

# MEDICAID: A SAFETY NET FOR THE “WEALTHY”

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## I. INTRODUCTION

At a time when the cost of long-term nursing home care is exceptionally high, most older middle-class Americans are struggling to foot the bill for the care they require. For wealthy Americans, on the other hand, this is a time of opportunity. Medicaid is a public assistance program initially intended to be a safety net for the truly needy, i.e., the individuals with low income and the medically needy.<sup>1</sup> However, Medicaid has become the primary payer for long-term care in the United States despite its intended role as a “safety net.”<sup>2</sup> Due to medical technology advancements and increases in life expectancy, long-term care has become so expensive that only a few can afford it.<sup>3</sup> Those facing a lengthy nursing home stay have two choices: deplete their lifetime savings until they are poor enough to qualify for Medicaid or engage in Medicaid planning to protect their assets. Wealthy couples quite easily can, and do, choose the latter.

As with everything in life, those with greater means have greater options. So, while the government takes measures to restrict Medicaid for the needy, members of the upper class have uncovered a slew of alternative legal strategies to qualify them for Medicaid benefits, nonetheless. During her 2011 congressional testimony, one 36-year career Medicaid eligibility supervisor provided a witness account of wealthy individuals repositioning significant resources to qualify for Medicaid:

It is *not at all unusual* to encounter individuals and couples with resources *exceeding a half million dollars*, some with *over one million*. There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant’s nursing home care. Wealthy applicants for Medicaid’s nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves.<sup>4</sup>

Moreover, research published in the American Economic Review discovered that

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1. Christopher J. Truffer et al., *2016 Actuarial Report on the Financial Outlook for Medicaid*, CTR. MEDICARE & MEDICAID SERVS. 1, 2 (2016), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf> [<https://perma.cc/RVH8-Z2LE>].

2. *Id.*

3. See generally Chris Pope, *Taking the Strain Off Medicaid’s Long-Term Care Program*, MANHATTAN INST. 1 (2020), <https://media4.manhattan-institute.org/sites/default/files/taking-strain-off-medicaids-long-term-care-program-CP.pdf> [<https://perma.cc/C3R8-EH6E>].

4. Stephen A. Moses, *How to Fix Long-Term Care Financing*, FOUND. GOV. ACCOUNTABILITY 1, 10 (2017), <https://thefga.org/wp-content/uploads/2017/07/How-To-Fix-Long-Term-Care-Financing.pdf> [<https://perma.cc/WS8Q-3FZE>] (emphasis added).

not only can the wealthy enroll in Medicaid, but when they do, their long-term care costs taxpayers more than long-term care for low-income individuals.<sup>5</sup>

This Note primarily applies where one spouse is seeking Medicaid benefits for nursing facility care and the other spouse remains at home. The nursing home applicant is the “institutionalized spouse,” while the spouse not seeking Medicaid benefits is the “community spouse.”<sup>6</sup> Part II of this Note briefly explains the Medicaid program and its history. Part III provides insight into the costs and budgetary impact of financing long-term care in America. Part IV discusses Medicaid’s eligibility requirements and penalties. Part V illustrates commonly used Medicaid planning techniques to preserve assets and gain Medicaid eligibility. Part VI explores a handful of proposals for reforming the Medicaid program. Part VII looks at an innovative partnership program offered by many states to encourage Americans to purchase private long-term care insurance. Finally, Part VIII provides a brief perspective and suggests the Medicaid program embrace rather than discourage the wealthy elderly from using Medicaid.

## II. AN OVERVIEW OF THE MEDICAID PROGRAM

Medicaid was first established by Congress in 1965 as part of the Social Security Act in response to the widespread perception that welfare medical care provided under public assistance was inadequate.<sup>7</sup> The federal government primarily funds Medicaid; however, Medicaid is administered exclusively by the states.<sup>8</sup> While state participation in the Medicaid program is technically voluntary, all 50 states have participated since 1982.<sup>9</sup> “[I]n exchange for federal funding, participating states must comply with the requirements imposed by the [Medicaid] Act and with regulations promulgated by the Secretary of Health and Human Services” (“HHS”).<sup>10</sup> The Centers for Medicare and Medicaid Services (“CMS”), a division of HHS, maintains oversight of state-administered Medicaid programs.<sup>11</sup> As long as the minimum requirements promulgated by HHS are met, states have relatively broad discretion in deciding whom to cover, what eligibility

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5. Pope, *supra* note 3, at 9.

6. Andrew D. Wone, *Don't Want to Pay for Your Institutionalized Spouse? The Role of Spousal Refusal and Medicaid in Funding Long-Term Care*, 14 ELDER L.J. 485, 493 (2006).

7. Barbara S. Klees et al., *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act*, CTRS. MEDICAID & MEDICARE SERVS. 1, 3 (2009), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-programratesstats/downloads/medicaremedicaidsummaries2009.pdf> [https://perma.cc/9JHU-QH8U].

8. Jeffrey R. Grimyser, *Missing the Forest for the Trees: Why Supplemental Needs Trusts Should Be Exempt from Medicaid Determinations*, 89 CHI.-KENT L. REV. 439, 441-42 (2014).

9. *Id.*

10. Missouri Dep't of Soc. Servs., Div. of Med. Servs. v. Great Plains Hosp., Inc., 930 S.W.2d 429, 431 (Mo. Ct. App. 1996).

11. John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 13 CORNELL J.L. & PUB. POL'Y 81, 85 (2003).

limits to set, and what medical services to cover.<sup>12</sup> While it sounds relatively straightforward on paper, interrupting the complex Medicaid Act is no easy feat for anyone, including the states and CMS themselves. One U.S. District Court summarized this complexity the best:

The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize. The Act has been called ‘an aggravated assault on the English language, resistant to attempts to understand it.’ The Medicaid Act has been characterized as one of the ‘most completely impenetrable texts within human experience’ and ‘dense reading of the most tortuous kind.’ The court has nothing but sympathy for officials who must interpret or administer the Act.<sup>13</sup>

Because of the complexity of the Medicaid Act and the broad discretion afforded to states, there is considerable variation in Medicaid programs across the county. For simplicity’s sake, this Note will reference a combination of Indiana and federal Medicaid requirements where applicable.

It is essential to note the distinction between Medicare and Medicaid. Generally, Medicare is the primary source of healthcare for people age 65 and older.<sup>14</sup> Medicare covers medically necessary services such as prescription drugs, lab tests, hospice care, and surgery.<sup>15</sup> Medicare does not provide long-term care benefits, most often associated with custodial care in a nursing home.<sup>16</sup> Under limited circumstances, Medicare may provide limited coverage for custodial care in a nursing home if a doctor orders the care as a follow-up to a qualifying inpatient hospital stay and if the care is related to the delivery of specialized medical services or rehabilitation.<sup>17</sup> Even then, Medicare only covers the total cost of custodial care in a nursing home for 20 days.<sup>18</sup> For days 20 through 100, Medicare’s coverage of custodial care in a nursing home is limited, and a daily coinsurance applies – \$185.50 per day in 2021.<sup>19</sup> After 100 days, Medicare

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12. Crystal Francis et al., *Medicaid for the Elderly and Disabled in Indiana*, IND. CONTINUING LEGAL EDUC. F. 1, 3 (2018).

13. *Mertz ex rel. v. Houstoun*, 155 F. Supp. 2d 415, 420 (E.D. Pa. 2001) (internal citations omitted).

14. Lita Epstein, *Medicaid and Nursing Homes: A Quick Guide to the Rules*, INVESTOPEDIA, <https://www.investopedia.com/articles/personal-finance/072215/quick-guide-medicare-and-nursing-home-rules.asp> [<https://perma.cc/3AKP-6XVJ>] (last updated Aug. 19, 2020).

15. Jill Seladi-Schulman, *Medicare Coverage for Long-Term Care: What You Need to Know*, HEALTHLINE (May 5, 2020), <https://www.healthline.com/health/medicare/does-medicare-cover-long-term-care#types-of-long-term-care> [<https://perma.cc/W5SP-EAT3>].

16. Epstein, *supra* note 14.

17. *Id.*

18. *Skilled Nursing Facility (SNF) Care*, MEDICARE.GOV, <https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care> [<https://perma.cc/5X4D-6CMN>] (last visited Mar. 11, 2021).

