confusion about the requirements of such trusts. See Peter J. Strauss, Medicaid Revisions in 1993 Budget Act, N.Y.L.J., Sept. 30, 1993, at 7 (questioning whether the terms of the trust must establish the applicant's estate as the sole remainderman upon the applicant's death); see also Schlesinger & Scheiner, supra note 74, at 76 (noting that it is unclear whether "a trust for the sole benefit of the spouse for life, with the remainder to someone else, [would] be a trust for the sole benefit of the spouse").

In light of the broad estate recovery provisions also included in OBRA '93, it seems that Congress would have intended this provision to apply only to trusts where any assets remaining at the beneficiary's death were to be paid to the estate. See discussion infra part II.C (detailing the broad estate recovery provisions enacted in OBRA '93). However, the record is silent. See generally Hearings, supra note 16; H.R. REP. No. 103-111, 103d Cong., 1st Sess. (1993), reprinted in 1993 U.S.C.C.A.N. 378, 512-515, 533-36; H.R. CONF. REP. No. 103-213, 103d Cong., 1st Sess. 399 (1993), reprinted in 1993 U.S.C.C.A.N. 1088, 1523-24 (all failing to refer to this issue in any way).
five years of age.\textsuperscript{114} Finally, Congress has provided that states may exempt uncompensated transfers if the denial of Medicaid benefits would cause an "undue hardship" upon an individual.\textsuperscript{115}

3. \textit{Treatment of Trusts Under the Rules}

a. \textit{General Changes}

As with outright transfers, Congress has made it increasingly difficult to utilize trust instruments to qualify for Medicaid. COBRA '85 marked the first significant effort to regulate trusts.\textsuperscript{116} Under COBRA '85, the maximum amount distributable to the applicant was considered an available asset regardless of whether the trustee ever exercised the discretionary power to make such a distribution.\textsuperscript{117} OBRA '93 repealed these provisions regarding Medicaid qualifying trusts and instead utilizes a broader set of rules to more effectively curtail the use of trusts or similar mechanisms to qualify for Medicaid.\textsuperscript{118}

Under the current law, Medicaid trust rules apply to any inter vivos trust established by either (1) the applicant;\textsuperscript{119} (2) the applicant's spouse;\textsuperscript{120} (3) any person, including a court or administrative body, with

\begin{itemize}
  \item \textsuperscript{114} 42 U.S.C. § 1396p(c)(2)(B)(iv) (1988 & Supp. V 1993); \textit{see also supra} note 113 (discussing criticism that Congress has created confusion by using the language "solely for the benefit of ")
  \item \textsuperscript{115} § 1396p(c)(2)(D). Standards for determining when the denial of Medicaid would result in an undue hardship are to be promulgated by the Secretary of the United States Department of Health and Human Services (HHS). \textit{Id.} Although Medicaid law previously allowed for a waiver in the cases of undue hardship, the waiver was seldom used. Roger A. McEowen, \textit{Estate Planning for Farm and Ranch Families Facing Long-Term Health Care}, 73 \textit{Neb. L. Rev.} 104, 117 (1994). By requiring the Secretary of HHS to establish criteria for granting undue hardship waivers, it appears that Congress wants waivers to be granted more liberally. \textit{Id.}
  \item \textsuperscript{116} The Consolidated Omnibus Budget Reconciliation Act deemed all "Medicaid Qualifying Trusts" available resources and provided, in relevant part:
    \begin{quote}
      \textit{[A]} "medicaid qualifying trust" is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.
    \end{quote}
  \item \textsuperscript{119} § 1396p(d)(2)(A)(i) (Supp. V 1993).
  \item \textsuperscript{120} § 1396p(d)(2)(A)(ii).
\end{itemize}
the legal authority to act on behalf of the applicant or spouse;\textsuperscript{121} or (4) a person, including a court or administrative body, acting at the direction or request of the applicant or spouse.\textsuperscript{122} Moreover, in contrast to the previous rules, this provision applies irrespective of the purpose behind the trust,\textsuperscript{123} the trustee's discretion over principal and income,\textsuperscript{124} any restrictions over trust distributions,\textsuperscript{125} and any restrictions on the use of such distributions.\textsuperscript{126} Of course, these rules do not invalidate the stated purpose of the trust, any limits placed on trustee discretion, or any distribution restrictions incorporated into the trust instrument. Rather, they merely provide that regardless of any such provisions, a trust formed from an applicant's assets will be counted as an available asset for the purpose of determining Medicaid eligibility.\textsuperscript{127}

\textit{b. Revocable Trusts Under the Current Law}

Unlike COBRA '85, the current law distinguishes between revocable and irrevocable trusts.\textsuperscript{128} The first notable rule with respect to revocable trusts provides that the corpus of a revocable trust will be considered an available resource.\textsuperscript{129} In addition, the current law states that any "payments from the trust to or for the benefit of the individual shall be considered income of the individual."\textsuperscript{130} As income, these payments apparently would not be subject to the thirty-six-month look-back period for outright transfers of assets, but instead would be added to items such as SSI

\begin{itemize}
  \item \textsuperscript{121} § 1396p(d)(2)(A)(iii). This provision addresses the broad use of supplemental needs trusts to establish Medicaid eligibility under the former law. \textit{See supra} text accompanying note 72 (describing this use of "SNT's"). However, OBRA '93 did not prohibit the use of SNT's for all purposes. \textit{See infra} notes 153-58 (describing how OBRA '93 implicitly sanctions the use of SNT's for certain purposes).
  \item \textsuperscript{122} § 1396p(d)(2)(A)(iv). This provision specifically addresses the use of donor trusts under the former law. \textit{See supra} text accompanying note 70 (describing the use of donor trusts).
  \item \textsuperscript{123} § 1396p(d)(2)(C)(i).
  \item \textsuperscript{124} § 1396p(d)(2)(C)(ii). This provision is designed specifically to limit the use of "trigger" or "convertible" trusts to qualify for Medicaid. \textit{See supra} notes 68-69 and accompanying text (discussing the use of this type of instrument to qualify for Medicaid under the previous law).
  \item \textsuperscript{125} § 1396p(d)(2)(C)(iii).
  \item \textsuperscript{126} § 1396p(d)(2)(C)(iv).
  \item \textsuperscript{127} \textsc{John J. Regan, Tax, Estate & Financial Planning for the Elderly} § 10.13[1], at 10-83 (1994).
  \item \textsuperscript{128} \textit{See} 42 U.S.C. § 1396p(d)(3)(A) & (B) (Supp. V 1993) (setting out separate rules for revocable and irrevocable trusts).
  \item \textsuperscript{129} § 1396p(d)(3)(A)(i). This is an equitable way to regard assets in a revocable trust considering that, by definition, the assets are available to the grantor by simply revoking the trust. \textit{See supra} notes 36, 44-45 and accompanying text (describing the "availability principle").
  \item \textsuperscript{130} § 1396p(d)(3)(A)(ii).
and private pension payments in determining an individual's eligibility for Medicaid.\footnote{131}

The most significant change in the treatment of revocable trusts relates to distributions made other than "to or for the benefit of the individual."\footnote{132} These payments are similar in effect to outright uncompensated transfers of assets, in that they are made to a third-party presumably to qualify the applicant for Medicaid.\footnote{133} Whereas the look-back period for outright transfers is thirty-six months, the look-back period for similar transfers from a trust is set at sixty months.\footnote{134}

Nonetheless, an applicant easily can circumvent the sixty month look-back period.\footnote{135} Instead of providing for a payment from the trust directly to a third party, the applicant simply must provide for the distribution of trust amounts to herself first and then transfer that amount to the third party.\footnote{136} This distribution is treated as an outright asset transfer, thereby triggering the thirty-six month look-back period.\footnote{137} Hence, the transfer would not affect Medicaid eligibility if the individual were to apply more than thirty-six months later.\footnote{138}

\begin{footnotes}
\item 131. 45 C.F.R. §§ 435.800 to 435.845 (1994). In light of the fact that these transfers of trust funds are made to the applicant and, therefore, could not have been made in order to qualify for Medicaid, it would be improper to treat them like other asset transfers. See supra text accompanying notes 92-99 (noting that the law focuses on "disposal" of assets). Rather, it is more appropriate to characterize these payments as income because they are liquid assets received by the applicant with which he or she can pay for goods or services. 42 C.F.R. §§ 435.800 to 435.845 (1994).
\item 133. Both types of transfers essentially are uncompensated transfers of assets belonging to the applicant made to third parties. § 1396p(d)(3)(A).
\item 134. § 1396p(c)(1)(B)(i).
\item 135. Cf. Forster, supra note 104, at 4 (noting that individuals who established revocable trusts in order to avoid probate now must be aware that their actions may impact Medicaid eligibility).
\item 136. Id.
\item 137. See id.
\item 138. Depending on the size of the payment and the average cost of nursing home care in the state, little or no benefit would be derived from this arrangement if the individual actually applied for Medicaid within the 36-month period immediately following the transfer because of the penalty provisions of the law. See supra text accompanying notes 97-99 (noting the extension of the look-back period from 30 to 36 months). Rather, the arrangement will work only if the applicant waits and does not apply until the look-back period no longer includes this transfer. Supra notes 98-99. Nonetheless, this situation illustrates the severe limitation of the policing approach incorporated in current rules. Even under the improved rules, no matter how wealthy an individual may be, she may be able to qualify for total Medicaid financing of long-term care needs by merely waiting to apply for Medicaid until 36 months after the asset transfer. See infra notes 221-26 and accompanying text (providing an example of this "bottom-line" effect of OBRA '93).
\end{footnotes}
c. Irrevocable Trusts Under the Current Law

In the case of irrevocable trusts, as with revocable trusts, the new rules provide that any portion of the corpus or income that could be distributed to or for the benefit of the individual is considered an available asset.139 Again, the test is not whether any distributions actually were made, but whether it is at all possible for distributions to be made.140 Furthermore, the current law treats as income any previous payments from an irrevocable trust to or for the benefit of the applicant.141

