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**MEDICAID PLANNING: CAN IT BE JUSTIFIED?
LEGAL AND ETHICAL IMPLICATIONS OF MEDICAID
PLANNING**

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[S]ome nursing home residents who need dentures will likely not be able to get them [due to recent Medicaid cuts]; but in those cases, nursing homes should grind, puree or blend residents' food so they can eat, the Idaho Department of Health and Welfare informed nursing

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home managers this month. The [insurance] cuts, [which went into effect April 1] were mandated by the Idaho Legislature as a budget-balancing measure and, among other reductions, limit dental care for Medicaid recipients over age 21 to emergencies only, unless they are pregnant.—*Idaho Mountain Express*, April 17, 2002.¹

Jane Bryant Quinn's June 3 column, "Shame Of The Rich: Making Themselves Poor," puts a needed spotlight on the unfortunate fact that impoverishing oneself is a prerequisite for Medicaid assistance.

Ms. Quinn's accurate depiction of the extent to which some wealthy Americans will go when it comes to hiding and sheltering assets in order to get "free" Medicaid coverage demonstrates how the system itself is in disarray. While some elderly with substantial financial nest eggs attempt to beat the system in an effort to qualify for Medicaid, those truly in need see daily their access to quality care threatened.

The fact of the matter is that in state after state, Medicaid is severely under funded in a manner that undermines the original intent of the program - which is to provide medical assistance to low-income Americans. Those most in need are being shortchanged by those who, long ago, should and could have been planning and saving for the possibility of long term care needs, had they been apprised of the consequences of not doing so and encouraged with appropriate government incentives.—American Health Care Association opinion editorial on Jane Bryant Quinn's June 3, 2001, *Washington Post* article.²

I. INTRODUCTION

For lawyers, ethics and morality are not equivalents. Although ethics is frequently the study of morals and, as such, is the study of what *ought to* happen,³ for the lawyer its primary meaning is

1. *In Idaho, Medicaid Cuts Means No Dental Care*, THE ELDER LAW eBULLETIN (April 23, 2002), at <http://www.tn-elderlaw.com/telb/020423.html#n3>.

2. *The Briefing Room: Opinion Editorial regarding Washington Post June 3, 2001 Jane Bryant Quinn Article*, American Health Care Association, at <http://www.ahca.org/brief/010603.htm> (last visited July 20, 2002).

3. See IMMANUEL KANT, *FUNDAMENTAL PRINCIPLES OF THE METAPHYSIC OF MORALS* 10 (Thomas Kingsmill Abbott trans., Prometheus Books 1987) (1785). In a purely relative ethical system, it may be difficult to identify what ought to happen. In fact, when one is told that he ought to do this or that, the response is

adherence to established canons of ethics. In practice, this means adherence to the Model Rules of Professional Conduct as adopted in the state of the lawyer's practice and to any other local rules that apply to lawyers.⁴

Rule 2.1 of the Model Rules of Professional Conduct [MRPC] distinguishes the lawyer's role as adviser from his role as advocate, and it is the adviser's "hat" that elder law attorneys wear when engaging in Medicaid planning. As advisers, lawyers may consider not only technical legal rules but also "moral, economic, social and political factors" relevant to the client's situation.⁵ Although the client, not the lawyer, ultimately decides what to do with the advice given,⁶ it is not inappropriate for the lawyer to refer to relevant moral and ethical considerations.⁷ Because the lawyer's ethical analysis is, in part, derivative, the practical challenge for us as elder law attorneys is whether we *ought to* provide Medicaid planning advice.⁸ If we advise clients concerning Medicaid planning, then our task is to provide competent advice within the bounds of law and applicable ethical canons.⁹

often, "You have been dreaming." See H. L. A. HART, *THE CONCEPT OF LAW* 186 (2d ed. 1994).

4. A few states, such as Tennessee, still follow the older American Bar Association Model Code of Professional Responsibility. For our purposes, however, the differences, if any, are unimportant, so we will focus on the newer Model Rules, first issued in 1983. BNA INC., *ABA/BNA LAWYERS' MANUAL ON PROFESSIONAL CONDUCT* 01:3 (2002).

5. MODEL RULES OF PROF'L CONDUCT R. 2.1 (2002) [hereinafter MRPC]. See also *id.* R. 2.1 cmt. 2 (stating that advice couched in narrowly legal terms may be of little value to a client).

6. *Id.* R. 1.2(a) (stating a lawyer shall abide by a client's decisions concerning the objectives of representation); RONALD D. ROTUNDA, *LEGAL ETHICS: THE LAWYER'S DESKBOOK ON PROFESSIONAL RESPONSIBILITY 2002-2003*, at §§ 3-3.2, 19-1 (2002). Interestingly, in a substituted judgment case, one court noted "it cannot be reasonably contended that a competent, reasonable individual . . . would not engage in the estate and Medicaid planning proposed in the petition." *In re John XX*, 652 N.Y.S.2d 329, 331 (App. Div. 1996).

7. MRPC, R. 2.1, cmt. 2.

8. Model Rule 1.2(b) underscores the derivative nature of the lawyer-adviser's task. *Id.* R. 1.2(b). Representation does not constitute an endorsement of the client's viewpoint. Nonetheless, the lawyer cannot provide the guidance suggested in Rule 2.1 without having examined moral, economic, social and political factors. Thus, the study of ethics in this context should yield practical, rather than theoretical, results. Cf. BERNARD MAYO, *THE PHILOSOPHY OF RIGHT AND WRONG* 1 (1986) ("Is ethics, or moral philosophy, a practical or a theoretical subject?").

9. See MRPC, R. 1.1; GEORGIA RULES OF PROFESSIONAL CONDUCT R. 1.1 (2000), <http://www.gabar.org/grpc11.htm>; Proposed TENNESSEE RULES OF PROFESSIONAL CONDUCT R. 1.1 (2001),

II. THE ELDER LAW ATTORNEY'S ETHICAL DILEMMA

Clients request Medicaid planning advice primarily to lessen the economic impact of long-term care.¹⁰ As detailed in this article, the cost of long-term care is often catastrophic for elderly, middle-class individuals and couples. Is it "wrong" to help the elderly protect their assets by engaging in Medicaid planning?¹¹ The short answer is "no." Health care costs threaten to deplete an elder's estate, during his lifetime and after death. The goal of Medicaid planning is therefore to minimize the financial impact of the cost of health care and long-term care. Ethical rules allow elder law attorneys to assist clients who wish to minimize those costs, even if the plan is aggressive, as long as the representation is carried out within the bounds of the law.¹²

We frame the issues by pointing out why the elderly seek out advice:

[O]lder Americans must devote 80% of their income to food, shelter, health care and transportation . . . Being old in America means taking the leftovers from a health care system that caters to the young. The 10% of our people over 65 account for 28% of the nation's total medical bill. Yet Medicare--for all the good it has done--pays less than 40% of the medical bills of its recipients, and the proportion has been declining. The strength of the medical lobby has prevented needed changes in the health care delivery system, perpetuating needless

<http://www.tba.org/committees/Conduct/Exhibit-A/newfinalred-a.pdf>); MPRC, R. 1.16(a)(1); *Durie v. State*, 751 So.2d 685, 691 (Fla. Dist. Ct. App. 2000) (reiterating that lawyers cannot engage in dishonest or unethical conduct). In this case, a lawyer was held accountable when he "stepped over the ethical and criminal line" by misrepresenting Medicaid's portion of a settlement. *Id.*

10. "If your parent wants to protect his assets before going on Medicaid, get him to meet with a lawyer who specializes in Medicaid planning because the rules are complicated." VIRGINIA MORRIS, *HOW TO CARE FOR AGING PARENTS* 260 (1996). For an analysis of the economic impact of long term care, see LISA ALEXIHI & DAVID KENNEL, *THE ECONOMIC IMPACT OF LONG-TERM CARE ON INDIVIDUALS* (1994), <http://aspe.hhs.gov/daltcp/reports/ecoimpes.htm>.