19. *Id.*

coverage ends, leaving the patient responsible for the entire cost of custodial care from that point on.<sup>20</sup> On the other hand, Medicaid includes coverage for most long-term care services and does not impose a durational limit on coverage.<sup>21</sup> Medicaid provides coverage for preventative, acute, and long-term care medical services for low-income individuals and individuals with disabilities.<sup>22</sup> In addition to income, Medicaid eligibility is based on additional factors, such as age, disability, other government assistance, other medical conditions, and financial resources (or assets).<sup>23</sup>

### III. FINANCING LONG-TERM CARE IN AMERICA

Healthcare in America is expensive. However, long-term care in America is unconscionably expensive. Fidelity Investments estimates that the average 65-year old couple *with* Medicare insurance will need approximately \$295,000 to cover medical expenses during retirement, *not including* long-term care expenses such as nursing home care.<sup>24</sup> When factoring in long-term care expenses from age 65 to death, the same couple would need an *additional* \$276,000 to \$500,000.<sup>25</sup> This is especially alarming, considering the median retirement savings among baby boomers is only \$288,000 per couple<sup>26</sup> – well short of the \$571,000 to \$795,000 that may be needed for medical and long-term care.<sup>27</sup>

Unfortunately, it is not a question of *if* those age 65 and older will need long-term care; it is a question of *when* they will need it. Of individuals reaching age 65, an estimated 70% will develop significant long-term care needs.<sup>28</sup> The number of Americans requiring long-term care is expected to more than double from 12 million in 2010 to a staggering 27 million by 2050.<sup>29</sup> While this increase may be attributed to the baby boomers, it can also be attributed to the rising life

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20. *Id.*

21. *Medicaid Coverage of Nursing Home Care: When, Where and How Much They Pay*, AM. COUNCIL ON AGING, <https://www.medicaidplanningassistance.org/medicaid-and-nursing-homes/> [https://perma.cc/M2AK-Z2SJ] (last updated Jan. 11, 2021).

22. See Alison Mitchell et al., *Medicare: An Overview*, CONG. RSCH. SERV. 1, 8 (2021), <https://fas.org/sgp/crs/misc/R43357.pdf> [https://perma.cc/J8GH-9WNX].

23. Truffer et al., *supra* note 1, at 2.

24. *How to Plan for Rising Health Care Costs*, FIDELITY (Aug. 31, 2021) [www.fidelity.com/viewpoints/retirement/retiree-health-costs-rise](http://www.fidelity.com/viewpoints/retirement/retiree-health-costs-rise) [https://perma.cc/29XY-5RVE].

25. Pope, *supra* note 3, at 6 (providing average *individual* long-term care expenses).

26. See Maurie Backman, *The Median Retirement Savings Balance Among Baby Boomers is Shockingly Low*, MOTLEY FOOL (June 15, 2020, 7:18 AM), <https://www.fool.com/retirement/2020/06/15/the-median-retirement-savings-balance-among-baby-b.aspx> [https://perma.cc/DL8G-45AT].

27. See *How to Plan for Rising Health Care Costs*, *supra* note 24; see also Pope, *supra* note 3, at 6.

28. Pope, *supra* note 3, at 6.

29. *Id.* at 5.

expectancy and significant advances in healthcare delivery.<sup>30</sup> The increase in the amount of elderly needing long-term care is sure to place a heavy burden on Medicaid and, ultimately, the working-age taxpayer (defined as persons aged 18 to 64).<sup>31</sup> In 2000 the ratio of working-age persons for every person age 65 and older was 5, but by 2030, the ratio will have dropped to only 2.9 working-age persons for every person age 65 and older – a whopping 44% decrease.<sup>32</sup> As this ratio drops, working-age taxpayers are likely to see a more significant portion of their earnings taxed to support the growing Medicaid program.

Medicaid spending represents a significant portion of state and federal budgets.<sup>33</sup> In 2015, federal and state spending on Medicaid totaled \$554 billion.<sup>34</sup> Moreover, Medicaid represents an estimated 28% of all state government spending.<sup>35</sup> Interestingly, Medicaid, not Medicare or private insurance, is the largest funding source for long-term care in the United States.<sup>36</sup> Of the \$379 billion spent on long-term care in 2018, Medicaid accounted for a whopping 52%, whereas private insurance, out-of-pocket spending, and other payers only accounted for 16%, 11%, and 20%, respectively.<sup>37</sup>

The intensity of care required drives much of the expense associated with an individual’s long-term care.<sup>38</sup> In 2019, annual costs averaged \$22,100 for adult daycare, \$49,200 for an assisted-living facility, \$52,624 for a home health aid, \$84,253 for a semi-private nursing home room, and \$102,200 for a private nursing home room.<sup>39</sup> The median wealth of the elderly admitted to nursing homes averages \$108,000 at the time of admission but quickly declines to about \$5,000 after only six months of long-term care-related expenses.<sup>40</sup> Of those admitted to nursing homes, only an estimated 14% had long-term care insurance.<sup>41</sup>

#### IV. ELIGIBILITY FOR MEDICAID LONG-TERM CARE BENEFITS

To qualify for Medicaid benefits, the applicant must first satisfy income and

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30. *Id.*

31. *Old-Age Support Ratio*, POPULATION REFERENCE BUREAU, <https://www.prb.org/usdata/indicator/elderly-support-ratio/snapshot/> [<https://perma.cc/ZGF4-GL8E>] (last visited Feb. 12, 2021).

32. *Id.*

33. Truffer et al., *supra* note 1, at 34.

34. *Id.* at 5.

35. *Id.* at 34.

36. *Id.* at 33.

37. Pope, *supra* note 3, at 6.

38. *Id.*

39. *Cost of Care Survey*, GENWORTH, <https://www.genworth.com/aging-and-you/finances/cost-of-care.html> [<https://perma.cc/J822-2BEP>] (last visited Nov. 8, 2020).

40. Pope, *supra* note 3, at 7.

41. *Id.*

resource requirements set by the state and federal Medicaid laws.<sup>42</sup> Before 1988, Medicaid subjected married couples to the same asset limitations as individuals, even if *only* one spouse sought benefits.<sup>43</sup> If the married couple had assets above the maximum allowance, they had to “spend down” all of their collective assets until the assets were within the permissible limit.<sup>44</sup> However, the asset spend-down usually left the community spouse impoverished, leaving many elderly couples to divorce as a strategy for avoiding poverty.<sup>45</sup> Congress recognized that problem and subsequently passed the “spousal impoverishment provisions” of the Medicare Catastrophic Coverage Act of 1988.<sup>46</sup>

[The spousal impoverishment provisions] were designed to ensure that the community spouse had a necessary, but not excessive, amount of assets protected from inclusion in the institutionalized spouse’s eligibility for Medicaid, and as such, these exempt assets did not need to be ‘spent down’ for the institutionalized spouse’s care.<sup>47</sup>

This Note will highlight that the legislature may have provided married couples with too much leniency. To be clear, the spousal impoverishment provisions apply when a married individual is seeking Medicaid long-term care benefits; they do not apply when an individual is seeking benefits under the traditional state Medicaid program (i.e., no long-term care benefits).<sup>48</sup>

#### *A. Income Eligibility*

For eligibility purposes, “income” means the applicant’s gross income minus Medicaid-permitted deductions, such as health insurance premiums, taxes, court-ordered payments,<sup>49</sup> and medical expenses not covered by Medicaid.<sup>50</sup> Typical income sources for elderly nursing home applicants include Social Security benefits, pensions, and interest from investments.<sup>51</sup> For an individual to be eligible for traditional Medicaid benefits, the income limit usually is 100% of the

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42. See generally 42 U.S.C. § 1396 *et seq.*; see also IND. CODE § 12-15 *et seq.* (2021).

43. Elizabeth D. Lauzon, Annotation, *Application of “Spousal Impoverishment Provisions” of Medicare Catastrophic Coverage Act (42 U.S.C.A. § 1396r-5)*, 186 A.L.R. Fed. 437 § 2[a] (2003).

44. *Id.*

45. *Id.*

46. *Id.*; see 42 U.S.C. § 1396r-5.

47. Lauzon, *supra* note 43.

48. *How Medicaid’s Minimum Monthly Maintenance Needs Allowance Works & 2021 Limits*, AM. COUNCIL ON AGING, <https://www.medicaidplanningassistance.org/mmmna-definition/> [<https://perma.cc/4M4S-EXW4>] (last updated Jan. 4, 2021).

49. See, e.g., *Mulder v. S.D. Dep’t of Soc. Servs.*, 675 N.W.2d 212 (S.D. 2004).

50. See generally IND. FAM. & SOC. SERVS. ADMIN., IND. HEALTH COVERAGE PROGRAM POLICY MANUAL § 3455.15.10 (2016), [https://www.in.gov/fssa/ompp/files/Medicaid\\_PM\\_3400.pdf](https://www.in.gov/fssa/ompp/files/Medicaid_PM_3400.pdf) [<https://perma.cc/3BLL-ZBW5>].