With respect to payments for any other purpose from the corpus or income of an irrevocable trust, the rule also is similar to that for revocable trusts.142 These payments are treated as transfers of assets.143 According to the strict language of the statute, the look-back period for these transfers is only thirty-six months,144 whereas similar transfers from revocable trusts are subject to a sixty-month look-back period.145

Finally, under the OBRA '93 amendments, all amounts paid into or earned by an irrevocable trust specifically barring distribution to the applicant are treated as transferred assets.146 In addition, Congress has provided that the amount transferred shall be calculated irrespective of any amounts disbursed from the trust since its creation.147 Moreover, unlike any other similar type of outright transfers by the applicant, these transfers are subject to a sixty-month look-back period.148

This inconsistent treatment of asset transfers from revocable and irrevocable trusts appears to be the product of minor drafting errors.149 In fact, it appears that Congress intended to apply the same rules—a sixty month look-back period to distributions from a trust and a thirty-six

140. § 1396p(d)(3)(B)(i).
141. § 1396p(d)(3)(B)(i)(I). The Supreme Court of Oklahoma recently ruled that this provision even requires that funds transferred to the applicant from a trust, which itself would be exempt from consideration in determining Medicaid eligibility, be treated as income. Trust Co. v. State ex rel. Dep't of Human Serv., 890 P.2d 1342 (Okla. 1995).
143. § 1396p(d)(3)(B)(i)(II).
144. § 1396p(c)(1)(B)(i).
145. Id.
146. § 1396p(d)(3)(B)(ii).
147. Id.
148. § 1396p(c)(1)(B)(i).
149. See Strauss, supra note 113, at 31 (stating that this inconsistent treatment must be the result of drafting errors); see also Forster, supra note 104, at 4 (stating that only a few points are clear from the rules).
month look-back period to amounts earned by or transferred to a trust—regardless of whether the trust is revocable or irrevocable.  

*d. Exempt Trusts*

Although the current law generally is designed to combat the use of Medicaid trusts, the rules specifically exempt certain trusts from consideration in determining Medicaid eligibility. These trusts will not be considered even when they distribute or receive assets that would otherwise be considered available.

The first exemption applies to trusts established "by a parent, grandparent, legal guardian of the individual, or a court" for the benefit of disabled persons under sixty-five years of age. This exemption implicitly sanctions the pre-existing practice of establishing a supplemental needs trust with assets received through judgments or settlements for the benefit of a disabled individual. Such trusts are designed to supple-

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150. See discussion supra part III.A.1 (illustrating that if these errors are corrected the statute is much more sensible and consistent in its treatment of irrevocable and revocable trusts).


152. Id. The availability principle is discussed supra note 36.

153. § 1396p(d)(4)(A); see In re Moretti, 606 N.Y.S.2d 543 (N.Y. Sup. Ct. 1993) (exempting a judgment-financed supplemental needs trust established for an incapacitated fifteen year-old by the court with his parents as conservators) (superseded by statute as stated in Link v. Smithtown, 616 N.Y.S.2d 171 (N.Y. Sup. Ct. 1994)). In Moretti, the court found that under § 1396p(d)(4)(A) "both the corpus and the income of the trust may be used during the beneficiary's lifetime with full trustee discretion for the benefit of the disabled individual." Id. at 546. Accordingly, the exemption applied. Id. at 546.

In Frerks v. Shalala, however, the United States District Court for the Eastern District of New York recently upheld a determination by HHS that a similar court-created trust was not an exempt asset where the discretion to distribute funds was held by the court. 848 F. Supp. 340, 354 (E.D.N.Y. 1994). In Frerks, the District Court found that although funds could not be withdrawn from the trust without a court order, the court's history in granting requests for other disbursements from this trust made reasonable the determination by HHS that the funds were available. Id. at 348-49.

154. § 1396p(d)(4)(A) (Supp. V 1993). Supplemental needs trusts previously were considered exempt in a number of states. See, e.g., In Re Escher, 438 N.Y.S.2d 293 (N.Y. 1981). However, in some states, such as New York, supplemental needs trusts were exempt only if they were created by a third party with no legal obligation to support the beneficiary. See N.Y. EST. POWERS & TRUSTS § 7-1.12(a)(5)(iv) (McKinney Supp. 1995), N.Y. MENT. HYG. § 43.03(d) (McKinney Supp. 1995), and N.Y. SOC. SERV. § 104(3) (McKinney Supp. 1995); State v. Coyle, 575 N.Y.S.2d 975, 976 (N.Y. App. Div.) (refusing to exempt self-settled trusts), appeal denied, 580 N.Y.S.2d 188 (N.Y. 1991); In re Garbow, 591 N.Y.S. 2d 754 (N.Y. Sur. Ct. 1992) (ruling that a supplemental needs trust established by the applicant's parents was "unavailable" because the applicant's parents had no obligation to support him). Thus, in some states the effect of OBRA '93 might be to expand this exemption slightly by requiring states to exempt even self-settled supplemental needs trusts so long as the settlor is over 65 years of age and the trust remainder passes to the state upon the
While OBRA '93 does not use the term supplemental needs trust, it endorses the use of such instruments for the benefit of disabled individuals under the age of sixty-five. While the assets for these trusts often are derived from litigation, this exemption is not restricted to assets acquired in that manner. The exemption is limited, however, only to trusts specifically providing that, upon the death of the applicant, the remainder of the trust will be used to reimburse the state for Medicaid expenditures made on her behalf.

The second type of exempt trusts are those that meet certain criteria and are established for disabled individuals, regardless of their age. To qualify, these trusts must be held and managed by a non-profit organization. The organization must maintain a separate trust account for each individual, but may pool the assets for investment and management purposes. In contrast to exempted trusts for disabled persons under sixty-five years of age, these trusts may be established not only by a parent, grandparent, legal guardian, or a court, but also by the applicant herself. Finally, the trust must provide that, upon the death of the individual, the funds either will remain in the pooled trust (apparently for the benefit of other participants) or will be used to reimburse the state to the extent of the Medicaid benefits provided.

The third type of exempt trusts are those with income payable to the individual. This exemption codifies the case of Miller v. Ibarra,
which allowed individuals in "income cap" states\textsuperscript{166} to qualify for Medicaid despite the fact that their income exceeded the cap.\textsuperscript{167} To qualify under this exemption, a trust must be composed solely of pension, SSI, and other income of the individual,\textsuperscript{168} and must entitle the state, upon the beneficiary's death, to the remainder of the trust to the extent of its Medicaid expenditures on her behalf.\textsuperscript{169}

Finally, an exemption from the trust rules is available to those who can establish that the application of the rules would result in an "undue hardship."\textsuperscript{170}

\textbf{B. Uncapping the Ineligibility Period for Fraudulent Transfers}

The period of ineligibility refers to the period for which an individual is ineligible for Medicaid benefits because of an improper transfer of assets applicant but are instead paid to another individual; and to the extent that corpus cannot be distributed to the applicant it is considered unavailable. \textit{See id.} at 1-3 (citing letter from Sally K. Richardson, Director, Medicaid Bureau of HCFA, authorizing the use of such trusts).

\textsuperscript{165} See Miller, 746 F. Supp. 19 (D. Colo. 1990).

\textsuperscript{166} States that provide Medicaid for individuals with income up to 300\% of the SSI federal benefit level in place of offering a "medically needy" option are termed "income cap" states. 42 U.S.C. § 1396b(f)(4)(C) (1988 & Supp. V 1993); 42 C.F.R. § 435.1005 (1994). The major difference in this program is that individuals may qualify for Medicaid by proving that they have "spent-down" their assets on medical costs. \textit{Cf. supra note 28} and accompanying text (detailing the spend-down provision in the traditional medically needy classification).

\textsuperscript{167} \textit{See Miller,} 746 F. Supp. at 34. In \textit{Miller,} Medicaid eligibility was established for four mentally incompetent nursing home patients by creating trusts permitting the trustees to distribute only an amount of income under the eligibility cap. \textit{Id.} at 21-23. In each case, the trustee's discretion was limited by a clause similar to that in the trust established for plaintiff Lottie Bernice Ham, which provided that

\begin{quote}
"[n]o event shall such amounts paid or applied each month for Beneficiary's basic living needs, from her income, the corpus of this trust, or any other source combined therewith, exceed the sum computed by subtracting twenty dollars ($20.00) from the monthly income eligibility standard currently in use by the Medicaid program . . . ."
\end{quote}

\textit{Id.} at 21; \textit{see also id.} at 21-22 (noting that each of the four plaintiffs had a trust established on her behalf with language identical to the other trusts). Accordingly, the amount of income "actually available" to the applicant was below the income cap. \textit{See supra} notes 36-37 and accompanying text (discussing the "availability principle"). \textit{Contra} Barham v. Rubin, 816 P.2d 965, 966-67 (Haw. 1991) (ruling that a judgment-financed, court-approved trust was an "available resource" which the applicant was required to spend-down to become eligible for Medicaid).


\textsuperscript{169} § 1396p(d)(4)(B)(ii).