11. While one "can debate whether Medicaid planning is sound public social or fiscal policy," it is nonetheless legal. *In re Baird*, 634 N.Y.S.2d 971, 974 (Sup. Ct. 1995); *In re Daniels*, 618 N.Y.S.2d 499, 500 (Sup. Ct. 1994). We recognize that lawyers who undertake representation for a client must abide by the client's objectives. See, e.g., MPRC, R. 1.2(a). The inquiry here is whether the attorney should accept employment.

12. ROTUNDA, *supra* note 6, at § 22-1.2 (discussing advice in the tax planning context, quoting A.B.A. Formal Opinion 85-352). Medicaid planning is *not* hiding assets. Medicaid planners use the rules of Medicaid to the advantage of the client.

inefficiencies that drive the costs of Medicare skyward. . . .
[W]e [must] alleviate the heavy medical bill burden now borne by the elderly.¹³

Since Morris Udall spoke those words 27 years ago, little has changed—except that America is getting older.¹⁴ Meanwhile, health care costs continue to increase as a percentage of income,¹⁵ and long-term care is often needed at a time when income has fallen.¹⁶ The elderly seek competent legal advice about how to respond when crisis looms, and when it strikes. In discharging his duty under MRPC 2.1, though, what factors should the elder law attorney focus on? This article will explore the “moral, economic, social and political factors” implicated by Medicaid planning.¹⁷

We examine differing stakeholder positions, current long-term care financing issues, and reform options, albeit with Medicaid planning as the focal point.¹⁸ The current system, or Medicaid planning, for that matter, is not necessarily the best long-term solution for the elderly.¹⁹ In the end, we believe the law should be structured to provide adequate health care, including long-term care, for all persons, regardless of economic status or age.²⁰ Elders

13. Morris K. Udall, Public Policy and the Future of Aging, Address given before the National Council on Aging (Sept. 30, 1975), http://www.library.arizona.edu/branches/spc/udall/aging_htm.html.

14. THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 3 (2d ed. 1998).

15. AARP, BEYOND 50.02: A REPORT TO THE NATION ON TRENDS IN HEALTH SECURITY 5 (2002) (reporting that persons aged fifty and older spent an average of \$3,881 per year for non-nursing home medical expenses in 1996, up 310% from 1977), http://www.aarp.org/beyond50/graphics/pdfs/beyond50_02one.pdf.

16. Income for households aged 65 and older averaged \$21,827, compared with income for households under sixty-five averaging \$84,591. U.S. CENSUS BUREAU, REPORT HINC-01, SELECTED CHARACTERISTICS OF HOUSEHOLDS, BY TOTAL MONEY INCOME IN 2000 (2001), http://ferret.bls.census.gov/macro/032001/hhinc/new01_001.htm.

17. To wit: a moral, economic, social and political base. As for ethics, it is the study of morals or moral issues. In a profession, ethics is an understanding, either formal or informal, of acceptable conduct. WILLIAM S. SAHAKIAN, ETHICS: AN INTRODUCTION TO THEORIES AND PROBLEMS 6 (1974). Ethics rules without practical application are defective. PETER SINGER, PRACTICAL ETHICS 2 (2d ed. 1993).

18. Since it would be impossible to adopt individual views of “right” and “good,” the “good” referred to in this article is Aristotle’s notion of the supreme good. See ARISTOTLE, XIX NICOMACHEAN ETHICS 5 (H. Rackham trans., 1968). Medicaid is a creature of politics and, therefore, its end should be the good of Man. *Id.* at 7.

19. MAYO, *supra* note 8, at 67 (“Laws are subject to criticism in a way in which morality is not.”).

20. “Age should never be recognized as the determinative factor in the balancing test for health care services.” George P. Smith II, *Allocating Health Care*

should be guaranteed access to good health care. Until universal access becomes a reality, we conclude that Medicaid planning is justified within a health care system that elevates profit over patient care.

III. HEALTH CARE IN THE UNITED STATES

The public health infrastructure consists of those resources necessary to deliver essential public health services to every community.²¹ Its goals are (or should be) to provide good care to more or less the entire population without bankrupting the treasury in the process.²² The value society places on health is pivotal when determining what resources will or must be devoted to delivering health care services.²³ Also pivotal, in the context of this article, is the value of an elderly person's life.²⁴ Assuming resources

Resources to the Elderly, 1 ELDER L. REV. 21, 24 (2002), <http://www.uws.edu.au/law/elderlaw/smith.pdf>. America's market system efficiently meets the needs of the young and strong. Its record is less impressive where elders are concerned, possibly due to the waning of productivity in later years. *Id.* at 21. "The way we treat our older citizens in this country is like certain ancient tribal societies, where a person who is too old for hunting and warfare was placed ceremonially on a raft and allowed to float down a river." Udall, *supra* note 13. This view emerged, in large part, during the Industrial Revolution. As jobs moved from farms to factories, "[o]lder citizens either could not compete or were seen as taking jobs from younger breadwinners. The result is that they came to be considered a burden on families and society in general." JIMMY CARTER, *THE VIRTUES OF AGING* 12 (1998).

21. 2 U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *HEALTHY PEOPLE 2010*, at 23-3 (2d ed. 2000), <http://www.health.gov/healthypeople/document/pdf/volume2/23PHI.pdf>. The public health infrastructure includes governmental and non-governmental entities that provide health care services. *Id.* A stated goal of *HEALTHY PEOPLE 2010* is the elimination of health disparities. *Id.* at 23-6.

22. David Wilsford, *Commentary: Ideas, Institutions, and Resources*, 25 J. HEALTH POL. POL'Y & L. 975, 975 (2000).

23. See H.R. Con. Res. 99, 107th Cong. (2001) (urging Congress to enact legislation by October 2004 that guarantees health care access to every person in the United States regardless of income, age, employment or health status); Roger N. Levy, *Ethical Issues: The Rationing of Care to the Geriatric Patient*, 2 ARCHIVES OF THE AM. ACAD. OF ORTHOPAEDIC SURGEONS 113, 114-115 (1998) (reviewing differing legal and philosophic positions relating to health care as a right), http://www.hospitalmanagement.net/informer/management/pc_social/index.html; Leonard Peikoff, *Health Care is Not a Right*, Speech delivered at a Town Hall Meeting on the Clinton Health Plan (Dec. 11, 1993) (arguing that socialized medicine is immoral), <http://www.bdt.com/pages/Peikoff.html>; see also WILLIAM D. NORDHAUS, *THE HEALTH OF NATIONS: THE CONTRIBUTION OF IMPROVED HEALTH TO LIVING STANDARDS* (2002) (arguing that health is a measure of national prosperity), available at <http://www.nber.org/papers/w8818>.

24. Smith, *supra* note 20, at 22.

are available,²⁵ should they be deployed to improve health and to save, or prolong lives? If society places a premium on health (and life) and dedicates resources to the delivery of health care services, access will expand and, presumably, the quality of life will improve.

Although many nations, and the World Health Organization, regard health care as a fundamental human right,²⁶ the United States does not.²⁷ Instead, in the United States health care is a commodity.²⁸ Health care services are bought and sold on the “free market.” The market is competitive, largely amoral, and (in theory) governed by the free market’s “invisible hand,” within a framework of public laws and regulations by non-governmental organizations (for example, accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations, which accredits the majority of the country’s medical facilities).²⁹ If

25. See discussion of rationing, *infra* this section.

26. See, e.g., WORLD HEALTH ORGANIZATION, HEALTH AS A HUMAN RIGHT, at <http://www.who.int/archives/who50/en/human.htm> (last visited July 20, 2002). For a Judeo-Christian perspective on health care as a right, see Herbert W. Titus, The Right to Medical Care Within a Biblical Worldview: The Declaration of Independence and the United States Constitution, Speech before the Conference on Health Care in Crisis: A Biblical Response (May 2, 1992), <http://bmei.org/jbem/volume10/num2/titus.htm>.