51. Lauzon, *supra* note 43.

federal poverty level.<sup>52</sup> While this income cap works for the traditional Medicaid program, it does not work for determining eligibility for nursing home care;<sup>53</sup> nursing home care averages \$84,253 for a semi-private nursing home room and \$102,200 for a private nursing home room.<sup>54</sup> Because the traditional income cap would leave too many elderly unable to pay for long-term care but too “rich” to qualify for Medicaid, the legislature established a higher income cap for determining Medicaid eligibility for nursing home residents.<sup>55</sup> Under the increased income cap, the applicant’s income may not exceed 300% of the Supplemental Security Income level – currently \$2,382 per month (or \$28,584 per year) for 2021.<sup>56</sup>

The preceding income rules apply to every Medicaid applicant, but due to the spousal impoverishment provisions, some special rules apply when determining a married applicant’s income. First, all income received *solely* by the institutionalized spouse is attributed to the institutionalized spouse for the eligibility assessment.<sup>57</sup> Second, income received *solely* by the community spouse is neither factored into the income eligibility assessment nor considered available to the institutionalized spouse after eligibility is established and institutionalization has occurred.<sup>58</sup> Third, concerning the income received by the couple *jointly*, half is considered income of the community spouse (thus, excluded from the eligibility assessment), and the other half is considered income of the institutionalized spouse (thus, factored into the eligibility assessment).<sup>59</sup> Once the institutionalized spouse’s income is determined, it must not exceed the 300% Social Security Income level threshold described above.<sup>60</sup> However, if an applicant’s income exceeds the eligibility income cap, he may still qualify for Medicaid benefits if he allocates the income over the cap into a Supplemental Needs Trust, more famously known as a “Miller Trust.”<sup>61</sup> Because Miller Trusts

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52. See 42 U.S.C. § 1382(a)(2). Under the regular Medicaid income eligibility rules for 2021, an individual applicant must not have income exceeding \$1,752 per month, or \$21,024 per year. A married applicant *and* his spouse must not have a combined income exceeding \$2,628 per month, or \$31,536 per year, regardless of if the spouse is not seeking benefits.

53. Francis et al., *supra* note 12, at 96.

54. *Cost of Care Survey*, *supra* note 39.

55. Francis et al., *supra* note 12, at 96-97 (the higher income cap for nursing home residents may also be referred to as the “Special Income Level”).

56. IND. FAM. & SOC. SERVS ADMIN., IND. HEALTH COVERAGE PROGRAM POLICY MANUAL § 3010.20.15 (2016), [https://www.in.gov/fssa/ompp/files/Medicaid\\_PM\\_3000.pdf](https://www.in.gov/fssa/ompp/files/Medicaid_PM_3000.pdf) [<https://perma.cc/JH2L-T2DQ>] [hereinafter Ind. Health Coverage Program Policy Manual]; Francis et al., *supra* note 12, at 96-97.

57. Francis et al., *supra* note 12, at 96-97; see IND. CODE § 12-15-3-1.5 (2021).

58. 42 U.S.C. § 1396r-5(b)(1); IND. CODE § 12-15-3-1.5.

59. *Spousal Impoverishment Protection Law*, IND. LONG TERM CARE INS. PROGRAM, <https://www.in.gov/iltcp/2340.htm> [<https://perma.cc/Y738-QBVE>] (last visited Mar. 29, 2021).

60. Wone, *supra* note 6.

61. Grimyser, *supra* note 8, at 447-48; see generally 42 U.S.C. § 1396p. The Miller Trust gets its name from *Miller v. Ibarra*, 746 F. Supp. 19 (D. Colo. 1990), which held that trusts

are frequently misunderstood and misrepresented, the following paragraph will deviate briefly to provide a clarifying overview of Miller Trusts.

“A trust is a fiduciary relationship in which a trustor gives another party, known as the trustee, the right to hold title to property or assets for the benefit of a third party.”<sup>62</sup> Because the beneficiary, or Medicaid applicant, does not technically own the assets held in the trust, he can utilize the trust to avoid specific legal requirements.<sup>63</sup> Concerning Medicaid eligibility, an applicant with income exceeding the income cap cannot qualify for Medicaid benefits unless he puts his excess income in a Miller Trust.<sup>64</sup> The now-Medicaid-eligible individual may then use the assets held in the Miller Trust to pay for services and items not covered by Medicaid – such as specialized therapy, clothing, toiletries, television, and books.<sup>65</sup> Interestingly, the common misconception between laypersons and some professionals alike is that a Miller Trust is some creative tool utilized by the wealthy to shelter assets. However, this is not the case because the Medicaid statute limits the potential for abuse by imposing two critical conditions.<sup>66</sup> First, Medicaid requires the use of the assets held by the trust only for the beneficiary of the trust, i.e., the individual receiving Medicaid benefits.<sup>67</sup> Second, Medicaid must be the sole beneficiary of the trust upon the individual’s death so that any remaining assets reimburse the state for its expenses.<sup>68</sup> In reality, the Miller Trust represents a “bargain” between the trust beneficiary and the state: “[t]he beneficiary remains eligible for Medicaid while using the [trust]..., but the state will be paid back before the beneficiary may give any remaining assets to his or her heirs.”<sup>69</sup>

Once the institutionalized spouse satisfies the income eligibility assessment, (which is easy to do thanks to the Miller Trust, as discussed in the deviating paragraph above), the next step is to determine how much of his income he must contribute toward his respective nursing home expenses (referred to as monthly “liability”).<sup>70</sup> Medicaid provides a limited amount of deductions when computing monthly liability.<sup>71</sup> Common deductions from the institutionalized spouse’s monthly liability include

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consisting of the income of nursing home residents were not countable income for Medicaid eligibility.

62. Julia Kagan, *Trust*, INVESTOPEDIA, <https://www.investopedia.com/terms/t/trust.asp> [<https://perma.cc/D6XS-QKBU>] (last updated Oct. 19, 2020).

63. Grimyser, *supra* note 8, at 443.

64. *What Are the Uses for a Miller Trust?*, HG.ORG, <https://www.hg.org/legal-articles/what-are-the-uses-for-a-miller-trust-45532> [<https://perma.cc/HS9W-49ZV>] (last visited Feb. 12, 2021).

65. Grimyser, *supra* note 8, at 443.

66. 42 U.S.C. § 1396p.

67. Grimyser, *supra* note 8, at 468.

68. *Id.* at 448.

69. *Id.*

70. Wone, *supra* note 6; *see* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 56, § 3455.15.00.

71. *See* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 56, § 3455.15.00.

- (1) a personal needs allowance of \$52 per month (which may be used to purchase items and services not covered by Medicaid);
- (2) health insurance premiums;
- (3) medical expenses not covered by Medicaid or a third party;
- (4) federal, state, and local income tax; and
- (5) a Minimum Monthly Maintenance Needs Allowance (“MMMNA”) for the community spouse.<sup>72</sup>

The last deduction mentioned, the MMMNA, represents an enormous opportunity to protect a couple’s assets and reduce the institutionalized spouse’s monthly liability. Under the spousal impoverishment provisions, the states must set a minimum monthly income allowance for the community spouse.<sup>73</sup> The allowance is deducted from income, and thus, it may not be allocated to monthly liability.<sup>74</sup> The MMMNA is established by assessing *the community spouse’s monthly income and her respective ability to pay monthly expenses* such as mortgage or rent, utilities, taxes, and other related household expenses.<sup>75</sup> MMMNA is only applicable if the community spouse’s income is under a particular limit – specifically, if her income is less than the MMMNA or her income is insufficient to pay her monthly expenses.<sup>76</sup> The MMMNA must be at least \$2,155 per month, regardless of the community spouse’s actual monthly expenses are less than that amount.<sup>77</sup> If the community spouse’s income is less than the prescribed MMMNA or her income is insufficient to cover her monthly expenses, a portion of the institutionalized spouse’s income will be allocated to her instead of his monthly liability.<sup>78</sup> However, if the institutionalized spouse’s income is also insufficient to meet the MMMNA, some of the couple’s countable income-producing resources may be allocated to the community spouse.<sup>79</sup> In summary, if the community spouse’s income is less than the MMMNA (the greater of her actual monthly expenses or \$2,155 per month), she may keep some of the institutionalized spouse’s income or some of the couple’s income-producing resources to reach the MMMNA.<sup>80</sup> However, regardless of the community spouse’s actual expenses, the MMMNA amount cannot exceed \$3,260 per month unless increased by administrative or court orders.<sup>81</sup>

### *B. Resource Eligibility*

Medicaid resource eligibility is determined by evaluating the resources

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72. *Id.* § 3455.15.10.

73. Lauzon, *supra* note 43.

74. *Id.*

75. Francis et al., *supra* note 12, at 106.

76. Lauzon, *supra* note 43.

77. *Spousal Impoverishment Protection Law*, *supra* note 59.

78. Lauzon, *supra* note 43.

79. *Id.*

80. *Spousal Impoverishment Protection Law*, *supra* note 59; Lauzon, *supra* note 43.