\textsuperscript{170} § 1396p(d)(5). This provision requires the state agency to promulgate procedures in accordance with standards set by the Secretary of the Department of Health and Human Services for determining whether the application of the rules would work an undue hardship upon the applicant. \textit{Id.} For a better understanding of the impact of this undue hardship provision, see \textit{supra} note 115.
or use of a trust to shelter assets.\textsuperscript{171} Prior to OBRA '93, the period of ineligibility could not extend beyond thirty months from the date of the transfer.\textsuperscript{172} The period was calculated as the lesser of thirty months or the number of months equal to the amount of the transfer divided by the average monthly cost of a private nursing home in the applicant's state of residence.\textsuperscript{173} In states that allowed for concurrent counting of transfers, however, the efficacy of the rule could be undermined.\textsuperscript{174}

More specifically, if an individual disposed of $40,000 and the average monthly cost of care was $4,000, a ten-month period of ineligibility would be created.\textsuperscript{175} If the individual then disposed of an additional $36,000 in the following month, the law imposed an additional nine-month period of ineligibility at the end of the original penalty.\textsuperscript{176} Hence, in most states the individual would be ineligible for Medicaid for nineteen months.\textsuperscript{177} In states allowing concurrent counting of transfers, however, the above transactions would have resulted in only ten months of ineligibility, because the nine-month penalty could be served concurrently with the ten-month penalty.\textsuperscript{178}

\textsuperscript{172} § 1396p(c)(1) (1988).
\textsuperscript{173} \textit{id.} The federal government, through periodic transmittals from HCFA, provides states with the appropriate figures for this average monthly cost.
\textsuperscript{174} MECCA '88, which provided that "[t]he period of ineligibility shall begin with the month in which such resources were transferred," \textit{id.}, did not clearly establish whether penalty periods of ineligibility were to be imposed consecutively or concurrently. Medicare Catastrophic Coverage Act of 1988, § 303, Pub. L. No. 100-360, 102 Stat. 683, 761. As a result, states took different approaches. See Medicaid Survey Results: Still No Nationwide Standards, \textit{THE ELDERLAW REP.} (Mar. 1992) (surveying the approaches implemented by the various states and concluding that the use of different rules among the states creates substantially different outcomes among applicants). HCFA, the agency charged with promulgating regulations under the Medicaid laws, recognized that the concurrent method tended to eliminate the connection between the size of the transfer and the penalty, but ruled, nonetheless, that the concurrent method was reasonable and valid absent regulations to the contrary. See Medicaid State Operations Letter 90-87, DEPARTMENT OF HEALTH AND HUMAN SERVICES NEWS RELEASE, MEDICARE AND MEDICAID GUIDE, NEW DEVELOPMENTS (providing the official opinion by HCFA permitting states to utilize concurrent counting).
\textsuperscript{175} The amount disposed ($40,000) divided by the average monthly cost ($4,000) equals 10.
\textsuperscript{176} The amount disposed ($36,000) divided by the average monthly cost ($4,000) equals 9.
\textsuperscript{177} The nine-month penalty would be added to the 10-month penalty.
\textsuperscript{178} In light of the 30-month ineligibility cap, the most significant discrepancy would occur in the case of two individuals disposing assets equal to 28 times the average cost of care. In a traditional state, the period of ineligibility would be 28 months, regardless of how the disposal was structured. In a concurrent counting state, however, an individual disposing the assets through a decreasing stream of monthly payments from seven times the monthly average down to one, would only serve a seven-month period of ineligibility.
As under the previous law, the penalty period is determined by dividing the uncompensated amount transferred by the average monthly cost of private nursing home care.\textsuperscript{179} OBRA '93, however, does not limit the period of ineligibility.\textsuperscript{180} Thus, persons disposing of large amounts of assets can now be ineligible for Medicaid for more than three years.\textsuperscript{181}

In addition to the changes regarding the penalty period cap, OBRA '93 addressed the inequities between states that utilized concurrent penalty periods and those that stacked the penalty periods.\textsuperscript{182} The revised law requires states to aggregate all transfers made within the look-back period for the purpose of calculating the penalty period.\textsuperscript{183}

Finally, the prior rules had imposed the period of ineligibility only if the applicant sought services in a nursing home.\textsuperscript{184} The current law allows states to apply the transfer rules to other long-term care services covered by Medicaid.\textsuperscript{185} Thus, as a result of improper asset transfers, an individual can be rendered ineligible not only for nursing home coverage, but also for services such as home health care, respite care, personal care services, and other long-term care services provided by the state.\textsuperscript{186}

\subsection*{C. Mandatory Estate Recovery}

Prior to OBRA '93, Congress granted states the option of recovering Medicaid payments from a recipient's probate estate.\textsuperscript{187} This option included the power to place a lien on the recipient's home, foreclosable

\begin{footnotes}
\item 179. 42 U.S.C. § 1396p(c)(1)(E) (Supp. V 1993). The new rules do provide one change with respect to this calculation—a state now may use either the average cost of private nursing home care for the entire state or the average cost for care in the community where the individual is institutionalized. § 1396p(c)(1)(E)(i)(II).
\item 180. See § 1396p(c) (lacking a penalty period limit). Prior to the passage of this provision for unlimited penalties, Connecticut applied for a waiver allowing it to extend both the penalty cap and the look-back period to 60 months. Kenneth M. Coughlin, \textit{Here Come the Trustbusters: States Move to Restrict Medicaid Planning}, THE \textsc{ElderLaw} REP., Nov. 1992, at 1. At the same time, Ohio was considering applying for a similar waiver. \textit{Id}.
\item 181. The average cost for nursing home care is approximately $40,000 annually, or about $3333 per month. \textit{See supra} note 13 (noting this average cost of care). Thus, to be ineligible for longer than 36 months an individual typically would have to dispose of more than $120,000 in assets.
\item 183. § 1396p(c)(1)(E)(i)(I)-(II).
\item 184. 42 U.S.C. § 1396p(c)(1) (1988), \textit{amended by} 42 U.S.C. § 1396p(c) (Supp. V 1993). This provision also extended to institutions essentially equivalent to nursing facilities. \textit{Id}.
\item 185. 42 U.S.C. § 1396p(c)(1)(C)(ii) (Supp. V 1993). Specifically, states may apply the transfer rules to "other long-term care services for which medical assistance is otherwise available under the State plan . . . ." \textit{Id}.
\item 186. \textit{See id}.
\end{footnotes}
under certain conditions,188 after it was clear that the recipient would not return home.189 Nonetheless, only one-half of all states maintained such estate recovery programs190 and, among those that did, very few were effective.191

Responding to the ineffectiveness of existing estate recovery programs, OBRA '93 substantially expanded the concept of recovery.192 The new law now requires states to recover the costs of Medicaid payments for nursing home or other long-term care from the estate of any individual receiving benefits after age fifty-five.193 The state may recover these amounts either from the individual's estate, or upon the sale of any property subjected to a lien imposed by the state.194 The law retains the previ-

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189. See id. at 370 (disallowing a lien unless "the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that [an applicant] cannot reasonably be expected to . . . return home").

190. A survey by the American Public Welfare Association indicated that during the year prior to OBRA '93, 25 states and the District of Columbia maintained estate recovery programs, while 23 states did not (two states failed to respond). AMERICAN PUBLIC WELFARE ASSOCIATION, ESTATE RECOVERY SURVEY RESULTS (1992).

191. In 1988, the Office of Inspector General studied state Medicaid estate recovery programs and found very few to be effective. See OFFICE OF INSPECTOR GENERAL, MEDICAID ESTATE RECOVERIES, HHS/OAI-09-86-00078 (June 1988). A subsequent study by the General Accounting Office in 1989 found that although many states recently had implemented changes to improve their estate recovery programs, most programs remained ineffective in recovering benefits from the estates of Medicaid recipients. GENERAL ACCOUNTING OFFICE, MEDICAID: RECOVERIES FROM NURSING HOME RESIDENTS' ESTATES COULD OFFSET PROGRAM COSTS, GAO/HRD-89-56 (Mar. 1989).

192. See 42 U.S.C. § 1396p(b) (Supp. V 1993); see supra note 191 (describing the ineffectiveness of pre-existing estate recovery programs).

193. § 1396p(b)(1)(B). The age 55 requirement may be another drafting error because the context of the section suggests, and the prior law provided, that this recovery would extend to benefits received after the age of 65. See Renee R. Neeld, Medicaid Planning: 1993 OBRA Asset Transfer Restrictions and Estate Recovery, 37 RES gestae 329, 330 (1994) (noting that "the text of the law says age 55, which is probably an error"). Nonetheless, as enacted the statute reads "55." See § 1396p(b)(1)(B) (stating, notwithstanding the fact that recipients of long-term care Medicaid benefits who qualify based on their financial status must be over age 65, that recovery provisions apply in cases of individuals over age 55 receiving benefits); see also Schlesinger & Scheiner, supra note 74, at 80 (stating that "the age 55 requirement may be a drafting error because the context of the new statute seems to imply that age 65—the requirement under the prior statute—was intended"); Strauss, supra note 113, at 31 (noting this inconsistency and suggesting a technical amendment to correct the language).

194. § 1396p(b)(1)(A). Prior to OBRA '93, the Commonwealth of Massachusetts had developed an effective scheme for estate recovery which could serve as a model for other states attempting to comply with the mandatory recovery requirement. See generally COMMONWEALTH OF MASSACHUSETTS, SPECIAL COMMISSION ON MEDICAID ESTATE RECOVERY: REPORT AND PROPOSED LEGISLATION (Nov. 1991). This approach requires
ous conditions that allowed recovery only after the death of the individual's surviving spouse, and only so long as there are no surviving children under the age of twenty-one, blind, or permanently disabled. \(^{195}\) While it remained unclear prior to OBRA '93 whether the recoverable estate was limited to the probate estate of the recipient, \(^{196}\) the new law explicitly includes within the recoverable estate all real and personal property, as well as all other assets included within the individual's estate as defined by that state's probate law. \(^{197}\) In addition, states may count any other assets in which the individual had an interest at the time of death, including those conveyed to others through probate and non-probate arrangements. \(^{198}\) Finally, the new law provides that the Secretary of the Department of Health and Human Services (HHS) shall establish standards for waiving the right to recovery in cases where recovery would work an undue hardship. \(^{199}\)

1. Medicaid estate planners may find dealing with these provisions to be especially complex in states with augmented estate statutes. See Forster, supra note 104, at 4. The Uniform Probate Code provides an example of an augmented estate statute. See Uniform Probate Code § 2-202 (1994) (defining property included in the augmented estate). Generally, the augmented estate is the sum of the decedent's probate estate, in addition to all property passed through the exercise or non-exercise of a general power of appointment held by the decedent, property passed through will substitutes utilized by the decedent, and property gratuitously transferred by the decedent within the previous two years. Id. §§ 2-202 (b)(1)-(2).