27. See, e.g., *In re Gonzalez*, 586 N.Y.S.2d 861, 865 (App. Div. 1992) (stating that since there is no system of public health insurance, all individuals who possess the means are required to pay for their own care); see also Editorial, *Where Health Care is Not a Right*, 359 THE LANCET 1871 (2002) (“Americans and their families are living shorter and sicker lives because they live in a country where access to health care remains a privilege and not a right.”), <http://www.thelancet.com>.

28. Wilsford, *supra* note 22, at 975; MARCIA ANGELL ET AL., PHYSICIANS’ WORKING PAPER ON SINGLE-PAYER NATIONAL HEALTH INSURANCE (2001), http://www.kaisernetwork.org/health_cast/uploaded_files/whitepaper.pdf; Leslie P. Francis, *Legal Rights to Health Care at the End of Life*, 282 MED. STDNT. J. AM. MED. ASS’N 2079 (1999), http://www.ama-assn.org/sci-pubs/msjama/articles/vol_282/no_21/jms90042.htm; see also BODENHEIMER & GRUMBACH, *supra* note 14, at viii, 21-46. “Access” means “the timely use of personal health services to achieve the best possible health outcomes.” 1 U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, HEALTHY PEOPLE 2010, at 1-40 (2d ed. 2000) [hereinafter HEALTHY PEOPLE I], http://health.gov/healthypeople/document/HTML/Volume1/01Access.htm#_Toc489432806. “Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States.” *Id.* at 1-3.

29. ADAM SMITH, AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS 194 (Encyclopedia Britannica, Inc. 1992) (1776); Donald W. Light, *Sociological Perspectives on Competition in Health Care*, 25 J. HEALTH POL. POL’Y & L. 969-970 (2000); see also *ID Sec. Systems Canada, Inc. v. Checkpoint Systems, Inc.*, 198 F. Supp. 2d 598, 611 (E.D. Pa. 2002) (explaining the notion that a business person will make decisions that tend to maximize profit is so basic to our economic system that it hardly requires citation). Markets can be disrupted by

health care services were viewed as a right instead of as a commodity, health care would be an entitlement that the right holder could demand regardless of cost.³⁰

America's free market health care system is a political construct regarding how health care will be delivered.³¹ This construct rests on the assumption that competition, driven by each provider's desire to maximize personal gain, will unleash energy and imagination and, thereby, increase societal wealth.³² Nonetheless, the reality is that persons *with* financial means have greater access to health care, while those *without* financial means

regulation. Conversion from a fee-for-service to an insurance model introduced moral hazard into the equation, arguably, giving the invisible hand a case of arthritis. See generally BODENHEIMER & GRUMBACH, *supra* note 14, at 7-20 (discussing evolution of the health care payment system from out-of-pocket payments to individual insurance, then to employer provided insurance and finally, the introduction of social insurance). For an interesting analysis, see MARTIN GAYNOR, ARE INVISIBLE HANDS GOOD HANDS?: MORAL HAZARD, COMPETITION, AND THE 2ND BEST IN HEALTH CARE MARKETS (1998) (arguing that insurance leads to excess consumption; however, competition, or even monopoly, in insurance markets reduces the market price for health care, which benefits consumers; the benefit to consumers outweighs the loss of profits suffered by the medical industry), <http://equilibrium.heinz.cmu.edu/mgaynor/papers/2ndbestfind2.pdf>.

30. Levy, *supra* note 23, at 114. Because health care resources are limited, most moralists therefore argue for health care as a limited right. *Id.* at 115. Of course, universal access would increase moral hazard (discussed later), which may introduce new problems, such as queuing for services. See, e.g., PETER LANDRY, BLUPETE'S COMMENTARY: A RIGHT TO MEDICAL CARE (1999) (complaining about the wait for health care services in Canada and noting that wealthy Canadians get immediate care in the U.S.), at <http://www.blupete.com/Commentary/MedCareMay'99.htm>. Recent research reported in the journal *Health Affairs*, however, found that surprisingly few Canadians travel to the United States for health care, despite the persistence of the myth, suggesting that anecdotes of long lines endured by Canadians in their own country may be nothing more than fodder for critics of universal health care. Steven J. Katz et al., *Phantoms in the Snow: Canadians Use of Health Care Services in the United States*, 21 HEALTH AFFAIRS, May-June 2002, at 19.

31. See Deborah Stone, *United States*, 25 J. HEALTH POL. POL'Y & L. 953, 953 (2000). The U.S. Department of Health & Human Services proposes that 100% of the U.S. population have access to health care by 2010; its proposal follows the free market model through the use of insurance. See HEALTHY PEOPLE I, *supra* note 28, at 1-13, 1-14.

32. See Light, *supra* note 29, at 969-71. Light notes that competition rewards innovation, those who create needs. There is nothing inherent about the free market system that rewards efficiency in meeting established needs. "The traditional debate pitted arguments of monopoly and monopsony on the one side, and innovation on the other. . . . it was feared that government production would be technologically inefficient and innovation would be stifled." DAVID M. CUTLER, NATIONAL BUREAU OF ECONOMIC RESEARCH, HEALTH CARE AND THE PUBLIC SECTOR 30 (2002), <http://www.nber.org/papers/w8802>.

enjoy only limited access.³³ The effect on the overall good health of persons with limited means is predictable.³⁴

Long-term care is the predominate issue in Medicaid planning, which makes those services most relevant to this examination. Long-term care services include:

[a] broad range of health and social services delivered in institutions, in the community and at home. Long-term care services include institutional services, such as those delivered in nursing homes, rehabilitation hospitals, subacute care facilities, hospice facilities, and assisted living facilities; services delivered in the home, such as home health and personal care, hospice, homemaker, and meals; and community-based services, such as adult day care, social services, congregate meals, transportation and escort services, legal protective services, and counseling for client as well as their caregivers.³⁵

People with physical or mental conditions that limit their capacity for self-care³⁶ need these services to improve functioning, maintain existing living functions, or to slow deterioration in functioning while care is delivered in the least restrictive environment.³⁷ Yet long-term care is expensive, thereby limiting access.³⁸

33. Whether access to health care should be defined in terms of wealth is a fundamental question for America. Although we value private property rights, and where they exist, there will always be inequalities of fortune, *see* *Coppage v. Kansas*, 236 U.S. 1, 17 (1915), one can legitimately question whether health care, which is often linked to life itself, should be held hostage in this manner. “Should, for example, a millionaire be allowed greater access to life-saving treatment than a pauper, even if we gladly allow greater access to exotic vacation spots?” Sanford Levinson, *The Welfare State*, in *A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 553, 555 (Dennis Patterson ed., 1996). We think not.

34. *See* Stone, *supra* note 31, at 954. Stone’s article is part of a series reviewing health care systems around the globe. In 1999, U.S. Census Bureau statistics showed that 44 million Americans were uninsured. *Id.* There is a clear relationship between health and wealth. “Poorer people die younger and are sicker than richer people . . .” Angus Deaton, *Policy Implications of the Gradient of Health and Wealth*, 21 *HEALTH AFFAIRS*, Mar.-Apr. 2002, at 13. For an interesting viewpoint on the virtues of a health care free market, *see* SHELDON L. RICHMAN, *A FREE MARKET FOR HEALTH CARE*, at <http://www.amatecon.com/etext/dosm/dosm-ch03.html> (last visited July 20, 2002).

35. *HEALTHY PEOPLE I*, *supra* note 28, at 1-41.

36. Ability to care for oneself is sometimes measured by reference to one’s ability to perform activities of daily living, 42 C.F.R. § 483.25(a)(1) (2001), or instrumental activities of daily living.

37. *HEALTHY PEOPLE I*, *supra* note 28, at 1-6.