81. Lauzon, *supra* note 43.

owned by the institutionalized spouse solely as well as the resources owned by the couple jointly.<sup>82</sup> The value of the couple's resources is determined on the "snapshot date."<sup>83</sup> The snapshot date is the first day of a continuous thirty-day period of the institutionalized spouse's institutionalization.<sup>84</sup> On the snapshot, the couple's resources are classified as "exempt" or "countable." Only countable resources that are "available" are considered when making the resource eligibility determination in Indiana.<sup>85</sup> Resources are considered available if either spouse "has the right, authority *or* ability to liquidate the property, or [their] share of the property."<sup>86</sup>

Generally, the following are countable resources

- (1) cash;<sup>87</sup>
- (2) bank assets (checking, savings, CDs);<sup>88</sup>
- (3) the cash surrender value of life insurance;<sup>89</sup>
- (4) stocks and bonds;<sup>90</sup>
- (5) IRAs, 401(k)s, 527(b)s, and other tax-deferred accounts owned by the institutionalized spouse;<sup>91</sup>
- (6) pensions and other retirement plans;<sup>92</sup>
- (7) real property (if not exempt in the list below).<sup>93</sup>

Conversely, the following are generally exempt (not counted) resources

- (1) irrevocable burial and funeral trusts (including those purchased for

82. Wone, *supra* note 6, at 494.

83. Lauzon, *supra* note 43.

84. 42 U.S.C. § 1396r-5(c)(1)(A).

85. *See* 405 IND. ADMIN. CODE 2-3-14 (2021).

86. *Id.*; *see generally* Willford v. N.C. HHS, 792 S.E.2d 843 (N.C. Ct. App. 2016) (holding that \$46,000 held in a workers' compensation Medicare-set-aside account was not a countable resource because the individual legally could not use the funds for purposes other than covering medical expenses arising from the work injury).

87. *Exempt and Non-Exempt Resources*, IND. LONG TERM CARE INS. PROGRAM, <https://www.in.gov/iltcp/2426.htm> [<https://perma.cc/WG23-SKCD>] (last visited Feb. 15, 2021); IND. FAM. & SOC. SERVS ADMIN., IND. HEALTH COVERAGE PROGRAM POLICY MANUAL § 2615.05.00 (2016), [https://www.in.gov/fssa/ompp/files/Medicaid\\_PM\\_2600.pdf](https://www.in.gov/fssa/ompp/files/Medicaid_PM_2600.pdf) [<https://perma.cc/9TJG-KPML>] [hereinafter IND. HEALTH COVERAGE PROGRAM POLICY MANUAL].

88. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.10.00.

89. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.25.05.

90. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.45.00.

91. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.15.00.

92. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.15.00.

93. *Exempt and Non-Exempt Resources*, *supra* note 87 (noting capital gains, interest, and dividends received earned by a countable resource are considered countable income).

the community spouse, the couple’s children, and the spouses of their children);<sup>94</sup>

- (2) home (there is a cap of \$603,000 on the amount of equity the couple or institutionalized spouse can have in the home; however, the equity cap does not apply if the community spouse is still living in the home);<sup>95</sup>
- (3) real property owned *solely* by the community spouse (*no cap*);<sup>96</sup>
- (4) income-producing real property (if the income generated is greater than the expense of ownership);<sup>97</sup>
- (5) term life insurance with no cash surrender value;<sup>98</sup>
- (6) IRAs, 401(k)s, 527(b)s, and other tax-deferred accounts owned by the community spouse;<sup>99</sup>
- (7) personal effects and household furnishings;<sup>100</sup> and
- (8) one vehicle of *any* value.<sup>101</sup>

Once the couple’s countable resources are determined, one-half of that total is considered the community spouse’s share, and the other half is considered the institutionalized spouse’s share.<sup>102</sup> The institutionalized spouse’s share is subject to the Medicaid spend-down, meaning his share of resources must be spent down to \$2,000 before Medicaid will begin coverage of any nursing home expenses.<sup>103</sup> The community spouse’s share is known as the “Community Spouse Resource Allowance” (CSRA).<sup>104</sup> The community spouse retains the CSRA without impacting the institutionalized spouse’s eligibility.<sup>105</sup> In Indiana, the CSRA must be at least \$25, 284 but not more than \$126, 420.<sup>106</sup> If the countable resources exceed the maximum CSRA limit, the community spouse’s resources to the extent that they exceed the CSRA limit are considered available to the

94. *Id.*; Francis et al., *supra* note 12, at 154-55.

95. IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2620.15.10.06; see also *Indiana Medicaid Income & Asset Limits for Nursing Homes & In-Home Long Term Care*, AM. COUNCIL ON AGING, <https://www.medicaidplanningassistance.org/medicaid-eligibility-indiana/> [<https://perma.cc/A8BW-7DAD>] (last updated Feb. 1, 2021).

96. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2640.10.15.06.

97. *Exempt and Non-Exempt Resources*, *supra* note 87.

98. *Id.*; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, §§ 2615.25.05-2615.25.05.20.

99. IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.15.00.

100. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.30.00.

101. *Exempt and Non-Exempt Resources*, *supra* note 87; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.60.20.05.

102. Lauzon, *supra* note 43, § 3.

103. *Spousal Impoverishment Protection Law*, *supra* note 59.

104. Lauzon, *supra* note 43.

105. *Id.*

106. *Spousal Impoverishment Protection Law*, *supra* note 59.

institutional spouse and subject to the spend-down.<sup>107</sup> Once the institutionalized spouse is deemed eligible for benefits and has been in a nursing home continuously for a thirty-day period, no resources acquired by the community spouse after that time shall be deemed available to the institutionalized spouse.<sup>108</sup>

### *B. Asset Transfer Rules & Ineligibility Penalties*

The Deficit Reduction Act was signed into law in 2006 to cut Medicaid spending by an estimated \$10 billion.<sup>109</sup> The Act most notably tightened the asset transfer rules by imposing a longer, more strenuous “look-back” period.<sup>110</sup> The look-back period is a five-year period that begins on the first date on which the institutionalized spouse has applied for Medicaid benefits and is institutionalized.<sup>111</sup> Simply put, the look-back is “the period of time examined to see if an individual has transferred assets for less than fair market value.”<sup>112</sup> Generally, countable resource transfers by the institutionalized spouse or the community spouse for below fair market value within the look-back period will result in a period of Medicaid ineligibility.<sup>113</sup> The legislature has not defined “fair market value,” however, the courts have.

Fair market value is the price at which property would change hands between a willing buyer and seller where neither is under any compulsion to consummate the sale. Anything affecting the sale value on the date of the taking is a proper matter for consideration in attempting to arrive at a fair market value. Generally, all facts which an ordinarily prudent man would take into account before forming a judgment as to the market value of [the] property he contemplates purchasing are relevant and material.<sup>114</sup>

Once it has been established that a transfer for below fair market value occurred, a penalty is assessed.<sup>115</sup> The penalty is expressed in terms of months.<sup>116</sup> The

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107. Lauzon, *supra* note 43.

108. 42 U.S.C. § 1396r-5(c)(4).

109. *Deficit Reduction Act: Changes to Medicaid*, COMMONWEALTH FUND, <https://www.commonwealthfund.org/publications/newsletter-article/deficit-reduction-act-changes-medicaid> [<https://perma.cc/8K3J-9VR3>] (last visited Feb. 16, 2021).

110. *Id.*

111. 405 IND. ADMIN. CODE 2-3-1.1 (2021); *see* 42 U.S.C. § 1396p(c); *see also* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2640.10.10.

112. *Deficit Reduction Act: Changes to Medicaid*, *supra* note 109.

113. 405 IND. ADMIN. CODE 2-3-1.1; *see* 42 U.S.C. § 1396p(c); *see also* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2640.10.10.

114. *Brown v. Ind. Fam. & Soc. Servs. Admin.*, 45 N.E.3d 1233, 1238-39 (Ind. Ct. App. 2015) (citing *Southtown Props., Inc. v. City of Ft. Wayne*, 840 N.E.2d 393, 400 (Ind. Ct. App. 2006)).

115. Laura Zdyhnc, *The Perilous Path to Long-Term Care It's Not Really About Asset Protection*, BENCH & BAR. MINN. 18, 19 (2013).