2. The new estate recovery provision authorizes states to recover funds from all of these sources, to the extent of Medicaid benefits paid on behalf of the decedent. 42 U.S.C. §§ 1396p(b)(4)(A)-(B) (Supp. V 1993). Accordingly, some states subject to recovery not only funds passed outside of the probate estate, but also transfers made up to two years prior to the decedent's death. See Uniform Probate Code, supra, at §§ 2-202(b)(1)-(2).

3. Although the Secretary has yet to promulgate regulations establishing the criteria to be used in determining whether estate recovery would result in an undue hardship, the House Committee Report states that the Committee intends:
D. Effectively Precluding Expansion of Integrated Long-Term Care Insurance Programs

The final important provision in the new law concerns private long-term care insurance policies. Prior to OBRA '93 some states had established programs granting asset protection and Medicaid benefits to individuals who had purchased long-term care insurance and exhausted their policy benefits. OBRA '93 frustrates the expansion of these integrated insurance programs, however, by requiring states to implement estate recovery mechanisms for individuals receiving benefits under such an arrangement, thereby obviating the principal purpose of these integrated programs.

III. OBRA '93—Medicaid Planning Made More Difficult but No Less Attractive

Certainly, OBRA '93 "provides greater assurance that individuals with substantial personal assets [will] pay a fair share for nursing home care . . . before they qualify for Medicaid." From simple definitional changes to more comprehensive operational changes in the law,

[T]he Secretary should provide for special consideration of cases in which the estate subject to recovery is (1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, or (2) a homestead of modest value or (3) other compelling circumstances. The Committee also expects the Secretary to provide guidance to States on how to address situations where recovery is not waived and beneficiaries of the estate from which recovery is sought wish to satisfy the State's recovery claim without selling a non-liquid asset subject to recovery.


200. § 1396p(b)(1)(C)(i).
202. § 1396p(b)(1)(C)(i) specifically provides:
   In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded [under an approved State plan] . . . the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

Id. Clause (ii) of this section specifically exempts states with pre-existing approved plans. § 1396p(b)(1)(C)(ii); see infra notes 255-61 and accompanying text (commenting that this provision undermined the most viable option for long-term care financing).

204. Among the most important of these simple definitional changes is the change from measuring "resources" to looking at "assets" when determining Medicaid eligibility, see discussion supra part II.A.1, and the abandonment of the concept of Medicaid qualifying trusts to determine the availability of funds, see discussion supra part II.A.3.a.
Congress has made it significantly more difficult for financially secure individuals to "cheat" their way onto Medicaid.\textsuperscript{206} In several ways, however, OBRA '93 is unsatisfactory. At the most basic level, several technical loopholes remain within the law and must be addressed.\textsuperscript{207} More importantly, though, OBRA '93 failed to provide fundamental changes in the long-term health care financing system.\textsuperscript{208} In fact, OBRA

\textsuperscript{205} The most prominent operational changes in the law include extending the look-back period for outright transfers of assets, see discussion supra part II.A.2, clarification of the rules regarding jointly held assets, see discussion supra part II.A.2.a, and requiring the use of cumulative rather than concurrent penalty periods of ineligibility for fraudulent transfers, see discussion supra part II.B.

\textsuperscript{206} The term "cheat" is intended to draw attention to the fact that, as Jane Bryant Quinn has noted, "[w]hen people with money sneak onto any of the other welfare programs, they're called 'welfare cheats.' If they sneak onto Medicaid, they're called 'savvy.'" Quinn, supra note 83, at H3. Nonetheless, this double standard may be warranted. See infra text accompanying notes 247-54 (describing how the predicament faced by many elderly essentially forces them to utilize Medicaid planning). The elderly truly are victims of the shortage of long-term health care planning options. Id. The shortage of planning options places many elderly persons in a situation where Medicaid Estate Planning is their only rational choice. Id. In this light, Medicaid Estate Planning indeed may deserve to be viewed differently than other forms of "welfare cheating." See Paul R. Willging, Financing Long-Term Care in America Poses a Major Challenge to Society, FED'N OF AM. HEALTH SYS. REV., Jan./Feb. 1988, at 47 (noting that elderly people are "forced" to rely on Medicaid). While this may seem an unpalatable distinction, it is a distinction inherent in the incentive-based proposal put forth in this Comment. See discussion infra part IV (suggesting that Medicaid Estate Planning can be eradicated only by creating more appealing alternatives for individuals to finance their long-term care).

\textsuperscript{207} Most prominent among these loopholes are the ease with which an individual may circumvent the statutory 60-month look-back period for transfers from trusts to a third party, subjecting the transfer to only a 36-month look-back by using himself or herself as a "middle-man," and a similar loophole created by the interaction of the unlimited penalty period and a look-back period capped at 36 months. See supra notes 98-99 and accompanying text.

The slight extension of the 30-month look-back period to 36-months perpetuates the most significant loophole in the law. At this most basic level, it is arguable that OBRA '93 merely forces Medicaid applicants to plan 180 days earlier to fraudulently qualify for Medicaid. See discussion supra part II.A.1 (noting the extension of the look-back period).

\textsuperscript{208} See Strauss, supra note 113, at 31 (noting that "the new law was enacted for budgetary reasons without regard to the basic problem older and disabled persons face in paying for long-term care"). Clearly, Congress failed to make fundamental changes to the Medicaid program, in part, because they expected to address long-term health care needs through the separate on-going efforts to reform the nation's health care system. See H.R. REP. NO. 103-111, 103d Cong., 1st Sess. 187, reprinted in 1993 U.S.C.C.A.N. 378, 514 (stating that "[t]he Committee recognizes that it will be considering the President's health reform proposal later this year, and that this legislation will significantly impact the... Medicaid program[.]. As a result, the Committee has not recommended any fundamental changes in the benefits or eligibility of these programs"). Under the Clinton health care reform proposal, however, the Medicaid program would have continued to pay for the nursing home expenses of the elderly without significant changes. See Strauss, supra note
'93 actually proves to be a step in the direction away from the most promising avenue for effectively ending this form of "Middle Class Welfare."

A. Technical Analysis of the Recent Changes

1. Disentangling the Inconsistent Treatment of Revocable and Irrevocable Trusts

The treatment of irrevocable trusts in OBRA '93 has been characterized as "clearly the product of midnight drafting done by the four horseman [sic] of the apocalypse." It has been criticized as a section of the Act in which "[m]ore questions are created rather than resolved . . . ." Notwithstanding some apparent drafting errors that should be corrected through amendments or regulations, however, these provisions do establish effective and comprehensive rules for the treatment of irrevocable trusts.

The statute extends the look-back period for most transfers of assets to thirty-six months. According to the precise language of the law, however, the look-back period for transfers into a trust is sixty months. This clearly is the result of a printing error.

Any transfer of assets into this type of trust essentially is equivalent to an outright transfer of assets (for which the look-back period is thirty-six months), because the assets become, by definition, unavailable to the applicant. Thus, there is no apparent reason that Congress would have intended for a sixty-month look-back period to apply to transfers into such trusts. In fact, it seems that instead of providing for a sixty-month look-back period for payments into a trust from which no distribution could be made to the applicant, Congress actually meant for this provision to apply to payments made from a revocable trust to an individual other than the donor. This construction of the statute would create

113, at 31 (noting that while Medicare would have been expanded to cover some home and community-based care, Medicaid would still cover nursing home costs).

209. See Strauss, supra note 113, at 31 (providing examples of the typographical errors in the law).

210. See Forster, supra note 104, at 4 (stating that only a few points are clear from the rules).

211. See Schlesinger & Scheiner, supra note 74, at 78 (stating that, while under the language of the previous law it was arguable that corpus from an "income only" irrevocable trusts should not be considered available, under the broad language of the new statute it would be risky to rely on such reasoning).


213. § 1396p(c)(B)(i).

214. See Strauss, supra note 113, at 3 (suggesting that this inconsistent treatment is the result of drafting errors).

215. Id.

216. Id.
consistent look-back periods for similar payments made from either revocable or irrevocable trusts.\textsuperscript{217}

Therefore, it appears that the law will require technical amendments to clarify some aspects of the new rules.\textsuperscript{218} It is likely that the look-back period for payments made into irrevocable trusts which bar distribution to the applicant will be lowered to thirty-six months, consistent with the period for other outright transfers of assets.\textsuperscript{219} Presumably, the look-back period for payments from an irrevocable trust not made to or for the benefit of the applicant will be extended to sixty months, consistent with the period for similar transfers from revocable trusts.\textsuperscript{220}

2. An Unlimited Penalty Period of Ineligibility—Congress Closes a Major Loophole . . . Halfway

OBRA '93 effected another significant change from the prior law by removing the thirty-six-month ineligibility period cap for fraudulent transfers.\textsuperscript{221} Under the new law, the period of ineligibility is determined by dividing the amount transferred by the average monthly cost of care, with no limit on the length of the penalty.\textsuperscript{222}

While this change makes it somewhat more difficult to arrange impoverishment, a major planning loophole remains in the law.\textsuperscript{223} For example, in a state with an average monthly cost of $4,000, an individual who transfers $200,000 outright would be ineligible for fifty months if she applied for Medicaid.\textsuperscript{224} However, the look-back period is only thirty-six months for this transfer.\textsuperscript{225} Therefore, if this individual waits to apply for Medi-

\textsuperscript{217} See \textit{id.} at 3 (maintaining that the inconsistencies are the result of drafting errors).

\textsuperscript{218} See \textit{id.} at 3 (maintaining that the inconsistencies are the result of drafting errors).


\textsuperscript{220} See Margolis, \textit{supra} note 219, at 2.

\textsuperscript{221} See discussion \textit{supra} part II.B (discussing the ineligibility period for fraudulent transfers).