38. Health care costs for America’s elderly rose three times faster than the

IV. THE DEVASTATING FINANCIAL IMPACT OF LONG-TERM CARE

Long-term care can be ruinously expensive for individuals and families.³⁹ When families need long-term care, paying for it can quickly put them between a rock and a hard place.⁴⁰ The national average monthly cost for nursing home care is \$4,654.⁴¹ By contrast, the median income in FY 2000 for the 11.6 million households headed by persons aged sixty-five or older was \$32,854 (or \$2,737.83 per month).⁴² Many elderly Americans simply cannot

CPI from 1977 through 1987; by 1996, excluding nursing home costs, “[m]edicare beneficiaries spent an average of \$2600 out-of-pocket on health care costs above what Medicare and private insurers paid. This represented 21% of household income for elderly individuals, up from 15% in 1987.” Mark P. Doescher et al., *Supplemental Insurance and Mortality in Elderly Americans*, 9 ARCHIVES OF FAMILY MEDICINE (2000), <http://archfami.ama-assn.org/issues/v9n3/ffull/foc9054.html>. Although the data source is not disclosed, the Americans for Long-Term Care Security Website includes a “Future Costs Calculator” that estimates the cost of long-term care based on gender, age and state, at <http://www.ltcweb.org>. For example, the estimated cost of long-term care for a male, aged 40, living in Tennessee is \$144,709.80.

39. See, e.g., *In re Shah*, 694 N.Y.S.2d 82, 86 (App. Div. 1999) (stating costs are “astronomical”), *aff’d* 711 N.Y.S.2d 824, 832 (2000) (describing medical treatment as “ruinously expensive”); *In re Tyler*, 2002 WL 1274125, at *10 (D.C. Super. May 30, 2002) (citing *Shah* in recognizing ruinously expensive cost of long-term care, but denying a community spouse’s petition - without prejudice to refile with additional evidence - where she sought to transfer her incompetent husband’s assets to herself in a support context).

40. DANA SHILLING, FINANCIAL PLANNING FOR THE OLDER CLIENT 109 (5th ed. 2001).

41. AARP, THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY 24 (2001), http://research.aarp.org/health/ltc_costs.pdf. A CNA study conducted in 2001, surveying 11,126 nursing homes throughout the United States concluded that daily charges ranged from \$115 to \$146 depending on the level of care required. CNA, STUDY FINDS NURSING HOME COSTS STEADILY INCREASING, at http://www.cna.com/cna/solutions/html/headline_072501.html (July 25, 2001). News stories circulating in March 2002 reported the findings of a survey commissioned by GE Long-term Care Insurance of San Rafael. Those findings suggest that the cost of long-term care in certain areas may be substantially higher. Nursing home care in the ten most expensive regions of the country can range from \$79,900 annually in the Philadelphia metro areas to \$163,400 in Alaska. See *Nursing Home Care Costs top \$80,000 a year survey says*, E. BAY BUS. TIMES, March 4, 2002, <http://eastbay.bizjournals.com/eastbay/stories/2002/03/04/daily2.html>.

42. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON AGING, A PROFILE OF OLDER AMERICANS: 2001, at 9 (2001), <http://www.aoa.dhhs.gov/aoa/stats/profile/2001/2001profile.pdf>. Over two million persons celebrated their 65th birthday in 2000. *Id.* at 1. Each of those persons has a life expectancy of an additional 17.9 years. *Id.* Seventy-six percent of older homeowners own homes (a principal subject of Medicaid planning) that are paid for, with an average value of \$96,442 in 1999. *Id.* at 10.

afford long-term care.⁴³ This quandary, *need* coupled with *limited or no access*, defines the initial role of the elder law attorney.⁴⁴

Given the expense of long-term care, many seniors who need that care are soon impoverished. There is only one government program to which families can turn for help financing long-term care: Medicaid.⁴⁵ “Medicaid is the major source of financing for long-term care for the elderly and for non-elderly persons with disabilities.”⁴⁶ No longer just the safety net for the poor, it is now the safety net for America’s middle class seniors.⁴⁷

The crisis that long-term care financing imposes is uniquely a

43. “Most elderly people live on limited incomes and few can afford the high cost of long-term care. Medicaid is the safety net because no other practical options exist to meet these seniors long-term care needs.” *Medicaid’s Role for Seniors: Challenges in a Fiscally Constrained Environment: Testimony given for “The Economic Downturn and Its Impact on Seniors”, Special Committee on Aging, United States Senate 2* (2002) (statement of Barbara Lyons, Deputy Director of The Kaiser Commission on Medicaid and the Uninsured), at <http://www.kff.org>. Of note, Medicare and Medicaid were created as a response to a shift in insurance pricing practices. Insurance companies shifted from community rating, which was more favorable to high risk insureds, to experience ratings. As a result, policy premiums rose for the elderly and disabled, putting the cost of insurance beyond reach. BODENHEIMER & GRUMBACH, *supra* note 14, at 14, 157.

44. A 1995 survey found that many elder persons go without care due to its expense, lack of available services, and lack of eligibility for government benefits that would provide care. Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFFAIRS, May-June 2000, at 40, 47. We note that elder self neglect is a serious problem which can be triggered by confusion. See THE NATIONAL CENTER ON ELDER ABUSE AT THE AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION, THE NATIONAL ELDER ABUSE INCIDENCE STUDY: FINAL REPORT SEPTEMBER 1998, at 4-33 (1998), <http://www.aoa.gov/abuse/report/main-pdf.htm>. By clearing up confusion regarding the availability of health care resources, elder law attorneys may help prevent self-neglect. See *id.*

45. Medicare funding for long-term care is subject to limiting criteria. When it is available, it is limited to 100 days of coverage. 42 U.S.C. § 1395d(a)(2)(A) (1994); JUDITH A. STEIN & ALFRED J. CHIPLIN, 2002 MEDICARE HANDBOOK § 3.02 (2002).

46. KAISER COMMISSION ON MEDICAID FACTS, MEDICAID’S ROLE IN LONG-TERM CARE (2001), <http://www.kff.org/content/2001/2186/2186.pdf>.

47.

[C]ontrary to the perceptions of some, Medicaid is not just a lifeline for America’s poorest citizens. Rather, for America’s seniors, Medicaid is now also very much a middle class program. Funded jointly by the states and the federal government, Medicaid today pays nearly two-thirds of all nursing home and long-term care bills. So when Medicaid is in trouble, so too is middle America.

The Economic Downturn & Its Effects on Seniors, Testimony to the Senate Special Committee on Aging (2002) (opening statement of U. S. Senator Larry Craig, Ranking Member of the U.S. Senate Special Committee on Aging), <http://aging.senate.gov/events/hr79lc.htm>.

middle-class problem.⁴⁸ This is true because Medicaid pays only for persons who meet the program's strict limitations on assets and income. Those who elect not to rely on Medicaid either have sufficient assets to pay for their long-term care or have purchased long-term care insurance to shift the cost to an insurance company. Most middle-class persons who are facing a lengthy nursing home stay do not have these options, however. They face the prospect of depleting their lifetime savings to pay for nursing home care. Once they deplete their assets, known as "spend-down," they are "poor enough" to qualify for Medicaid.⁴⁹ Middle-class people don't want to pay the nursing home, and they don't want to be poor either. So what do they do? To avoid this harsh result, they engage in Medicaid planning, to protect their assets for the benefit of themselves, their spouses, and their heirs. Because Medicaid is means-tested, Medicaid planning is the process of helping clients "rearrange" their assets so as to qualify for Medicaid nursing home benefits. This is done by helping the client meet Medicaid's seemingly inscrutable eligibility rules⁵⁰ by putting assets out of the reach of the Medicaid program (and, often, out of the legal reach of the client himself). Effective Medicaid planning shifts the cost of long-term care from the Medicaid applicant to the government (in other words, to the taxpayers).

48. NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, WHITE PAPER ON REFORMING THE DELIVERY, ACCESSIBILITY AND FINANCING OF LONG-TERM CARE IN THE UNITED STATES 1 (2000) [hereinafter NAELA WHITE PAPER], <http://www.naela.org>.

49. ALEXI & KENNEL, *supra* note 10.

At an average national cost of \$51,000 per year for long-term care services and supports an individual or family cannot maintain economic security even if they are prepared for retirement. Unfortunately, most Americans are unaware of how long-term care is paid for in this country. They do not realize until it's too late that we use Medicaid, a welfare program that requires them to spend down their assets in order to receive assistance with staggering costs.