116. *Id.*; *see also* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, §

number of months the penalty will last is determined by dividing the total uncompensated value of the transfer during the look-back period by the average monthly private pay rate for nursing facilities located within that state.<sup>117</sup> In Indiana, the Family and Social Services Administration establishes the average monthly private pay rate – which is \$6,681 for 2020.<sup>118</sup> For example, a transfer \$53,448 below fair market value would result in a penalty for eight months ( $\$53,448 \div \$6,681 = 8$ ). So, for the eight months following proof of eligibility, Medicaid will not pay for the individual’s long-term care expenses.<sup>119</sup> If there are multiple transfers for below fair market value, all transfers are consolidated into one penalty.<sup>120</sup> Indiana does not have a durational limit on the penalty that may be assessed as a result of transfers below fair market value.<sup>121</sup> The ineligibility penalty does not start to run until the applicant is Medicaid-eligible and would otherwise be receiving institutionalized long-term care at Medicaid’s expense.<sup>122</sup>

To be clear, not all transfers of resources during the look-back will incur a penalty. For example, no penalty is assessed if the countable resources are transferred for fair market value or adequate compensation.<sup>123</sup> Additionally, thanks to the spousal impoverishment provisions, there is no penalty for transfers of countable resources made to the community spouse for the *community spouse’s sole benefit*, even if the transfer exceeds the CSRA.<sup>124</sup> As the next section will highlight, many Medicaid planning strategies begin here. Medicaid also does not impose a penalty for the transfer of countable resources if the transfer was made *exclusively* for a purpose other than to qualify for Medicaid.<sup>125</sup> Note that the preceding transfer exception is interpreted quite narrowly on a case-by-case basis based on the applicant’s specific circumstances.<sup>126</sup> Additionally, limited transfers of resources such as household goods, personal effects, trusts, the applicant’s home, property used in a trade or business, and irrevocable annuities may be allowed subject to resource-and-situation-specific requirements.<sup>127</sup> Finally, there is no penalty for transfers that occur before the look-back – i.e., transfers made

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2640.10.35.

117. See Zdychnec, *supra* note 115; see also IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2640.10.35.

118. IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 51, § 3006.00.00.

119. Francis et al., *supra* note 12, at 133.

120. *Id.* at 148.

121. *Id.* at 150.

122. *Id.* at 148.

123. See 42 U.S.C. § 1396p(c)(2)(C); see also 405 IND. ADMIN. CODE 2-3-1.1(k)(7)(A) (2021); see generally Brown v. Indiana Family & Soc. Servs. Admin., 45 N.E.3d 1233 (Ind. Ct. App. 2015) for further discussion of transfers below fair market value.

124. See 42 U.S.C. § 1396p(c)(2)(B)(i); see also 405 IND. ADMIN. CODE 2-3-1.1(k)(2).

125. 42 U.S.C. § 1396p(c)(2)(C)(ii). Note that the individual seeking benefits must make a satisfactory showing to the State that assets were transferred exclusively for a purpose other than to qualify for Medicaid.

126. Francis et al., *supra* note 12, at 137.

127. *Id.* at 149-50.

more than five years before the Medicaid application was submitted.<sup>128</sup>

#### V. “REPOSITIONING” THE WEALTHY’S ASSETS USING MEDICAID PLANNING

The complexity of the Medicaid eligibility requirements and the lack of clear, concise, and readily accessible literature make preserving assets and avoiding ineligibility penalties no easy feat for the average elderly. However, Medicaid is also an area where foresight and access to good legal advice are rewarded. Thus, the wealthy enjoy a considerable advantage over their less wealthy counterparts when preserving assets and avoiding Medicaid penalties.<sup>129</sup> Asset repositioning is a commonly used Medicaid planning technique to convert countable resources into excluded, non-countable resources.<sup>130</sup> Simplified examples include purchasing a new car, making home improvements, prepaying funeral expenses, and paying off debt.<sup>131</sup> However, to the wealthy, these simplified examples represent the tip of the Medicaid planning iceberg. This section will sample a handful of Medicaid planning strategies employed by the wealthy. The examples in this section will follow the wealthy couple, Greg and Susan. Greg is the institutionalized spouse, and Susan is the community spouse. Greg and Susan seek to preserve their wealth while qualifying Greg for Medicaid long-term care benefits.

A common Medicaid planning strategy used by wealthy couples is the purchase and transfer of real estate.<sup>132</sup> Real estate owned solely by the community spouse is an exempt resource, and resource transfers to spouses are exempt transfers.<sup>133</sup> This means that countable real estate already owned by a couple jointly can be sheltered when it is transferred to the community spouse solely.<sup>134</sup> Additionally, a couple can use nonexempt resources (such as cash) to purchase real estate solely in the community spouse’s name.<sup>135</sup> After the snapshot date, the community spouse could keep the real estate and use it for her sole benefit; or the community spouse could transfer or sell the real estate without affecting the institutionalized spouse’s eligibility.<sup>136</sup> As mentioned previously, Indiana has a cap of \$603,000 on the amount of equity a Medicaid applicant can have in his primary home.<sup>137</sup> As long as the individual’s home equity exceeds the cap, he will be ineligible for Medicaid benefits.<sup>138</sup> However, with a married couple, the home

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128. *Id.* at 134-35.

129. Miller, *supra* note 11, at 92.

130. *Id.* at 94.

131. *Id.*

132. See Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can it be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 WM. MITCHELL L. REV. 111, 143 (2002).

133. *Id.* at 141.

134. See *id.*; Miller, *supra* note 11, at 95.

135. Francis et al., *supra* note 12, at 87.

136. Miller, *supra* note 11, at 95.

137. Francis et al., *supra* note 12, at 70.

138. *Id.*

equity cap does not apply to the couple’s jointly owned home if the community spouse is still living in the home.<sup>139</sup> More alarming, there is no limit on the value or amount of real estate the community spouse may own *solely*.<sup>140</sup> For example, Greg could still qualify for Medicaid benefits despite Susan’s sole ownership of the couple’s \$600,000 residence in Indiana, Susan’s \$400,000 condo in Florida, and Susan’s \$500,000 ski chalet in Colorado.

Another method to protect assets is to convert countable resources to income-producing real estate. Income-producing real estate is also an exempt resource, even if owned by the institutional spouse – the caveat – income generated by the real estate is countable and must be allocated toward the institutionalized spouse’s care.<sup>141</sup> The average life expectancy in a nursing home is just over two years,<sup>142</sup> so a considerable amount of resources can be protected by sacrificing a relatively small amount of income. Indiana does not require the real estate to generate a set amount of income; instead, the real estate qualifies as “income-producing” if it produces income greater than the expenses of ownership (like insurance, repairs, and taxes)<sup>143</sup> If the real estate is rented out for less than fair market value, a penalty may be assessed.<sup>144</sup> To put this method in context, as one savvy Medicaid planning attorney explained, “a couple with a second vacation home could simply rent its own home and claim the rental income as necessary for the [community] spouse’s maintenance needs, converting it into a non-countable resource.”<sup>145</sup> The perks of income-producing real estate are further compounded when a couple uses its countable resources to purchase income-producing real estate in the name of the community spouse solely, because not only is the real estate excluded, so is the income generated by the real estate since the community spouse only receives the income.<sup>146</sup> For example, imagine Greg and Susan purchase an apartment building from their son, Wilson, for \$300,000 and subsequently deed it to Susan solely. The apartment building is no longer a countable resource because it is owned by Susan, thus reducing the couple’s countable resources enough to make Greg eligible for Medicaid. After the snapshot date, Susan can sell the apartment building back to Wilson for \$300,000, or she can keep all the rental income generated by the apartment building – either way, Susan can keep all the proceeds without disqualifying Greg.

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139. *Id.*

140. 42 U.S.C. § 1396p(f)(3); *Indiana Medicaid Income & Asset Limits for Nursing Homes & In-Home Long Term Care*, *supra* note 95.

141. Francis et al., *supra* note 12, at 70.

142. David Levine & Lisa Esposito, *How to Pay for Nursing Home Costs*, U.S. NEWS (Oct. 15, 2021), <https://health.usnews.com/best-nursing-homes/articles/how-to-pay-for-nursing-home-costs>.

143. Francis et al., *supra* note 12, at 70; see IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 51, § 3420.05.05.

144. Francis et al., *supra* note 12, at 165; 405 IND. ADMIN. CODE 2-3-1.1(I) (2021); IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2640.10.25.

145. Moses, *supra* note 4.

146. See 42 U.S.C. § 1396p(f)(3); see 42 U.S.C. § 1396r-5(b)(1).

Another planning technique involves artificially increasing the amount of the couple's countable resources before the snapshot date and then reducing the countable assets after the snapshot is taken.<sup>147</sup> The higher the countable resources on the snapshot date (while still being under the eligibility threshold), the higher the CSRA.<sup>148</sup> For example, Greg and Susan have \$120,000 of countable resources in addition to owning their home.<sup>149</sup> If Greg applies for Medicaid now, Susan's CSRA will be \$60,000 (half of the couple's countable resources). However, if they take out a home equity loan of \$120,000 before the snapshot date, making the total countable resources \$240,000, Susan's CSRA will be \$120,000.<sup>150</sup> After the snapshot date, the couple can pay off the home equity loan and thus, allow Susan to keep practically *all* of the couple's original \$120,000 without disqualifying Greg.<sup>151</sup> On the other hand, Greg's half of the countable resources will have been spent down by paying off the home equity loan.