\textsuperscript{223} See Barbara J. Collins, \textit{Recent Changes in Federal Medical Assistance Law, in Elder Law Institute 1994: Representing the Elderly Client of Modest Means,} 123, 127 (PLI Est. Plan. & Admin. Course Handbook Series No. D-235, 1994) (discussing this change as "a trap for the unwary"). While Collins views the change as making the prior loophole "half-closed," this Comment discusses it from the viewpoint of remaining "half-open."

\textsuperscript{224} The amount transferred ($200,000) divided by the average cost ($4,000) equals 50.

\textsuperscript{225} See 42 U.S.C. § 1396p(c)(1)(B)(i) (Supp. V 1993) (uncapping the potential penalty period of ineligibility); see also discussion \textit{supra} part II.B (discussing the ineligibility period for fraudulent transfers).
caid until the look-back period expires, she would avoid fourteen months of ineligibility.\textsuperscript{226}

Congress could have prevented this situation by commencing the period of ineligibility on the date of application rather than on the date of the transfer.\textsuperscript{227} OBRA '93, however, still commences the period of ineligibility on “the first day of the first month during or after which the assets have been transferred.”\textsuperscript{228} Congress considered a proposal for commencing the period of ineligibility at the time of application,\textsuperscript{229} but the Conference Committee failed to adopt the Senate bill section containing this change.\textsuperscript{230} Thus, in OBRA '93, as in past changes in the Medicaid laws, Congress merely narrowed the loophole, rather than eliminating it.


The broad estate recovery provisions enacted as part of OBRA '93 could substantially limit Medicaid planning and allow the government to recoup a large amount of public funds spent on individuals.\textsuperscript{231} Nonetheless, this loophole could have been narrowed further by extending the look-back period beyond 36 months.

\begin{itemize}
\item \textsuperscript{226} See Strauss, supra note 113, at 3, 7. A simple rule of thumb for this calculation is: if the uncompensated value of the assets transferred is greater than 36 times the average monthly cost of care, it would be unwise to apply for Medicaid until the look-back period has expired. \textit{Id.}
\item \textsuperscript{227} Indeed, the committee hearings on these provisions demonstrated clearly that this result would occur. \textit{See Hearings, supra note 16, at 444 (statement of Vincent J. Russo, President, National Academy of Elder Law Attorneys (NAELA)). It is important to note that NAELA, while pointing out this loophole, actually opposed altering the penalty period to commence at the time of transfer. \textit{Id.} at 443. Nonetheless, this loophole still could have been narrowed further by extending the look-back period beyond 36 months.}
\item \textsuperscript{228} 42 U.S.C. § 1396p(c)(1)(D) (Supp. V 1993).
\item \textsuperscript{229} S.2264, 103d Cong., 1st Sess. § 13611(a)(1)(D)(1993).
\item In addition, it is important to note that the House Committee hearings on the Medicaid provisions of OBRA '93 were held without members knowing the details of the actual proposal. \textit{See Hearings, supra note 16, at 333-34 (statement of Chairman Waxman) (deadpanning that although the Clinton Administration had been able to state exactly how much money would be saved by these provisions, they failed to articulate the details of how they intended to accomplish this feat). Those testifying before the Committee were unable to analyze the legislation and comment on any certain provisions. \textit{Id.} Rather, their role was limited to suggesting what should be included in a bill that already had been drafted without their input. \textit{Id. Thus, in a sense these hearings may be helpful only for future amendments.}
\item \textsuperscript{231} \textit{See Hearings, supra note 16, at 348 (statement of Gerald Rohlfes) (noting that California alone recovers approximately $21 million per year at a cost of $2.5 million using 35 employees and a mandatory estate recovery system).}
\end{itemize}
less, by defining the property that states may reach as that "in which the individual had any legal title or interest at the time of death," Congress may have precluded broad estate recovery. At the time of death an individual ceases to have legal title or interest in property she held in joint tenancy, jointly with a right of survivorship, or in a life estate. Therefore, this provision will not increase estate recovery.

Still, if Congress provides a technical correction or if courts actively interpret this section as meaning "immediately before death," this definitional change could substantially increase the amount of money recovered. Indeed, these recovery provisions could allow assets that the current law exempts to be levied against by the state following the death of the recipient.

B. A Public Policy Analysis of OBRA '93—Congress Fails to Address the Cause of Medicaid Planning

Although most public coverage of Medicaid planning focuses on ethical questions, it simply will not be possible to stop Medicaid planning by convincing people that it is morally wrong. In this sense, ethical considerations are irrelevant from a policy standpoint. Accordingly, this Comment purposely does not address the ethical propriety of Medicaid Estate Planning.

233. See Strauss, supra note 113, at 31 (asserting and elaborating on this point).
234. Id.
235. See id. (maintaining that the statute may have excluded the property interests that Congress intended to encompass).
236. See id. (explaining that this change could come from a technical amendment or court interpretations).
237. For example, under this language the recipient's home, which is an exempt asset for the purposes of establishing Medicaid eligibility, could be levied against to the extent of the recipient's ownership interest. See Schlesinger & Scheiner, supra note 74, at 80.
238. See, e.g., Fein, supra note 16, at 39 (noting that the growth of Medicaid planning "has prompted an intense ethical debate over whether people with money should benefit from a medical program intended for the poor"); Jeffrey L. Soltermann, Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?, 1 Elder L.J. 251, 276-77 (1993) (stating that "a major piece of social engineering—the conversion of a need-based program for the poor to a more universal entitlement program—is underway in this country, and lawyers are inevitably involved. But is it right?").
239. See Burwell, supra note 12, at 32 (stating that "[i]t will not be possible to address the problem of Medicaid estate planning through persuasion of the elderly and their heirs that it is "morally wrong"").
240. To be sure, the ethical propriety of Medicaid Estate Planning is somewhat of a conundrum. Attorneys in the practice of Medicaid planning claim that they merely are advising their clients with respect to what is legal, just as tax lawyers help clients minimize their taxes. See Helvering v. Gregory, 69 F.2d 809, 810 (2d Cir. 1934), aff'd, 293 U.S. 465 (1935), wherein Judge Learned Hand wrote his now-famous statement: "Any one may so
Just as ethical concerns will not sufficiently deter Medicaid planning, however, neither will incremental\textsuperscript{241} tinkering with rules and enforce-

\begin{quote}
arrange his affairs that his taxes shall be as low as possible; he is not bound to choose that pattern which will best pay the Treasury; there is not even a patriotic duty to increase one's taxes." \textit{Id.} Indeed, one prominent attorney has stated: "[E]very city in America has thousands of lawyers whose job it is to help wealthy people and corporations avoid as much tax as legally possible. What I do is the same thing. Only I help the little people." \textit{See Miller, supra} note 197, at 588-89 (citing Andrew Bates, \textit{Golden Girls}, \textit{New Republic}, Feb. 3, 1992, at 17).

Moreover, attorneys providing Medicaid Estate Planning services claim that by not advising a client about loopholes in the law, they may be subject to a malpractice claim. \textit{See, e.g., Drake County Bar Assoc. v. Brumbaugh}, 602 N.E.2d 606, 607 (Ohio 1992) (per curiam) (holding that a delay in recertifying a client's Medicaid entitlement causing the client to incur a $4,000 debt warranted a six month license suspension). Indeed, the Model Rules of Professional Conduct arguably require such assistance. \textit{See Model Rules of Professional Conduct} Rule 1.1 (1994) (stating that "[a] lawyer shall provide competent representation to a client").

Those opposed to Medicaid planning, however, claim that such schemes conflict with the objective of the Medicaid program—to provide health care to the truly poor—and force taxpayers to pay the medical bills of those who can afford to pay for their own care. \textit{See supra} text accompanying notes 1-3 (noting that "[t]he Medicaid program . . . is designed to cover a portion of the health care costs for needy persons of all ages.") (emphasis added). \textit{But see Model Rules of Professional Conduct} Rule 1.2 cmt. (1994) (noting that "[t]here is a critical distinction between presenting an analysis of legal aspects of questionable conduct and recommending the means by which a crime or fraud might be committed with impunity").

The futility of this debate was illustrated in 1992, when the Ohio Senate Ways and Means Committee considered legislation revoking the licenses of attorneys who advised clients how to transfer assets to qualify for Medicaid. Kenneth M. Coughlin, \textit{Ohio Flirts with License Revocation}, \textit{The ElderLaw Rep.}, Nov. 1992, at 2. Because attorneys were advising clients about what acts are permitted by the law, it was impossible to draft language making this practice illegal. \textit{Id.}

\textsuperscript{241} "Incrementalism" refers to the government policy-making model developed by Charles E. Lindblom. \textit{See Charles E. Lindblom, The Science of "Muddling Through",} 19 PUB. ADMIN. REV. 79, 79-88 (1959). The incremental model contrasts to the rational-comprehensive policy-making model. \textit{Id.} at 79. Under the rational-comprehensive model, decision-makers clearly define the problem to be addressed, determine satisfactory levels of addressing the problems, canvass alternatives to achieve these goals, compare those alternatives, and, ultimately, choose the approach that achieves the goals at the least cost. \textit{John W. Kingdon, Agendas, Alternatives, and Public Policies} 82 (1984). Under the incremental model, policy-makers presume the propriety of the basic approach of any policy and, therefore, make only small, incremental changes. \textit{Id.} at 83; \textit{see also Lindblom, supra}, at 84 (developing this model originally). This inertial tendency results from both the decentralized nature of our system of government and the political concerns of legislators anathema to the potential political fallout that is concomitant to any major policy change. \textit{See Lindblom, supra}, at 85-86.