Senator David Durenberger, Chairman, Citizens for Long-term Care, Statement (Apr. 7, 1999), <http://www.citizensforlrc.org/speeches.htm>.

50. The federal and state Medicaid statutes have been described as the regulatory equivalent of the "Serbonian bog." See John Milton, *Paradise Lost*, in GREAT BOOKS OF THE WESTERN WORLD; 32 JOHN MILTON, Bk. 2, at 124 (Robert Maynard Hutchins ed., William Benton 1952) (1667) ("A gulf profound, as that *Serbonian* bog Betwixt *Damiata* and Mount *Casius* old, Where armies whole have been sunk."). These laws and regulations have also been characterized as "almost unintelligible to the uninitiated," *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977), as an "aggravated assault on the English language, resistant to attempts to understand it," *Friedman v. Berger*, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976), and as "labyrinthian," *Roloff v. Sullivan*, 975 F.2d 333, 340 n.12 (7th Cir. 1992).

V. MEDICAID TODAY: A STRAINED SYSTEM

Title XIX of the Social Security Act on Medical Assistance,⁵¹ commonly called Medicaid, is a cooperative federal-state program funded in large part by the federal government and administered by the states.⁵² While state participation is voluntary, participating states must adopt plans that comply with certain requirements imposed by federal statutes and regulations.⁵³ The program itself is “basically administered by each state within certain broad requirements and guidelines.”⁵⁴ As a result, the Medicaid program varies considerably from state to state, as well as within each state over time.⁵⁵

The federal government’s stated goal is 100% access to health care.⁵⁶ Access to long-term care is ensured through Medicaid, which is sometimes referred to as the “safety net.”⁵⁷ Medicaid is the largest public source of funding for long-term care in the United States.⁵⁸

Who pays for long-term care? The United States Centers for Medicare & Medicaid Services (CMS) is the largest purchaser of health care in the world.⁵⁹ “Medicare and Medicaid outlays,

51. 42 U.S.C. §§ 1396a-1396v (1994).

52. *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985).

53. *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990).

54. *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 15 (3d Cir. 1989).

55. Medicaid is discussed exhaustively in every major elder law treatise. For more information, the federal government’s explanation of Medicaid is available at <http://www.cms.hhs.gov/medicaid/medicaid.htm>.

56. See HEALTHY PEOPLE I, *supra* note 28, § 1-3; see also U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CLOSING THE HEALTH GAP, at <http://www.healthgap.omhrc.gov> (last visited July 20, 2002).

57. “These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people.” *Schweiker v. Hogan*, 457 U.S. 569, 590 (1982) (viewing a congressional decision to distribute public assistance benefits on the basis of income and resources as “rational”).

58. Medicaid is the largest source of funding for medical and health-related services for America’s poorest people. HEALTH CARE FINANCING ADMINISTRATION, MEDICAID: A BRIEF SUMMARY, at <http://hcfa.gov/pubforms/actuary/ormedmed/default4.htm> (last visited July 20, 2002); see also *Long Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets: Testimony to the Special Committee on Aging, United States Senate 4* (2002) (statement of David M. Walker, Comptroller General of the United States) (noting in 2000, Medicaid paid for 45% of total long-term care expenditures) [hereinafter *Long Term Care*], <http://www.gao.gov>. It is described as “one of the pillars that holds up the American health care system.” ACADEMY FOR HEALTH SERVICES RESEARCH AND HEALTH POLICY, STATE COVERAGE INITIATIVES, STATE OF THE STATES 5 (2002) (quoting Sara Rosenbaum); see also NAELA WHITE PAPER, *supra* note 48, at 3.

59. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, HCFA FINANCIAL

including State funding, represent thirty-three cents of every dollar spent on health care in the United States—fifty-eight cents of every dollar spent on nursing homes, forty-eight cents of every dollar received by U.S. Hospitals, and twenty-seven cents of every dollar spent on physician services.”⁶⁰ At present, Medicare and Medicaid pick up fourteen percent and forty-five percent of the tab for total long-term care expenditures respectively.⁶¹ An additional three percent is paid through other public programs, with the remainder coming from private sources.⁶² Medicaid expenditures will total \$245 billion in FY 2002, compared with \$230 billion for Medicare.⁶³ Medicaid expenditures will increase from \$228,026,089,368 in FY 2001⁶⁴ and \$206,083,216,717 in FY 2000.⁶⁵

Spending on long-term care is on an upward spiral, and there is no ceiling in sight. From 1987 to 1996, annual nursing home expenses in the United States increased from \$28 billion to \$70 billion, and the cost per resident day increased from \$56 to \$118.⁶⁶ By 2000, annual spending on long-term care (which includes non-

REPORT FISCAL YEAR 2000, at v (2001) [hereinafter HCFA FINANCIAL REPORT], <http://www.cms.hhs.gov>. HCFA is now Centers for Medicare & Medicaid Services, or “CMS.”

60. *Id.* at 1; cf. JONATHAN GRUBER, NATIONAL BUREAU OF ECONOMIC RESEARCH, MEDICAID 17-19, 21-22 (2000), available at <http://www.nber.org/papers/w7829>.

61. *Long Term Care*, *supra* note 58, at 4; see also *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed: Testimony Before the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives, 107th Cong. 3* (2002) (statement of Linda M. Calbom, Director, Financial Management and Assurance) (reporting that between 1992 and 2000, the federal share of Medicaid rose seventy-four percent, from \$69 billion to \$120 billion), <http://www.gao.gov/new.items/d02706t.pdf>.

62. *Long-Term Care*, *supra* note 58, at 4.

63. *Id.* In FY 2002, Medicaid will serve 44.7 million persons; by comparison, Medicare will serve 40 million. *Id.* The CBO projects the average annual rate of growth in Medicaid spending as 9.5% for FY 2001-2002 and as 8.5% for fiscal years 2002-2012. See CONGRESSIONAL BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2003-2012, at 69, Table 4-2 (2002) [hereinafter BUDGET AND ECONOMIC OUTLOOK], available at <http://www.cbo.gov>.

64. See FY 2001 NET REPORTED MEDICAID AND SCHIP EXPENDITURES (2002), <http://www.cms.hhs.gov/medicaid/totexp01.pdf>.

65. See NET REPORTED MEDICAID AND SCHIP EXPENDITURES, FY 2002, <http://www.cms.hhs.gov/medicaid/totexp00.pdf>. In FY 1999, the number was \$189,861,201,380. See NET REPORTED MEDICAID AND SCHIP EXPENDITURES FY 1999, <http://www.cms.hhs.gov/medicaid/totexp99.pdf>. By way of contrast, in 1965, combined spending on the programs that became Medicaid was \$1.3 billion. GRUBER, *supra* note 60, at 2-3.

66. MEDICAL EXPENDITURE PANEL SURVEY, NURSING HOME EXPENSES, 1987 AND 1996, at 6 (2001), http://www.meps.ahrq.gov/papers/cb6_01-0029/cb6.pdf.

nursing home care) increased to \$137 billion. By 2011, long-term care spending is projected to be \$237 billion. "By 2030," says the Congressional Budget Office, "the number of workers is expected to rise by only 15% while the number of Social Security and Medicare beneficiaries will nearly double. That growth, combined with increases in life expectancy, will boost spending on long-term care, about half of which is financed by Medicare and Medicaid."⁶⁷ The cost *just for the elderly* could reach \$379 billion by 2050.⁶⁸ Moreover, costs are expected to accelerate during the next decade due to expanded eligibility for home- and community-based services.⁶⁹

In 2000, 281.4 million persons resided in the United States.⁷⁰ Thirty-five million (12%) were age sixty-five or older.⁷¹ As baby boomers (those born from 1946 through 1964) begin qualifying for entitlements such as Medicare and Social Security at the end of this decade, government budgets will be further strained.⁷²

Absent reform, spending for net interest, Social Security, Medicare, and Medicaid will consume three-quarters of federal revenue by 2030.⁷³ Total federal spending on health care is projected to increase from 13.4% of GDP in 1999 to 15.9% of GDP in 2010.⁷⁴ Within state budgets, Medicaid is one of the largest categories of spending, second only to education.⁷⁵ Spending

67. BUDGET AND ECONOMIC OUTLOOK, *supra* note 63, at 5; *see also* NATIONAL HEALTH CARE EXPENDITURES PROJECTIONS: 2001-2011 (2002), <http://www.cms.hhs.gov/statistics/nhe/projections-2001/highlights.asp>.