Another technique commonly used by individual applicants to pass wealth on to loved ones utilizes non-negotiable promissory notes because promissory notes, loans, and mortgages that are non-negotiable are easily qualified as exempt resources.<sup>152</sup> To qualify as an exempt resource, a promissory note must (1) have an actuarially sound repayment term, (2) require payment to be made in equal amounts throughout the term of the note, and (3) must prohibit the balance from being canceled upon the applicant's death.<sup>153</sup> Neither the federal statute nor Indiana requires a minimum repayment period or a minimum return rate for the promissory note to meet the first requirement of actuarially sound.<sup>154</sup> So, as long as the promissory note has a repayment term shorter than the applicant's life expectancy<sup>155</sup> and a reasonable interest rate, the note should be considered compliant.<sup>156</sup> For example, Greg and Susan have countable resources of \$200,000 above the maximum allowed CSRA.<sup>157</sup> Before Greg's eligibility, Susan enters into a loan agreement with Wilson where she lends him \$200,000, and in

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147. Miller, *supra* note 11, at 95-96.

148. Francis et al., *supra* note 12, at 78-80.

149. *Id.*

150. *Id.*

151. Francis et al., *supra* note 12, at 79; Miller, *supra* note 11, at 95-96.

152. See 42 U.S.C. § 1396p(c)(1)(I); see also IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.50.00.

153. 42 U.S.C. § 1396p; IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.50.00.

154. Francis et al., *supra* note 12, at 161.

155. *Id.* The life expectancy table used by the Indiana Family and Social Services Administration can be found in the IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.50.00.

156. *Id.* Consider the IRS Applicable Federal Rate when determining a reasonable interest rate.

157. See Michael Amoruso et al., *Medicaid Planning Tool Intensive for Promissory Notes and Spousal Refusal*, NAT'L ACAD. ELDER L. ATT'YS 1, 13-15 (2018), <https://www.naela.org/404.aspx?aspxerrorpath=/Custom/BSIDocumentSelector/Pages/DocumentViewer.aspx> [<https://perma.cc/W72D-GV4R>].

exchange, he issues her a non-negotiable promissory note. Wilson’s promissory note has a 6-month term, an interest rate of 2% per year, and provides for payments to be made in equal amounts on a monthly basis. As a result, the couple’s resources have sufficiently decreased below the CSRA limit, making Greg eligible.<sup>158</sup> Over the next six months, Wilson will pay Susan a total of \$202,000 ( $\$200,000 \times 2\% \text{ annual interest} \times 0.5 \text{ years} = \$202,000$ ). Because Wilson’s payments occur after Greg is receiving Medicaid benefits, the entire \$202,000 Susan receives from Wilson is exempt income under the spousal impoverishment rules. Alarming, it appears as if 100% of the spend-down can be avoided by using a non-negotiable promissory alone since federal and state laws are silent on a maximum amount permissible.<sup>159</sup>

## VI. REFORM PROPOSALS

Numerous proposals have been set forth to rein in the Medicaid “loopholes” exploited by Medicaid planning; and, more generally, the issue of financing long-term care in America.<sup>160</sup> While more radical reform proposals highlighted in this section look to significantly overhaul or repeal the current Medicaid program, more moderate proposals look to reduce America’s reliance on Medicaid long-term care benefits. For ease of discussion, this section will group reform proposals into generalized categories.

During the 2020 Democratic presidential primaries, Elizabeth Warren and Bernie Sanders proposed to repeal the Medicaid program in its entirety and replace it as part of universal healthcare coverage – i.e., “Medicare for All.”<sup>161</sup> Under Medicare for All, the income and eligibility tests associated with Medicaid eligibility would be eliminated.<sup>162</sup> However, only long-term care services deemed “medically necessary and appropriate” by CMS would be covered – with eligibility and provider reimbursement rates left entirely to CMS executive discretion.<sup>163</sup> Moreover, “[s]pending at each nursing home would be capped by law, and private payment for equivalent services by long-term care insurance, life insurance, or personal funds would have been prohibited.”<sup>164</sup>

The second category of reform proposals looks to discourage expensive nursing home admissions altogether by increasing the support given to family caregivers. More than 17 million Americans currently provide some form of long-term care assistance to elderly family members.<sup>165</sup> Interestingly, in 2013 “[t]he

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158. *Id.* at 18.

159. *See* 42 U.S.C. § 1396p(c)(1)(I); *see also* IND. HEALTH COVERAGE PROGRAM POLICY MANUAL, *supra* note 87, § 2615.50.00.

160. Pope, *supra* note 3, at 5-6.

161. *Id.* at 8.

162. *Id.*

163. *Id.*

164. *Id.*

165. Everette James et al., *In This Next Phase of Health Reform, We Cannot Overlook Long Term Care*, HEALTH AFFAIRS (Mar. 16, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog>

Congressional Budget Office[estimated the value of informal LTC provided [by family caregivers] to be greater than what was then spent on formal care” – \$234 billion and \$192 billion, respectively.”<sup>166</sup> Better yet, family caregivers often provide long-term care assistance with little to no cost to public programs like Medicaid.<sup>167</sup> However, while there is little to no cost on the Medicaid program, family caregiving is by no means free. “[T]he cost of family caregiving can be felt in other areas, such as reduction or loss of work productivity or increased risk of illness and injury.”<sup>168</sup> President Joe Biden has previously suggested that providing family caregivers a \$5,000 non-refundable tax credit would help ease the financial burden of family caregiving and encourage more families to look after their elderly relatives.<sup>169</sup> While a \$5,000 non-refundable tax credit is a decent start, it is likely insufficient, considering a 2011 MetLife study estimates that leaving the workforce to provide care for an elderly parent costs women an average of \$324,044 in lifetime wages and benefits.<sup>170</sup>

The third category of proposals suggests raising Medicaid’s current resource limit or establishing tiered Medicaid eligibility and benefits levels.<sup>171</sup> This approach is centralized on solving the all but unique predicament where the lower-middle-class members are too rich to qualify for Medicaid but too poor to pay for long-term care.<sup>172</sup> Proponents argue that if the elderly were allowed to leave a modest inheritance for their loved ones or were allowed limited Medicaid benefits despite their increased resources, fewer people would engage in asset repositioning.<sup>173</sup> These proponents further argue, “[t]he denial of a poor person’s right to leave a modest inheritance to his loved ones at a time when the super-wealthy are being excused from paying estate taxes is simply unconscionable.”<sup>174</sup>

The fourth category of proposals attempts to discourage reliance on Medicaid by encouraging more Americans to plan and save for long-term care, just as they do for retirement (or as they *should* be doing for retirement). The possibility of individual medical accounts (“IMAs”), a variant on the individual retirement account, has been raised.<sup>175</sup> Proponents argue IMAs would provide individuals tax advantages to save for long-term care, thus reducing American reliance on

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20170316.059218/full/ [https://perma.cc/CEN2-WLRX].

166. Pope, *supra* note 3, at 6.

167. James et al., *supra* note 165.

168. *Id.*

169. Pope, *supra* note 3, at 8.

170. *Id.* at 6.

171. See Miller, *supra* note 11, at 107; Cf. Vernon K. Smith et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, KAISER FAM. FOUND. 1, 8 (2001), <https://www.kff.org/wp-content/uploads/2001/04/2239-eliminating-the-medicaid-asset-test.pdf> [https://perma.cc/UP7X-YRZM].

172. See generally Miller, *supra* note 11, at 107.

173. *Id.*

174. *Id.* at 107-08.

175. *Id.* at 103.

Medicaid-financed long-term care.<sup>176</sup> However, critics of IMAs quickly point out that a significant amount of those who do save may never actually need the savings since they will not require long-term care.<sup>177</sup> Additionally, critics point out that those who are likely to fund IMAs are the individuals who have the least financial need for them – i.e., the wealthy.<sup>178</sup> Moreover, many Americans are not saving enough for retirement, let alone are enough of them using the tax-advantaged retirement accounts already available to them.<sup>179</sup> According to a report published by the Federal Reserve, nearly a quarter of Americans have no retirement savings at all.<sup>180</sup> Convincing Americans to fund IMAs will undoubtedly be no easy task.

The final category of proposals encourages individuals to finance their long-term care using private long-term care insurance. Of the proposals mentioned in this section, this category seems to have the most traction. Notably, Indiana was one of the first four states to implement a creative partnership program to encourage this very goal.<sup>181</sup> Indiana’s program and partnership programs offered by other states will be discussed more thoroughly in the next section. Other than the partnership programs that will be discussed separately in the next section, other strategies to increase the use of private long-term care insurance include “allowing employees to use retirement account funds to pay long-term care insurance premiums without a federal tax penalty[and encouraging employers to offer long-term care insurance plans to employees...”<sup>182</sup> One commentator creatively suggests that an above-the-line tax credit for the total cost of private long-term care premiums would serve as a strong incentive for those who are financially suitable and healthy enough to obtain private long-term care insurance.<sup>183</sup> Similarly, another commentator suggests that allowing long-term care insurance premiums to be fully deductible would encourage private long-term care insurance ownership, just as the mortgage deduction encourages home buying.<sup>184</sup> Moreover, encouraging more people to purchase long-term care

176. *Id.*

177. *Id.*

178. *Id.*

179. Alicia Adamczyk, *25% of US Adults Have No Retirement Savings*, CNBC (May 24, 2019), <https://www.cnn.com/2019/05/24/25-percent-of-us-adults-have-no-retirement-savings-feds-finds.html> [<https://perma.cc/5NFF-6GCY>].