The budgetary process, within which Medicaid eligibility policy is traditionally developed, has been characterized widely as the policy endeavor most closely conforming to this incremental model. \textit{See, e.g., Aaron Wildavsky, The Politics of the Budgetary Process} ch. 2 (3d ed. 1979); \textit{Otto A. Davis, et al., A Theory of the Budgetary Process}, 60 AM. POL. SCI. REV. 529, 529-47 (1966). \textit{But see John F. Padgett, Bounded Rationality in Budgetary Research,} 74 AM. POL. SCI. REV. 354 (1980) (arguing that the incremental model
In the most simple case, OBRA '93 does not apply well to the budgetary process. Indeed, the history of frequent but minor changes in Medicaid eligibility rules exemplifies the incremental approach at work in the budget process. See discussion supra part I.C (demonstrating implicitly that past policy efforts have entailed merely developing stricter rules and enforcement mechanisms for policing fraudulent transfers); see also Strauss, supra note 113, at 31 (noting that budgetary concerns, not concerns for the long-term health care needs of the elderly and disabled, drove the 1993 changes in the Medicaid laws). Moreover, it appears that the incremental approach will continue to dominate policy-making, notwithstanding predictions like that of the Pepper Commission more than five years ago stating that rational policy-making would come to predominate in this area. See Marshall B. Kapp, Options for Long-Term Care Financing: A Look to the Future, 42 Hastings L.J. 719, 754 (1991) (citing Coopers & Lybrand, Healthcare Financial Management Ass'n, Long-Term Care for the Elderly in the 1990's: Structure and Financing 18-19 (1990) ("suggesting that the 'muddle through' incremental tinkering model will continue to dominate the national response—or lack of response—to the eldercare financing challenge.") and John D. Rockefeller IV, The Pepper Commission Report on Comprehensive Health Care, 323 New. Eng. J. Med. 1005 (1990) (stating that "[i]n long-term care, . . . broad-based support and limited opposition will promote consensus on action . . ."). Id. at 754.

Notwithstanding the predominance of incrementalism in budgetary politics, the alternative advanced in this Comment — implementing changes that would break the incremental model by discarding the policing approach of the past in favor of an incentive-based approach for limiting Medicaid planning — is not unrealistic. See discussion infra part IV (promoting incentive-based, integrated policies). Previous policy responses to this impending crisis have demonstrated that mere incremental refinements of the existing Medicaid eligibility structure will be insufficient. See infra notes 242-44 (indicating that stricter rules will merely be circumvented by more innovative planning as long as there is a lack of dignified choices for financing long-term care). Moreover, surging demographic expansion in both the number of elderly and the cost of care are further exacerbating the need for swift and significant changes in the current long-term care marketplace. See Kapp, supra, at 720-21 (noting that the elderly population is expected to nearly double between the years 1990 and 2020 and that expenditures on long-term care will continue to rise); see also Theresamaria Mantese & Gerard Mantese, Nursing Homes and the Care of the Elderly, 51 J. Mo. B. 155, 155 (1995) (stating that in the next 25 years, the percentage of the population aged 65 years or older also is expected to increase from 12.6% to 16%) (citing The Population Reference Handbook (1990), published by the Population Reference Bureau, a non-profit demographics study group in Washington, D.C.); Erick J. Bohlman, Financing Strategies: Long-Term Care for the Elderly, 2 Elder L.J. 167, 168 (1994) (noting that "projections are that by 2030, 18.3% of the population will have reached that age [65]" and providing several detailed statistics predicting different aspects of the growth in the elderly population) (citing M. H. Hoeflich, Housing the Elderly in a Changing America: Innovation Through Private Sector Initiative, 1985 U. Ill. L. Rev. 1,2).

As experiments in several states have demonstrated, integrating Medicaid eligibility with private long-term care insurance is the most viable policy alternative for resolving this crisis. See infra notes 255-61 and accompanying text (describing long-term care insurance). Under these conditions, it is possible to overcome the tendency for incrementalism and enact fundamental changes in the long-term care financing marketplace. See generally Kingdon, supra, at ch. 8 (theorizing that incrementalism is overcome, and significant changes in policy are achieved, when elements of the "problem stream" and "policy stream" are coupled).

242. Based on the adaptability that planners have demonstrated in responding to every prior attempt to tighten the law, there is no reason to believe that the most recent en-
merely will force the elderly to plan six months earlier.\textsuperscript{243} With regard to the more complex changes in the law, Medicaid planners can be expected to find other means of impoverishing their clients on paper.\textsuperscript{244} Realistically, individuals will find ways to circumvent the law as long as Medicaid Estate Planning remains the most rational option available\textsuperscript{245} In this way, Medicaid Estate Planning is a symptom of a broader problem—the lack of dignified choices for financing long-term health care.\textsuperscript{246}

Under the current system, the elderly have three options for financing long-term care.\textsuperscript{247} The first option is to purchase private long-term health care insurance.\textsuperscript{248} Because most individuals do not consider long-term
devor will significantly curtail Medicaid planning. See \textit{Burwell}, supra note 39, at 2 (noting that every effort to curtail Medicaid planning has been hampered by imperfect legislation leaving loopholes in the law and a concomitant expansion in planning knowledge and techniques resulting in a veritable “industry” of planning).

\textsuperscript{243} See discussion supra Part II.A.2.a. Under the new law, the look-back period for uncompensated transfers of assets is extended from 30 to 36 months. \textit{Id.}

\textsuperscript{244} See \textit{Hearings}, supra note 16, at 389 (statement of Steven Chies, representative of the American Health Care Association) (observing that while tightening rules and enforcement might yield some savings, planners certainly will “find other means of dealing with those issues as they come up”).

\textsuperscript{245} \textit{Id.} at 351 (statement by Vincent J. Russo, President, National Academy of Elder Law Attorneys) (observing that “the current health care system for long-term care . . . tells middle-income Americans that they must plan impoverishment since . . . it is the only rational alternative to losing their life savings”); see also Eleanor M. Crosby & Ira M. Leff, \textit{Ethical Considerations in Medicaid Estate Planning: An Analysis of The ABA Model Rules of Professional Conduct}, 44 Soc. Sec. Rep. Ser. 897 (1994) (available on WESTLAW). Crosby and Leff write that:

Older people expect that the money they have saved all their lives will have value in funding their retirement and in securing the lives of their children and grandchildren. People will not save for a lifetime in order to see those savings go down the drain in a matter of a few months or a few years, just to save the government some Medicaid dollars. \textit{It denies the essence of the middle class view of American life and the American dream.}


\textsuperscript{246} See \textit{Hearings}, supra note 16, at 365 (statement of Sheldon L. Goldberg, President, American Association of Homes for the Aging) (referring to Medicaid planning as a “symptom[ ] of a much broader problem: inadequate access to long-term care services and financial protection against catastrophic long-term care expenses”); see also \textit{id.} at 389 (statement of Steven Chies, representative of the American Health Care Association) (referring to Medicaid planning as “one symptom” of the long-term health care financing system).

\textsuperscript{247} For an overview of the finer points of these three options, and guidance on developing an integrated estate plan for elderly clients, see \textit{Regan}, supra note 127, § 10.19, at 10-129 to 10-130 (advocating the purchase of long-term care insurance, as opposed to planned divestment or legitimately spending-down to Medicaid eligibility).

\textsuperscript{248} This option is the least frequently utilized—among those individuals entering nursing homes, a mere 1% are covered by private long-term health care insurance. \textit{Medicaid Source Book: 1993 Update}, supra note 9, at 59-60.
care financing until the need for care is imminent, however, private insurance is usually cost-prohibitive. Accordingly, a second option is for an individual to spend-down almost all of her assets on medical care until she is poor enough to qualify for Medicaid. Understandably, most elderly seek to avoid this “impoverishment option,” hoping instead to live their final years in financial security and grant a modest legacy to the next generation. This leaves available only the third option of Medicaid Estate Planning—divesting assets to qualify for Medicaid on paper. In this way, “the elderly . . . [are] forced to rely on basic welfare mechanisms to assure protection against the catastrophic costs of nursing home services.”

249. [See supra note 98 (noting that because most individuals cannot accurately anticipate when they will need long-term care, they typically do not plan for care until the need is imminent).]

250. See Burwell, supra note 12, at 34. This observation reflects two fundamental concepts of insurance. First, the longer an individual waits to purchase insurance, the higher his or her premiums must be for the insurer to collect enough funds over the insured’s lifetime for the policy to be actuarially sound. Secondly, the older a new purchaser is, the greater the insurer’s concern for adverse selection—the tendency for only those who need care because of some impending situation to purchase insurance—and the higher the premiums those individuals will have to pay.

251. At this point, the individual will qualify for Medicaid as medically needy. See supra text accompanying notes 25-28 (discussing this legitimate form of spending-down assets).

252. It is important to remember that very often the next generation themselves are behind these decisions. See Burwell, supra note 12, at 32 (noting that long-term health care and estate planning decisions are typically prompted by children of the elderly). Regardless of whether this decision is motivated by the applicant’s concern for his or her children, prompting by the children themselves, or the elderly individual’s desire for his or her own financial security, it remains true that many elderly seek to avoid this option.

253. In a way, this option is “only a different route to the same destination. Instead of spending virtually all of one’s resources for care, the client . . . transfer[s] . . . resources to his children.” Regan, supra note 127, at 10-130.

254. Willing, supra note 206, at 47. Leaving the elderly with such a Hobson’s choice is intolerable. As Thomas Burke, Director of Communications for the New York State Health Facilities Association, has written with eloquent simplicity, “[a]ny health care system that requires those who need its help to go bankrupt to qualify is not a good system.” W. Thomas Burke, People Should be Planning for Long-Term Care, The Legislative Gazette, Oct. 16, 1995, at 14 (Letter to the Editor); see also Soltermann, supra note 238, at 278-79. Soltermann writes:

A system that requires people needing long-term care to impoverish themselves before qualifying for assistance will have a demoralizing effect upon the middle class. It will discourage saving because there is little point to putting aside money which will only be eaten up by a few years of nursing home care. Any system that so demoralizes its citizens must be ‘bad.’ Similarly, any system that encourages people to hide their assets sets a dangerous precedent. If people feel they can save thousands of hard-earned dollars by deceiving the welfare agencies, then they will probably have fewer qualms about misstating their income to the IRS. Id. at 277-78 (citations omitted).
Several states previously developed policies to integrate the purchase of long-term care insurance with Medicaid eligibility for their residents.\textsuperscript{255} Under these integrated arrangements, an individual who purchases approved\textsuperscript{256} private long-term care insurance qualifies for Medicaid benefits without having to spend-down or divest her assets.\textsuperscript{257} Unfortunately, OBRA '93 precludes expansion\textsuperscript{258} of this program by specifically requiring states to include in estate recovery any assets disregarded as a result of an integrated plan involving private long-term health care insurance.\textsuperscript{259} In so doing, Congress has undermined the most viable option for achieving the dual goals of preserving the integrity of the Medicaid system\textsuperscript{260} and allowing people to "finish well"\textsuperscript{261} by financing their long-term health care in a dignified manner.