68. *Long-Term Care*, *supra* note 58, at 2. "In 2000, Medicaid paid 45% (about \$62 billion) of total long-term care expenditures." *Id.* at 4.

69. *See* BUDGET AND ECONOMIC OUTLOOK, *supra* note 63, at 76.

70. U.S. CENSUS BUREAU, AGE: 2000, at 1 (2001), <http://www.census.gov>.

71. *Id.* Census data shows that 4.5% of people sixty-five years and older were living in nursing homes in 2000. U.S. CENSUS BUREAU, THE 65 YEARS AND OVER POPULATION: 2000, at 7 (2001), <http://www.census.gov>. The U.S. is not alone; one in ten persons world-wide is sixty years or older. Press Release, United Nations Releases New Statistics on Population Aging 2 (Feb. 28, 2002), <http://www.un.org/ageing/note5713.doc.htm>. Over 12 million people in the United States need long-term care. KAISER COMMISSION, MEDICAID'S ROLE IN LONG-TERM CARE 1 (2001), <http://www.kff.org>. Most people who need long-term care receive it at home or in the community. About 12% are in nursing homes. "Of the 1.3 million elderly in nursing homes, half are over the age of 85." *Id.*

72. Although the elderly and disabled comprise 28% of Medicaid enrollees, they account for 67% of program spending. *See* HCFA FINANCIAL REPORT, *supra* note 59, at 7.

73. *Id.*

74. Economic Report of the President, Transmitted to the Congress, 145-46 (Feb. 2002), http://w3.access.gpo.gov/usbudget/fy2003/pdf/2002_erp.pdf.

75. VERNON K. SMITH, NATIONAL GOVERNOR'S ASSOCIATION, MAKING MEDICAID

growth, particularly in costs for nursing homes and community-based programs, has triggered fiscal crises in many states.⁷⁶

The cost of long-term care will be ultimately born by taxpayers regardless of whether care is provided privately or through a public delivery system.⁷⁷ To maintain care at present levels, the “graying of America” will force the market to devote a higher percentage of labor to the delivery of long-term care, thereby adding to the burden of the nation’s long-term care costs. We cannot measure that cost in dollar terms. The real cost is the lost opportunity of placing that labor elsewhere. Twenty to thirty years from now, will there be enough workers to care for America’s elderly?⁷⁸

VI. MEDICAID STEPS IN

Need for Medicaid is determined on a case-by-case basis, using eligibility criteria that initially divide recipients into three groups: (i) mandatory categorically needy; (ii) optional categorically needy; and (iii) medically needy.⁷⁹

To become eligible for Medicaid nursing-home benefits, the applicant demonstrates categorical eligibility by showing that he or she is: (i) aged sixty-five years or older;⁸⁰ (ii) a United States citizen, a lawfully admitted alien, or an alien permanently residing in the United States under color of law;⁸¹ (iii) a resident of the state where the Medicaid application is filed;⁸² and (iv) confined

BETTER: OPTIONS TO ALLOW STATES TO CONTINUE TO PARTICIPATE AND TO BRING THE PROGRAM UP TO DATE IN TODAY’S HEALTH CARE MARKETPLACE 3 (2002), *available at* <http://www.nga.org/cda/files/MAKINGMEDICAIDBETTER.pdf>.

76. *Id.* at 7.

77. “[A]ll funds for health services ultimately come from private households, regardless of whether they flow through government, business, or charities.” Stone, *supra* note 31, at 953.

78. Growth of the pool of available health care workers has not kept pace with the pool of prospective long-term care residents. *See* ROBYN I. STONE, LONG-TERM CARE FOR THE ELDERLY WITH DISABILITIES: CURRENT POLICY, EMERGING TRENDS, AND IMPLICATIONS FOR THE TWENTY-FIRST CENTURY 31 (2000) (noting there is a current shortage of doctors with training to meet the needs of the elderly; the problem will worsen in the future; there are similar shortages in the nursing and paraprofessional labor pools), <http://www.milbank.org/0008stone/>.

79. 42 U.S.C. § 1396a(a)(10)(C) (1994); HFCA’S STATE MEDICAID MANUAL, § 3601 (1997), http://www.cms.hhs.gov/pubforms/pub45/pub_45.htm; *see also* JANE PERKINS & SARAH SOMERS, NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM 3.3 (2001).

80. 42 U.S.C. § 1396a(b)(1) (1994); 42 C.F.R. § 435.520 (2001).

81. 42 C.F.R. § 435.406 (2001).

82. 42 C.F.R. § 435.403 (2001).

continuously to a medical institution for thirty days prior to attaining Medicaid eligibility.⁸³ In addition, the applicant must be financially eligible (poor enough).⁸⁴ In general, the applicant's income cannot exceed 300% of the current SSI benefit amount,⁸⁵ and resources must not exceed those applicable to SSI applicants. The SSI rules divide resources (or assets) into two categories: countable and excluded.⁸⁶ Excluded assets are the home, household goods, a car, a burial plot and irrevocable prepaid burial contract, a nominal life insurance policy, and very little else.⁸⁷ Countable assets—essentially, whatever is left—must be “spent down” to Medicaid's resource limit (\$2000 in most states). The applicant may instead give away his assets, voluntarily impoverishing himself, in the hopes of attaining Medicaid eligibility. Doing this without counsel is like walking through a minefield blindfolded.

Any transfer of assets by a Medicaid applicant (or his spouse) invokes the provisions of 42 U.S.C. § 1396p, which places limits on voluntary impoverishment for the purpose of becoming Medicaid eligible.⁸⁸ Section 1396p(c) (1) requires that states impose periods of ineligibility for asset transfers made either without consideration or for less than fair market value during a pre-application time called the “look back period.”⁸⁹ The look back period is thirty-six months, or sixty months in the case of transfers to or from certain trusts.⁹⁰

Interestingly, not every transfer for less than fair market value will result in the imposition of a period of Medicaid ineligibility. Congress has created numerous exceptions to the transfer penalty rules. No penalty is applied with respect to transfers of any

83. 42 U.S.C. § 1396a(a) (10) (A) (ii) (V) (1994).

84. See TIMOTHY L. TAKACS, ELDER LAW PRACTICE IN TENNESSEE § 5-5(a) (1998).

85. 42 C.F.R. § 435.1005 (2001). Typically, persons who qualify for SSI are also eligible for Medicaid. Some states, called “209(b) States,” use more restrictive criteria than those applicable to current SSI applicants. To further the objective of brevity, see PERKINS & SOMERS, *supra* note 79, at 3.6 for a discussion of the 209(b) rules.

86. Compare 20 C.F.R. § 416.1201 (2001) (countable resources) with 20 C.F.R. § 416.1210 (2001) (excluded resources).

87. 20 C.F.R. § 416.1210.

88. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, TRANSFERS OF ASSETS, at <http://www.cms.hhs.gov/medicaid/obs8.htm> (last visited July 20, 2002).

89. 42 U.S.C. § 1396p(c) (1) (1994).