180. *Id.*

181. *What You Should Know About Long Term Care*, IND. LONG TERM CARE INS. PROGRAM 1, 7 (2017), <https://www.in.gov/iltep/files/2017-6-14-doi-what-you-should-know-booklet.pdf> [<https://perma.cc/269N-GK4C>].

182. James et al., *supra* note 165.

183. Carol Murin, Comment to *In This Next Phase of Health Reform, We Cannot Overlook Long Term Care*, HEALTHAFFAIRS (Mar. 16, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170316.059218/full/> [<https://perma.cc/CEN2-WLRX>].

184. Rick Dilaurenzo, Comment to *In This Next Phase of Health Reform, We Cannot Overlook Long Term Care*, HEALTHAFFAIRS (Mar. 16, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170316.059218/full/> [<https://perma.cc/CEN2-WLRX>].

insurance would strengthen the long-term care insurance market, resulting in better long-term care insurance at a better price.<sup>185</sup> Critics of this category point out that long-term insurance is likely to be purchased by the wealthy, not the middle-class, and certainly not the lower-middle-class in the “too rich, but too poor” predicament, as mentioned previously.<sup>186</sup>

## VII. LONG-TERM CARE PARTNERSHIP PROGRAMS

The Deficit Reduction Act (as discussed *supra* in section IV) not only sought to place tighter restrictions on asset transfers, it also sought to incentivize Americans to purchase private long-term care insurance.<sup>187</sup> To do such, the Act authorized states to offer unique Medicaid asset disregards for individuals who purchase qualified long-term care insurance policies under programs commonly known as “Long-Term Care Partnerships Programs.”<sup>188</sup> As mentioned in the previous section, Indiana was one of the first four states (along with California, Connecticut, and New York) to pioneer such an innovative long-term care insurance program.<sup>189</sup> Today, all but five states offer some variation of a Long-Term Care Partnership Program like Indiana’s.<sup>190</sup> Long-Term Care Partnership Programs are a partnership between state governments and private insurance companies, where the insurance companies agree to offer long-term care insurance policies that satisfy more stringent state requirements than traditional private long-term care policies.<sup>191</sup> Unlike traditional long-term care insurance policies, policies under the Long-Term Care Partnership Program protect the insured’s assets through a unique Medicaid Asset Protection feature that subjects the insured to alternative, more favorable Medicaid eligibility rules.<sup>192</sup>

If a state adopts a qualified Long-Term Care Partnership Program, the benefits paid under a qualified long-term care policy create dollar-for-dollar protection [or total asset protection] for the insured against such Medicaid spend-down requirements. Assets previously required to be spent down in order for the individual to be eligible for Medicaid coverage are now preserved for the insured or the insured’s estate, to the extent of long-term care benefits paid or payable from the qualified long-

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185. Murin, *supra* note 183; Dilaurenzo, *supra* note 184.

186. Miller, *supra* note 11, at 103, 107.

187. See Pope, *supra* note 3, at 12.

188. *Long Term Care Insurance Partnership Plans: Added Protection Ideally Suited for Middle-Income Americans*, AM. ASS’N LONG-TERM CARE INS., <https://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php> [<https://perma.cc/R478-P9VY>] (last visited Feb. 16, 2021).

189. *What You Should Know About Long Term Care*, *supra* note 181.

190. See *State Partnership Programs and Reciprocity*, N.Y. ST. PARTNERSHIP LONG TERM CARE, <https://nyspltc.health.ny.gov/reciprocitymap.htm> [<https://perma.cc/EW47-LCXV>] (last visited Feb. 13, 2021) [hereinafter *State Partnership Programs and Reciprocity*].

191. *What You Should Know About Long Term Care*, *supra* note 181.

192. *Id.* at 7-9.

term care insurance policy.<sup>193</sup>

A qualified long-term care policy may provide two basic types of asset protection: *dollar-for-dollar protection* and *total asset protection*.<sup>194</sup> Most states offer dollar-for-dollar protection; however, some states, such as Indiana, offer a combination of the two.<sup>195</sup> To qualify for total asset protection, a policy must have (1) a minimum state-set daily benefit, (2) a total benefit equal to or more than the state-set minimum for the year the policy is purchased, and (3) a benefit that increases according to the inflation protection percentage set by the state.<sup>196</sup> In Indiana, a long-term care policy with total asset protection issued in 2021 must have a daily benefit of at least \$115, a total policy benefit of at least \$430,014, and a compound inflation factor of 5%.<sup>197</sup> Both types of qualified long-term care policies protect assets from spend-down when the insured applies for Medicaid benefits after the policy’s benefits have been exhausted.<sup>198</sup> A policy with total asset protection protects all of the individual’s assets regardless of value and regardless of whether the assets are classified as countable under the Medicaid eligibility tests.<sup>199</sup> On the other hand, a policy with dollar-for-dollar protection provides asset protection equal to the amount paid out in benefits *up to* the policy maximum.<sup>200</sup>

Now apply Indiana’s Long-Term Care Partnership Program to our institutional spouse, Greg, who has \$500,000 of countable resources and a qualifying long-term care policy. For the following scenarios, Greg’s marital status and the repositioning strategies discussed previously in section V are not relevant. For scenario one, Greg’s qualifying long-term care policy has a total benefit of \$160,000 with dollar-for-dollar protection. If Greg enters a nursing home and uses up his full policy benefits of \$160,000, he may need to apply to Medicaid to pay for his continuing nursing home care. Because Greg had a qualifying long-term care policy with dollar-for-dollar protection, Medicaid will

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193. Jamie P. Hopkins et al., *Leveraging Filial Support Laws Under the State Partnership Programs to Encourage Long-Term Care Insurance*, 20 WIDENER L. REV. 165, 185 (2014).

194. *Frequently Asked Questions*, IND. LONG TERM CARE INS. PROGRAM (Oct. 2009), <https://www.in.gov/iltcp/2362.htm> [<https://perma.cc/3MUT-EFBE>].

195. Aaron Skloff, *Partnership Qualified Long Term Care Insurance Policies*, LEXISNEXIS (Dec. 12, 2009), <https://www.lexisnexis.com/legalnewsroom/estate-elder/b/estate-elder-blog/posts/partnership-qualified-long-term-care-insurance-policies> [<https://perma.cc/H8ZT-DRF4>].

196. *Frequently Asked Questions*, *supra* note 194.

197. *What You Should Know About Long Term Care*, *supra* note 181, at 9, 18. Long-term care policies issued or renewed in Indiana after June 30, 2022 will be subject to new inflation protection requirements that vary depending on the age of the insured when the policy is purchased. Individuals younger than 61 must have compound inflation protection; individuals aged 61 to 75 must have some level of inflation protection; and individuals aged 76 or greater *may* have some level of inflation protection. IND. CODE § 12-15-39.8-3(5)(A)-(C) (2021).

198. *See* Skloff, *supra* note 195.

199. *Frequently Asked Questions*, *supra* note 194.

200. *Id.*

disregard \$162,000 of his countable assets (\$160,000 of protected assets, which is equal to the insurance benefits used + \$2,000 for the standard Medicaid resource allowance).<sup>201</sup> This means Greg will still have to spend down \$338,000 of his \$500,000 countable assets before Medicaid benefits begin. For scenario two, Greg's qualifying long-term care policy has a total benefit of \$430,014 with total asset protection. Unlike the first scenario, Medicaid will now disregard *all* of Greg's countable assets after Greg exhausts his policy's benefits. This means that Greg will not have to spend down *any* of his \$500,000 countable assets before Medicaid benefits begin. A final advantage qualifying policies have over traditional policies is that the premiums for qualifying long-term care policies may be deducted from the insured's state taxes.<sup>202</sup>

While the prospects of Long-Term Care Partnership Programs are primarily positive, there are a few drawbacks. First, long-term care insurance does not always provide the same level of coverage as that provided by Medicaid provides—for instance, prescription drugs are not often covered by long-term care policies.<sup>203</sup> Second, despite most states now offering some form of a Long-Term Care Partnership Program, the asset protection offered in one state may or may not be honored if the insured moves to another state.<sup>204</sup> Third, as mentioned in the previous section, long-term care insurance is likely to be purchased by the wealthy, not the lower-middle-class.<sup>205</sup> Finally, many insurance companies require applicants to pass rigorous medical underwriting before providing long-term care insurance coverage.<sup>206</sup> While passing the required underwriting may be easy for a young adult in good health, it may be considerably more difficult for a 55-year-old with a preexisting health problem.<sup>207</sup>

#### VIII. PROSPECTIVE

While the proposals to reform Medicaid are respectable, they fail to address the ultimate question: how did a program intended for the “needy” turn into an entitlement for the middle-class and wealthy alike? Not only does society have a generalized distaste toward using Medicaid,<sup>208</sup> but purposeful impoverishment to gain Medicaid benefits conflicts with the American values of pride, hard work, and self-reliance. So, why are so many Americans engaging in Medicaid planning? While it is tempting to say the answer is “greed,” a more honest answer may be “fear” – the fear of losing the “American Dream” and the fear of being forgotten by loved ones. “The one thing that elderly people fear the most is

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201. *What You Should Know About Long Term Care*, *supra* note 181, at 10.