\textsuperscript{255} With planning assistance from the Robert Wood Johnson Foundation, California, Connecticut, Indiana, and New York have developed plans that generally rely on Medicaid for re-insurance after an individual's private long-term health care insurance benefit has been exhausted. Regan, \textit{supra} note 127, at 10-138.

\textsuperscript{256} State requirements for "approved" plans vary. New York requires "approved" policies to provide at least a $100 daily nursing home benefit with a three-year coverage period and $50 per day for home care with a six-year coverage period. Id. at 10-138 to 10-139. New York also requires plans to provide inflation protection at 5% annually for premiums until the beneficiary reaches age 80. Id. at 10-138. In addition, all policies bear a special logo indicating that they are approved under the New York State Long-Term Care Security Program. Id. at 10-139. Under the New York system a purchaser of an approved plan may retain an unlimited amount of assets (but not income from these assets) and still qualify for Medicaid. Id. at 10-138. For a detailed discussion of the New York State Long-Term Care Security Program, see Walter Feldesman & JoAnn Canning, \textit{Long-Term Care Insurance Helps Preserve an Estate}, 2 Est. Plan. 76 (1993).

In Connecticut, individuals who exhaust the benefit of an approved policy are eligible for Medicaid, but may protect assets only to the extent of their benefit. Regan, \textit{supra} note 127, at 10-142. Under this arrangement, known as "dollar-for-dollar" protection, a person with a policy limited to $300,000 in coverage would be eligible for Medicaid once he or she has spent-down assets to $300,000. See id. For a more detailed analysis of this type of plan, see Kevin J. Mahoney & Terrie Wetle, \textit{Public-Private Partnerships: The Connecticut Model for Financing Long-Term Care}, 40 J. Am. Geriatrics Soc'y. 1026 (1992).

\textsuperscript{257} It is important to note that while resources may be protected under these plans, income from such assets must be spent down on medical costs until the usual Medicaid impoverishment level is reached. See Regan, \textit{supra} note 127, at 10-138 (referring specifically to the New York plan).

\textsuperscript{258} The four states that previously were granted waivers for these partnerships are exempted from these provisions and may continue to operate their plans. 42 U.S.C. § 1396p(b)(1)(C)(ii) (Supp. V 1993).

\textsuperscript{259} § 1396p(b)(1)(C)(i); see Tobin, \textit{supra} note 1, at 215 (describing this as "a somewhat surprising provision" in light of the adoption in several states of pilot programs excluding such assets from consideration).

\textsuperscript{260} See Richard Price, \textit{Congressional Research Service}, No. 93-302 EPW, \textit{Medicaid: Long-Term Care and the Elderly} 39 (1993) (noting that "private long-term care insurance is generally considered to be the most promising private sector option for providing the elderly additional protection for long-term care expenses"); see also Kevin J. Mahoney, \textit{The Connecticut Partnership for LTC}, \textit{Generations}, Spring 1990, at 71-72.
IV. INTEGRATING MEDICAID WITH LONG-TERM CARE INSURANCE—
AN INCENTIVE-BASED APPROACH FOR ENDING MEDICAID
PLANNING

Because Medicaid Estate Planning is very much a symptom of the
broader problem of limited long-term care financing options, the extent
to which improved or more aggressively enforced eligibility rules can pre-
vent the exploitation of Medicaid eligibility loopholes is limited.262
Rather, a comprehensive public policy response must promote progres-

(notating the success of an integrated approach in Connecticut); infra text accompanying
notes 262-70 (noting that the Medicaid Estate Planning form of Medicaid fraud can be
stopped only by creating more rational alternatives for the elderly to finance their care). But see United States Gen. Accounting Office, Long-Term Care Insurance: Proposals To Link Private Insurance and Medicaid Need Close Scrutiny, GAO/HRD-90-154 (Sept. 1990) (discussing the hazards of an integrated system that does not involve highly regulated policies).

261. The concept of “finishing well” was developed by Terry Hargrave, keynote
speaker at the 1991 American Association of Marriage and Family Therapists Annual Con-
end of life with resolved issues so that they can empower one another with love and
trust’”) (quoting Hargrave, Tape of 1991 American Association of Marriage and Family
Therapists Annual Conference (Nov. 3, 1991)). The concept of finishing well is implicit in
the following statement by Jeffrey L. Soltermann:

If an individual has to exhaust most of the assets accumulated over a lifetime the
first time a long-term care need arises, then both the individual and spouse will
thereafter have to depend upon the faceless bureaucracy of the welfare system. If
they can retain some assets, however, then the community spouse can be finan-
cially secure, and the one needing care can retain some degree of independence
and control, even in a nursing home. Furthermore, once nursing home care is no
longer necessary, the individual can afford to return home.

Soltermann, supra note 238, at 271.

This concept of “finishing well” is intertwined with a fundamental premise of this Com-
ment—that the elderly seek the most rational alternative available for financing long-term
care. See supra notes 238-54 and accompanying text (reasoning that Medicaid Estate Plan-
ning persists because it is the most rational financing option). Ensuring that the elderly
“finish well” motivates children, family, friends, and the elderly themselves to promote
selection of the most rational alternative available. See supra note 17 (stating that Medi-
caid planning usually is prompted by an individual’s children, seeking to maximize their
inheritances); see also Soltermann, supra note 238, at 273. Soltermann also rationalizes the
situation as follows:

Although this attitude seems selfish and somewhat insensitive, it is often soundly
based upon economic reality. In today’s world, it is harder than ever to achieve
and maintain middle-class status. . . . [T]he middle class’s share of the economic
pie seems to be shrinking. Consequently, a modest, middle-class inheritance may
seem to be the key to surviving in such a world—or at least easing the financial
struggle . . . .)

Id. But see Mark 10:25 (noting the burdens of finishing too well).

262. See supra note 246 (quoting several sources suggesting that Medicaid planning is merely a symptom of this broader problem).
sive and pragmatic financing options so that Medicaid Estate Planning no longer remains the most rational option for financing long-term care.\textsuperscript{263} Inasmuch as the individual crisis faced by each applicant reflects that individual's failure to plan for her own long-term health care, public policy must more actively educate, encourage, and assist individuals in responsibly planning for their own care.\textsuperscript{264}

Although the issue of Medicaid Estate Planning is especially complex,\textsuperscript{265} as Congressman Henry Waxman has noted, "[o]nce you wade through the maze of Medicaid eligibility rules and trust and estate law, the issue goes to some very fundamental questions."\textsuperscript{266} A comprehensive and well-reasoned public policy should be consistent with the purpose of the Medicaid program, limit Medicaid fraud, and remedy the problem motivating fraud. OBRA '93 clearly respects the original purpose of the Medicaid program—to cover some of the medical costs of needy persons.\textsuperscript{267} Moreover, the numerous changes in eligibility rules under OBRA '93 will make it significantly more difficult to qualify for Medicaid fraudulently.\textsuperscript{268} The law, however, still ignores the underlying problem

\textsuperscript{263} See Soltermann, \textit{supra} note 238, at 290 (concluding that "the long-term health care crisis cannot be solved unless the public and private sectors cooperate and share the responsibility for financing the system"); see also \textit{supra} text accompanying notes 253-61 (demonstrating that, under the current system, Medicaid Estate Planning is the most rational alternative for financing long-term health care).

\textsuperscript{264} Indeed as Michael Bagge has written:

While often viewed as a 'legal' problem, Medicaid eligibility for long term care is more properly viewed as a crisis of policy making which has rendered all the elderly poor, conventionally, nearly or fictionally. All elderly, regardless of income or resources, now in fact share a common concern with the ongoing transformation of the Medicaid program as the only social response to the long term health care crisis.

\textit{Michael Bagge, \textbf{The Eye of the Needle: Trust Planning, Medicaid and the Ersatz Poor}, N.Y. St. B.J., Feb. 1992, at 14, 34; see also \textit{Burwell}, \textit{supra} note 12, at i (noting one reason the elderly utilize Medicaid Estate Planning is that public policy neither encourages nor assists the elderly in developing financing alternatives).

\textsuperscript{265} The Supreme Court has described the structure of the Medicaid Program as "among the most intricate ever drafted by Congress," Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981), and "a morass of bureaucratic complexity," Herwag v. Ray, 455 U.S. 265, 279 (1982) (Burger, C.J., dissenting). Judge Friendly described the regulations developed under the Medicaid legislation as "labyrinthine," Friedman v. Berger, 547 F.2d 724, 727 (2d Cir. 1976), \textit{cert. denied}, 430 U.S. 984 (1977), and noted that "there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated." \textit{Id.} at 727 n.7.


\textsuperscript{267} See \textit{supra} text accompanying notes 1-3 (stating the purpose of the Medicaid program).

\textsuperscript{268} See \textit{supra} notes 204-05 and accompanying text (referring to several minor changes in the law); see also \textit{supra} discussion part III.A (discussing the most significant changes in the law).
motivating this form of Medicaid fraud—a lack of long-term health care planning options. Incentering into the eligibility rules incentives for individuals to purchase private long-term health care insurance is the most viable option for addressing this problem. Although long-term health care insurance is not flawless, with effective consumer protection standards it can serve as an effective part of an integrated long-term health care financing system.