90. *Id.* Section 1396p(d) discusses how trusts are to be treated under the Act, particularly with respect to the transfer of asset provisions in subsection (c).

resource:⁹¹

- To a spouse, or to a third party for the sole benefit of the spouse;⁹²
- From a spouse to a third party for the sole benefit of the spouse;⁹³
- To a blind or permanently and totally disabled child, or to a trust established solely for the benefit of such child;⁹⁴ or
- To a trust established solely for the benefit of a disabled person under the age of sixty-five (65).⁹⁵

Nor is there a penalty when the principal residence is transferred to:

- The individual's spouse;⁹⁶
- A child under the age of twenty-one (21);
- A child who is blind;
- A child who is permanently and totally disabled;⁹⁷
- A sibling who has an equity interest in the residence and who resided in the home for at least a year prior to the applicant's institutionalization;⁹⁸ or
- A child who resided in the home for at least two years prior to the applicant's institutionalization and who provided care to the individual, thereby permitting the individual to remain at home instead of going to a nursing home.⁹⁹

Transfers do not trigger a period of ineligibility where the transfer is for a purpose other than to qualify for Medicaid,¹⁰⁰ or

91. 42 U.S.C. § 1396p(c)(2) (1994).

92. 42 U.S.C. § 1396p(c)(2)(B)(i) (1994); *see Pacente v. Jindal*, 751 So.2d 343, 344-46 (La. Ct. App. 1999) (stating transfer of an annuity by the annuitant to his wife, but if she dies to his son "for as long as the Annuitant lives" held to be a transfer "for the sole benefit of the spouse.") 42 U.S.C. § 1396p(c)(2)(B)(i) (1994).

93. 42 U.S.C. § 1396p(c)(2)(B)(ii) (1994).

94. 42 U.S.C. § 1396p(c)(2)(B)(iii) (1994).

95. 42 U.S.C. § 1396p(c)(2)(B)(iv) (1994).

96. 42 U.S.C. § 1396p(c)(2)(A)(i) (1994).

97. 42 U.S.C. § 1396p(c)(2)(A)(ii) (1994).

98. 42 U.S.C. § 1396p(c)(2)(A)(iii) (1994).

99. 42 U.S.C. § 1396p(c)(2)(A)(iv) (1994); *see Scinto v. Rowe*, No. CV 930308973, 1995 WL 31091, at *7 (Conn. Super. Ct. Jan. 23, 1995). Here, although he had provided primary care to his mother, the son failed to prove that the care avoided institutionalization for two years. *Id.* at *2.

100. 42 U.S.C. § 1396p(c)(2)(C)(i) (1994); *see Pentuik v. Florida Dept. of Health & Rehabilitative Serv.*, 584 So.2d 1098, 1098-1101 (Fla. Dist. Ct. App. 1991). In this case, the Medicaid applicant transferred assets the day before undergoing surgery because he believed the operation would kill him. This was determined not a transfer in order to qualify for Medicaid. *Id.* at 1101. Because, *ipso facto*,

where the applicant intended to exchange the asset for fair market value.¹⁰¹ Nor is a period of ineligibility imposed where the transferred assets are returned,¹⁰² or where imposition of a penalty would cause undue hardship.¹⁰³

So, for example, an individual may transfer all of his countable assets to his disabled child without penalty. Note that the disabled child does not have to demonstrate a need for the assets: that is, Medicaid does not require an asset test of the disabled child to make the transfer non-disqualifying.¹⁰⁴

An individual who owns a \$500,000 home may qualify for Medicaid provided he meets all other criteria for eligibility. The theory is that when the Medicaid recipient's health improves, he should have a home to return to; he should not have to sell it to pay for his nursing home care. This benefit is largely illusory, however. Because Medicaid limits the assets and income that the Medicaid recipient may retain, there are seldom enough assets or income available to keep up the house—that is, pay property taxes, insurance, utilities, and the like. As a result, the burden of keeping up the house usually falls upon the Medicaid recipient's family. Furthermore, upon the death of Medicaid recipients age fifty-five or older, states are required to seek recovery of Medicaid payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals.¹⁰⁵ This is called "estate recovery."¹⁰⁶

Courts and commentators have discussed the purpose of estate recovery statutes. The California Supreme Court has observed that estate recovery programs serve the purpose of permitting a state to assist those in need, while easing the financial burden of doing so by recouping benefits from a recipient's estate, thereby preventing heirs of the recipient "from unfairly benefiting from the

exempt assets are not counted, a transfer of an exempt asset other than the principal residence is not disqualifying. *Id.* at 1100.

101. 42 U.S.C. § 1396p(c)(2)(C)(ii) (1994).

102. 42 U.S.C. § 1396p(c)(2)(C)(iii) (1994).

103. 42 U.S.C. § 1396p(c)(2)(D) (1994).

104. 42 U.S.C. § 1396p(b)(1)(B) (1994).

105. 42 U.S.C. § 1396p(b)(1)(B) (1994).

106. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, ESTATE RECOVERY PROVISION, at <http://www.cms.hhs.gov/medicaid/obs1.htm> (last visited July 20, 2002).

program.”¹⁰⁷ The Minnesota Supreme Court has characterized the Medicaid estate recovery program as a means “whereby money paid to qualified individuals for health care purposes may be recovered and reused to help other similarly situated persons.”¹⁰⁸ A commentator has noted that “[t]he foremost consideration behind estate recovery is the reduction of the overall cost of Medicaid to states by recouping some portion of Medicaid expenditures.”¹⁰⁹

The practice is not without its critics. U.S. Senator Russell Feingold, D-Wis., has described estate recovery as the real death tax because it effectively imposes a 100% estate tax on the country’s most vulnerable citizens.¹¹⁰ Some states object to estate recovery. Texas, Michigan, and Georgia have informed federal officials of their intention not to participate in estate recovery efforts, apparently without repercussion.¹¹¹ Trying a similar gambit has failed the state of West Virginia, at least to date. The Governor, Attorney General, and a Congressman publicly oppose estate recovery but have been told that unless the state continues its estate recovery program, the federal government would withhold Medicaid funds for long-term care services. West Virginia’s opposition to Medicaid estate recovery was featured on the front page of *USA Today*. According to *USA Today*, “A year after 85-year-old Aunt Rose died, [her niece] got a letter from a collection agency saying her aunt’s estate owed Medicaid \$51,000.” Aunt Rose bequeathed her home, which apparently was all she had left, to her niece. Now Medicaid is trying to take the house unless the niece comes up with the money.¹¹² West Virginia argued unsuccessfully to a federal district court that Congress

107. *Kizer v. Hanna*, 767 P.2d 679, 681 (Cal. 1989).

108. *In re Estate of Turner*, 391 N.W.2d 767, 770 (Minn. 1986).

109. Jon M. Zieger, *The State Giveth and the State Taketh Away: In Pursuit of a Practical Approach to Medicaid Estate Recovery*, 5 *ELDER L.J.* 359, 374 (1997).

110. Sen. Feingold proposed a Medicaid amendment on May 21, 2001, which would have eliminated estate recovery. 147 *CONG. REC.* S5406 (daily ed. May 22, 2001). The amendment was defeated on a procedural challenge. 147 *CONG. REC.* S5229 (daily ed. May 21, 2001).

111. ELDERLAWANSWERS.COM, W. VA. LOSES LATEST ROUND IN EFFORT TO BLOCK ESTATE RECOVERY, <http://www.elderlawanswers.com/news/XcNewsPlus.asp?cmd=view&articleid=162> (citing Laura Parker, *West Virginia Fights Law that Makes Heirs Sell Homes to Pay Off Medicaid Bill*, *USA TODAY*, May 1, 2002, at 1A, <http://www.usatoday.com/usatoday/20020501/4073417s.htm>) (last visited May 28, 2002).