202. *Id.* at 17.

203. *Id.*

204. *Frequently Asked Questions*, *supra* note 194; *see State Partnership Programs and Reciprocity*, *supra* note 190 (mapping the reciprocity amongst state partnership programs).

205. Miller, *supra* note 11, at 103, 107.

206. *See generally What You Should Know About Long Term Care*, *supra* note 181, at 6.

207. *See generally id.*

208. Miller, *supra* note 11, at 100, 101.

financial impoverishment, with its attendant restrictions on their ability to remain independent and to leave an inheritance to their heirs. Furthermore, the greatest single threat to the financial security of the elderly is the cost of long-term care.”<sup>209</sup>

For many elderly individuals, the assets they have spent a lifetime acquiring and maintaining represent the total sum of their adult lives—their pursuit of the American Dream. Furthermore, the elderly may view voluntary impoverishment as an honorable sacrifice so that their children, grandchildren, and great-grandchildren have a better shot at achieving the American Dream than they did. Beyond the sentimental and societal reasons, maybe leaving an inheritance fulfills a fundamental elderly need—the need not to be forgotten.

A man wishes to perpetuate and immortalize himself, as it were, in his great-grandchildren. For middle-class seniors who need long-term care, the present Medicaid system is, in effect, a health lottery that deprives them of this opportunity. No rational person would enter such a lottery voluntarily.<sup>210</sup>

Leaving an inheritance for loved ones ensures the elderly will not be forgotten, or so it would seem. After all, why do we work so hard to achieve the American Dream only to relinquish its supposed benefits once we get there? “Imagine spending a lifetime trying to accumulate wealth, and then the last three years of your life trying to get rid of it so you can get Medicaid.”<sup>211</sup>

While Medicaid was intended to be an assistance program *exclusively* for the “needy,”<sup>212</sup> it hardly seems that intention remains today. While some argue that the development of the look-back period, the restriction on the use of certain types of trusts, and the extension of penalty periods, are examples of Congressional intent to restrict Medicaid to only the needy.<sup>213</sup> At face value, the former examples appear to support the Congressional intent for Medicaid to remain exclusively for the poor. However, if we consider Congressional actions and policies on a broader scope, a scope not limited exclusively to the Medicaid program, it appears as if Congress all but enables the wealthy to engage in Medicaid planning. For example, consider the following. Congress has increased the estate tax exemption to the point that in 2021 a wealthy couple can leave over to \$23 million to their heirs with no estate or gift tax bill.<sup>214</sup> Moreover, the

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209. Jeffrey L. Soltermann, *Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?*, 1 ELDER L.J. 251, 289 (1993).

210. Takacs & McGuffey, *supra* note 132, at 141.

211. Teresa Wiltz, *Getting Older, Going Broke: Who's Going to Pay for Long-Term Care?*, PEW CHARITABLE TRUST (July 25, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/07/25/getting-older-going-broke-whos-going-to-pay-for-long-term-care> [<https://perma.cc/K6AU-MSLU>].

212. Joseph S. Karp & Sara I. Gershbein, *Poor on Paper: An Overview of the Ethics and Morality of Medicaid Planning*, 79 FLA. BAR J. 61, 64 (2005).

213. *Id.*

214. Ashlea Ebling, *IRS Announces Higher Estate and Gift Tax Limits for 2021*, FORBES (Oct.

mortgage interest deduction allows the wealthy to deduct mortgage interest for multiple vacation homes.<sup>215</sup> Finally, the 2020 Social Security tax is only taxable on \$137,700 of income, meaning millionaires and billionaires only paid a measly \$8,537.40 in Social Security tax, although the Social Security Trust Fund is slated to run out by 2035.<sup>216</sup> At a minimum, these entitlements afforded to the wealthy seem to stand in stark contrast to the imposition that Medicaid's spend-down rules are intended to strip away every last vestige of a person's inheritance.<sup>217</sup>

Regardless of the restrictions imposed, those with access to good legal counsel will always find creative (and legal) entry into the Medicaid system. Nevertheless, the most straightforward reform could also be the most effective reform. What if the wealthy were allowed into the Medicaid program, but there was a limitation on the duration of benefits or limitations delaying the effective date benefits begin? For example, benefits could be delayed for those with assets above a set threshold for two years. According to the National Nursing Home Survey, the average life expectancy in a nursing home is just over two years.<sup>218</sup> Moreover, only 15% of nursing home residents receive long-term care for more than two years, and only 2% receive long-term care for more than ten years.<sup>219</sup> So, theoretically, this simple proposal may result in a cost decrease to the Medicaid program since most of the wealthy will likely end up paying all or a significant portion of their nursing home care before Medicaid is obligated to step in.

The United States is not the only industrialized country with a growing elderly population in need of expensive long-term care. However, the United States is undoubtedly the outlier on the international stage.<sup>220</sup> "While the United States has embarked on efforts to relieve pressure on its means-tested Medicaid program by enhancing private insurance, many other industrialized countries have taken a different route."<sup>221</sup> Countries such as Norway, Sweden, Denmark, Finland, Germany, France, Japan, Korea, and the Netherlands have all

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26, 2020, 10:22 PM), <https://www.forbes.com/sites/ashleaebeling/2020/10/26/irs-announces-higher-estate-and-gift-tax-limits-for-2021/?sh=563f3de9459e> [<https://perma.cc/FSSU-UCCY>].

215. Emily Badger & Christopher Ingraham, *The Rich Get Government Handouts Just Like the Poor. Here Are 10 of Them*, WASH. POST (Apr. 9, 2015, 2:12 PM), <https://www.washingtonpost.com/news/wonk/wp/2015/04/09/the-rich-get-government-handouts-just-like-the-poor-here-are-10-of-them/> [<https://perma.cc/W6K6-ECMA>].

216. See Hunter Kuffel, *Social Security Tax Limit for 2021*, SMARTASSET (Dec. 28, 2021), <https://smartasset.com/retirement/social-security-tax-limit> [<https://perma.cc/H3W8-GJJB>].

217. Miller, *supra* note 11, at 99.

218. Levine, *supra* note 142.

219. Pope, *supra* note 3, at 6.

220. Joel Dodge, *The No-Brainer Case for Universal Long-Term Care*, PEOPLE'S POL'Y PROJECT (July 26, 2018), <https://www.peoplespolicyproject.org/2018/07/26/the-no-brainer-case-for-universal-long-term-care/> [<https://perma.cc/S8M2-2KWE>].

221. Howard Gleckman, *The Future of Long-Term Care: What is its Place in the Health Reform Debate?*, URBAN INST. & BROOKINGS INST. TAX POL'Y CTR. 1, 11 (2009), <https://www.taxpolicycenter.org/sites/default/files/alfresco/publication-pdfs/411908-The-Future-of-Long-Term-Care-What-Is-Its-Place-in-the-Health-Reform-Debate-.PDF> [<https://perma.cc/KQ9F-RQY4>].

implemented government-funded or government-provided long-term care programs.<sup>222</sup> “Adopting a similar system would bring the United States in line with the rest of the developed world.”<sup>223</sup> So, while attempts to restrict the current Medicaid system continue to fail, it may be time for the United States to seriously consider implementing some form of a universal long-term care program like that offered by many of its developed peers.

#### IX. CONCLUSION

Annual Medicaid spending is projected to exceed \$1 trillion by 2028.<sup>224</sup> While longer life expectancies, skyrocketing healthcare costs, and an increasing amount of elderly requiring long-term care are mostly to blame for Medicaid’s ever-growing spending, it is easy to overlook the fact that individuals with ample financial means can, and do, take advantage of a welfare program never intended for them.<sup>225</sup> While closing the loopholes exploited by the wealthy and their lawyers is undoubtedly a start to reining in Medicaid spending, solving the much larger issue of financing long-term care will require complex reform. However, the outlook for reform anytime soon is grim. The deepening political divide, never-ending gridlock, and lack of political courage in Washington make it unlikely that any complex reform will occur soon – leaving the status quo: Medicaid as the primary payer of long-term care in America.

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222. *See id.*; Dodge, *supra* note 220.

223. Dodge, *supra* note 220.

224. *See* Sean P. Keehan et al., *National Health Expenditure Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth*, 39 HEALTH AFFAIRS 704 (2020), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00094> [<https://perma.cc/W7Y9-RT7V>].

225. Pope, *supra* note 3, at 5.