A. Improving Long-Term Health Care Insurance for the Benefit of Consumers and Providers

The private long-term health care insurance industry is a relatively new, but rapidly expanding, market. For both providers and consumers, it contains many pitfalls. Insurance providers are concerned about the potential for adverse selection, induced demand, and, given the

269. See supra notes 252-54 and accompanying text (explaining how the elderly are forced into Medicaid planning).

270. See Soltermann, supra note 238 at 289-90 (concluding that Congress must provide incentives for the middle class to invest in long-term health care insurance); see also supra note 260 and accompanying text (arguing that long-term health care insurance is the most viable option for eradicating Medicaid planning).

271. In 1986, approximately 30 insurance providers were selling long-term care insurance policies to approximately 200,000 consumers. See Price, supra note 260, at 39. By 1987, a Department of Health and Human Services Task Force on Long-Term Care Insurance found 73 providers writing policies for 423,000 people. Id. By 1991, the Health Insurance Association of America documented more than 135 providers insuring over 2.4 million people. Id.

272. "Adverse selection" refers here to the tendency for only those people who are likely to need care to actually buy the insurance. See Bruce A. Radke, Meeting the Needs of Elderly Consumers: Proposed Reforms for the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act, 1 Elder L.J. 227, 232 (1993) (defining adverse selection as "the risk that only those persons who have a greater chance of needing long-term care will purchase the insurance") (citing Angela S. Curran, Long-Term Health Care Insurance Challenges: Meeting the Needs of an Aging Population, 21 Loy. U. Chi. L.J. 1075, 1086 (1990)). "Since few people consider buying long-term care insurance until they are old and frail (that is, until they are at high risk of claiming the covered benefit), private insurers cannot spread their risk over a sufficiently sizeable pool to avoid adverse selection." Kapp, supra note 15, at 748. For a more general definition and discussion of the concept of adverse selection see Robert E. Keeton & Alan L. Widiss, Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices 14 (1988).

273. "Induced demand" is the tendency for individuals to decide to use more services than they otherwise would because they have insurance which will cover the expense. See Radke, supra note 272, at 232 (defining induced demand as the phenomenon "in which the presence of insurance encourages use of the covered services when the insured would not have used such services in the absence of insurance"); see also Price, supra note 260, at 39-40; Alice M. Rivlin & Joshua M. Wiener, Caring for the Disabled Elderly: Who Will Pay? 14 (1988) (defining this concept, also known as "moral hazard," as the premise that, once insurance coverage is provided for a particular service, insured individu-
nature of elderly illnesses, the existence of somewhat "open-ended liability." Unfortu-

nately, in designing policies to account for these risks, providers have created several problems for consumers. Too often, current policies exclude certain illnesses, restrict benefits to a low level, limit the period of coverage, or fail to provide inflation protection. In some cases, policies simply can be cost-prohibitive. For these reasons, private long-term care insurance has remained generally unattractive.

Clearly the problems faced by consumers and providers are interdepen-
dent. The first step in solving these problems is to develop minimum federal standards for long-term care policies. These standards will assure consumers that they are receiving a quality product. The second step is to incorporate into the Medicaid eligibility rules asset-protection incentives for individuals to purchase private insurance rather than tend to utilize the service more frequently and often unnecessarily). This tendency also has been more colloquially described as the "woodwork effect." See Melinda Beck et al., Be Nice to Your Kids, Newsweek, Mar. 12, 1990, at 72, 73 (noting that people would "come out of the woodwork" to use a benefit once it is made available).

274. “Open-ended liability” means that the insurer will be paying benefits for the rest of the insured's life. See Price, supra note 260, at 39-40.

275. Id. at 40.

276. See Staff of House Comm. on Ways and Means, 103d Cong., 1st Sess., 1993 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means 263 (Comm. Print 1993) (maintaining that many elderly persons cannot afford long-term care insurance premiums); see supra note 250 (noting that policies often are cost-prohibitive).

277. Fundamentally, insurance involves a simple two-step process of identifying and distributing risks. See Keeton & Widiss, supra note 272, at 8-13. In exchange for a premium, an insurer agrees to be liable for certain costs associated with the identified risks. Id. at 11. These premiums are based on actuarial calculations incorporating both the foreseeable cost of liability and an insurer's ability to distribute this risk among many people. Id. at 12-13. Of course, this is a bilateral process—the degree of risk the insurer is willing to assume is based on the established premium that the insured will pay. In this case, any risks that the insurer does not cover are said to be retained risks. Id. at 13-14. Accordingly, each insurance transaction is a bargained agreement between the insured and the insurer that strikes a balance between these interrelated factors.

278. Several groups have advocated the development of federal standards for private long-term health care insurance in order to guarantee uniformity among plans and protect the consumer. See, e.g., Hearings, supra note 16, at 440 (memorandum from Vincent J. Russo, President, National Association of Elder Law Attorneys) (proposing the establishment of consumer protection standards); id. at 376 (memorandum of the American Association of Homes for the Aging) (recommending the establishment of minimum federal standards); Long-Term Care Insurance, Hearing Before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce, 101st Cong., 2d Sess. 204 (1990) (testimony of Ronald D. Hagen, AMEX Life Assurance Company) (supporting the establishment of federal minimum standards legislation as a means of encouraging further purchase and sales of long-term health care insurance).

279. See Hearings, supra note 16, at 376 (memorandum of American Association of Homes for the Aging) (noting that "federal minimum standards for such insurance . . . [will] protect consumers").
than engage in Medicaid Estate Planning. Together, these steps will encourage individuals to utilize private insurance to finance their long-term care needs. As investment in private insurance increases and the size of the risk pool expands, consumers additionally will benefit from more affordable premiums.

B. Integrated Long-Term Health Care Financing—A Proven Solution to the Long-Term Health Care and Medicaid Budget Crises

An integrated approach, utilizing both private long-term health care insurance and Medicaid re-insurance, would provide middle-income individuals with a dignified alternative to Medicaid planning. Under this type of program the poor still could rely on Medicaid to cover a portion of their long-term care expenses. In fact, because Medicaid Estate Planning should decrease under such an arrangement, more funds should be available for care of the truly needy. At the same time, an integrated approach would allow the middle class elderly to “finish well” by offering a dignified and responsible means of financing long-term health care. This approach would allow them to preserve a reasonable portion of their assets and rely on the safety net of Medicaid for extraordinary expenses.

280. See id. at 374 (declaring that “individuals who can afford to protect themselves against the risk of long-term care should be given strong incentives to do so, while scarce public resources are preserved for those most in need”); id. at 403-04 (statement of Steven Chies on behalf of American Health Care Association). Mr. Chies stated: we should encourage and enforce an expectation of personal responsibility on the part of those with access to the means to plan for and pay for long term care. Government must help in this effort through measures to ensure that individuals have the information and resources they need to take on personal responsibility for meeting their long term care needs. . . . AHCA’s plan calls for public education . . . [and] incentives.

Id.

281. Although these steps are listed individually, they are mutually dependent. See supra note 277 (relating these steps).

282. A “middle-income” individual is defined here as “one which has managed to accumulate assets from, say, $100,000 to $400,000 or so, over and above the home.” See Burwell, supra note 12, at 7 (emphasis in original) (quoting Alexander Bove, The Medicaid Planning Handbook: A Guide to Protecting the Assets of Massachusetts Families (1990)).

283. “Poor” in this case refers specifically to the “categorically needy” and the “optionally categorically eligible.” See discussion supra part I.A (describing these categories).

284. See Hearings, supra note 16, at 365 (statement of Sheldon L. Goldberg, President, American Association of Homes for the Aging) (declaring that “[f]or every Medicaid dollar spent on someone who divested significant resources to qualify for public assistance, one less dollar is spent on the truly disadvantaged who literally have no other alternatives”).

285. See supra note 261 and accompanying text (describing the concept of “finishing well” in relation to long-term health care financing options).
Finally, an effective integrated program also could prevent potential abuse by wealthy individuals who otherwise never would spend-down to Medicaid eligibility.286 For example, a "dollar-for-dollar" asset protection framework would protect assets only up to the extent of an individual's benefit.287 To protect a large amount of assets under a "dollar-for-dollar" scheme, a very wealthy individual would have to purchase insurance that provides extremely high levels of benefits.288 In that unlikely event, although Medicaid would cover some of the costs for this wealthy individual, the individual's purchase of such large amounts of long-term care insurance would greatly expand the risk pool. This would allow insurance benefit levels to be increased, thereby indirectly saving money within the Medicaid program.289

V. Conclusion

Medicaid planning has allowed many individuals, who otherwise would not be eligible for taxpayer financed long-term health care, to qualify for Medicaid. In response, Congress has attempted to develop Medicaid eligibility rules to limit this practice. Indeed, under OBRA '93, Congress made it more difficult for individuals to qualify for Medicaid through planned divestiture.

Nonetheless, OBRA '93 remains inadequate on two levels of analysis. First, the legislation failed to address several well-known planning options. Second, and more fundamentally, the legislation ignores the underlying problem motivating Medicaid Estate Planning—the lack of long-term care financing options. To the contrary, by thwarting expansion of integrated public-private partnerships for long-term care financing, OBRA '93 tragically undermines the most viable option for addressing this crisis. Thus, for many Americans, Medicaid Estate Planning will re-

286. Apparently, concern for abuse of this system by the very wealthy was one factor motivating Congress to preclude the expansion of integrated plans. See PRICE, supra note 260, at 41 (noting that this was among the concerns expressed about the integrated plans already in operation).

287. See supra note 256 (distinguishing dollar-for-dollar asset protection from unlimited asset protection).

288. See supra note 256 (distinguishing dollar-for-dollar asset protection from unlimited asset protection).

289. This is especially true in light of the fact that, although the health care expenses of each wealthy individual can be expected to be no greater than that of the average person, wealthy individuals will purchase more insurance to protect more assets. In this way they will expand the risk pool for insurance more than the average purchaser, but will not burden the Medicaid program any more than the average person.
main the most rational method of financing long-term care, and Congress' ersatz solution to the long-term health care crisis.

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