112. See Laura Parker, *Medicaid Patient Dies: Who Gets the House?*, *USA TODAY*, May 1, 2002, at 1A, <http://www.usatoday.com/news/nation/2002/05/01/usatcov-medicaid.htm>.

unconstitutionally coerces the states to implement estate recovery programs as a condition to receiving federal Medicaid funds.¹¹³ The Fourth Circuit Court of Appeals ruled against West Virginia on May 7, 2002.¹¹⁴

A. *What is Medicaid Planning?*

Effective Medicaid planning guides the applicant through the minefield of potential ineligibility. The effective Medicaid planner helps an applicant preserve assets, while fitting within the financial criteria for Medicaid eligibility. A typical Medicaid plan calls for the applicant to transfer assets to other persons, thereby artificially “impoverishing” the applicant. He is then “needy” enough to qualify for Medicaid. Medicaid planning also helps applicants plan around estate recovery issues. As a consequence, the cost of the Medicaid recipient’s long-term care is shifted to the state.¹¹⁵

Often, too, Medicaid planning is an explicit attempt to shift from a private pay package of health care benefits to a “Medicaid-Plus” benefits package. Theoretically, “individuals cannot purchase a supplement to Medicaid.”¹¹⁶ This is true, in part, because Medicaid recipients (who do not plan) cannot qualify for program benefits until they have exhausted their personal resources. It is also true because providers are proscribed from charging additional fees for covered services.¹¹⁷ However, effective Medicaid planning can result in the creation of a pool of protected assets that a family member uses to pay for goods and services that Medicaid does not pay for, such as dental care or sitters, thereby

113. W. Va. *ex rel. McGraw v. United States Dept. of Health & Human Serv.*, 132 F. Supp. 2d 437, 437 (S.D. W.Va. 2001).

114. W. Va. *ex rel. McGraw v. United States Dept. of Health & Human Serv.*, 289 F.3d 281, 281 (4th Cir. 2002).

115. Ultimately, whether government (taxpayers) should fund health care is a policy decision that remains controversial. LIAM MURPHY & THOMAS NAGEL, *THE MYTH OF OWNERSHIP* 5 (2002). It is apparent, given the cost, that no individual consumer can fund the cost of America’s public health infrastructure, which must be maintained “at the ready” to be effective. Further complicating matters, the public health infrastructure must be maintained to meet potential but unknown future demands for services. One can argue (and we do), that under these circumstances, the cost of the public health infrastructure is an appropriate subject for “government intervention.” *Id.* at 6.

116. GRUBER, *supra* note 60, at 28. Even in non-Medicaid contexts, supplements remain controversial because they may allow certain users of health care services to jump to the front of the line. CUTLER, *supra* note 32, at 70-71.

117. 42 C.F.R. § 483.12(d)(3) (2001).

improving the Medicaid recipient's health and enhancing his quality of life.¹¹⁸

B. Objections to Medicaid Planning

Medicaid planning is legal. It is not uncontroversial, however. A number of objections have been posed to Medicaid planning. Seemingly, these objections stem from divergent views concerning whether some higher moral rule, beyond the law, should guide citizens who participate in the health care market system.¹¹⁹ Assuming America retains a free-market health care system (as opposed to moving toward universal health care), these criticisms are largely irrelevant to the extent they urge elders to refrain from self-interested conduct, while other market players, such as health care providers and insurers, remain free to condition health care access on payment (and profit).

Common Objection 1. Medicaid is for "the poor," not for those who voluntarily impoverish themselves to qualify for benefits. Transferring assets to qualify for benefits is against public policy as demonstrated by repeated acts of Congress to put a stop to it. In 1982, Congress enacted additional penalties for transferring assets and, for the first time, authorized states to impose Medicaid ineligibility periods and initiate estate recovery efforts. In 1985, Congress restricted the use of certain types of trusts, such as the "Medicaid Qualifying Trust." In 1988, Congress added to the length of the penalty period and eliminated exceptions to the asset transfer rules (although at the same time adding protections for the spouses of nursing home residents). In 1993, Congress further tightened up the asset transfer rules and made estate recovery mandatory. In 1996 Congress made transferring assets in order to

118. 42 C.F.R. § 483.12(d)(3)(i) (2001).

119. Compare Brian Bix, *Natural Law Theory*, with Jules L. Coleman & Brian Leiter, *Legal Positivism*, in *A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 233-60 (Dennis Patterson ed., 1996). Natural law theorists hold that a higher law exists against which society's law can be judged, while legal positivists generally hold that the law is fundamentally a social fact and that no connection exists between it and morality. Bix, *supra*, at 223. The other philosophic camp many American scholars fall into is legal realism, which examines, not the law as a principle, but what judges actually do with the law. Brian Leiter, *Legal Realism*, in *A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 261-79 (Dennis Patterson ed., 1996). Given the natural inclination virtually all persons have toward protecting their assets, our approach could be labeled "positive realism" given our discussion of MRPC. See MRPC, *supra* note 5 and accompanying text.

qualify for Medicaid a crime; in 1997, this was changed to make advising persons to transfer assets a crime.¹²⁰

Common Objection 2. Medicaid's eligibility criteria were put in place to ensure that only the truly needy obtain benefits. They were not put in place to enable the taxpayers to subsidize inheritances for the Medicaid recipient's children.¹²¹

Common Objection 3. If left unchecked, Medicaid planning will bankrupt the program.¹²² Low Medicaid reimbursement rates to nursing homes contribute to the understaffing and other problems nursing homes face in delivering quality care to their residents. The result will be a two-tier system of long-term care: one for wealthy people who pay privately in private-pay-only facilities, and the other for poor people in substandard, Medicaid-only nursing homes.

Common Objection 4. Children who engage in Medicaid planning for their parents are depriving them of good care. If indeed this assumption is true -- beneficiaries of Medicaid nursing home benefits receive poorer care than those who pay privately --

120. Popularly known as "Granny's Lawyer Goes to Jail," 42 U.S.C. § 1320a-7b(a)(6) provides:

Whoever for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396(p)(c) of this title, shall . . . be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.

42 U.S.C. § 1320a-7b(a)(6) (1997). In 1998 the United States was enjoined from enforcing this statute, which, while technically still on the books, makes such counseling illegal. The provision was declared to be an unconstitutional limitation on free speech. *N.Y. Bar Ass'n v. Janet Reno*, 999 F. Supp. 710, 710 (N.D.N.Y. 1998). In a March 11, 1998 letter, Attorney General Janet Reno informed the Speaker of the House and the Vice President of the United States that the Justice Department would not enforce the statute because "the counseling prohibition . . . is plainly unconstitutional under the First Amendment . . ." Letter from Janet Reno, U.S. Attorney General, to Newt Gingrich, Speaker of the U.S. House of Representatives (Mar. 11, 1998), <http://www.seniorlaw.com/reno.htm>.

121. "Allowing states to recover from the estates of persons who previously received assistance furthers the broad purpose of providing for the medical care of the needy; the greater amount recovered by the state allows the state to have more funds to provide future services." *Belshe v. Hope*, 38 Cal. Rptr. 2d 917, 925 (Ct. App. 1995).

122. "The Medicaid program would be at fiscal risk if individuals were permitted to preserve assets for their heirs while receiving Medicaid benefits from the state." *Forsyth v. Rowe*, 629 A.2d 379, 385 (Conn. 1993).

under this view a child's effort to accelerate Medicaid eligibility for a helpless parent who does not know any better would be immoral.

Common Objection 5. Medicaid planning (that is, transfer of assets) engaged in by children with their parents' money is the moral equivalent of elder financial abuse.¹²³ In some instances, the elderly person is exploited by relatives, who would rather see the family fortune in their pockets than utilized for the elder's nursing home care. The elder is often unaware of the planning and transferring of assets or is not informed fully of the impact of being on public benefits.

Common Objection 6. In a health care system of limited resources, Medicaid planning will lead to a deprivation of health care from the truly needy, those who are really poor, not those who have artificially impoverished themselves in order to qualify for Medicaid. Medicaid planning may be legal, but it is against public policy.¹²⁴

Common Objection 7. Medicaid planning discourages people from purchasing long-term care insurance or saving to pay their own long-term care costs.¹²⁵

Common Objection 8. Those who can pay privately have a civic duty to do so, even if they could legally shift the cost to the Medicaid program, so as to preserve Medicaid benefits for those who are in genuine need.

Many elder law attorneys are sensitive about the public image associated with Medicaid planning. Medicaid planners are often

123. See *Rainey v. Guardianship of Mackey*, 773 So.2d 118, 122 (Fla. Dist. Ct. App. 2000) (noting that courts must retain discretion to respond to abuse).

124. See *Allen v. Wessman*, 542 N.W.2d 748, 753 (N.D. 1996) ("Public policy will not allow the social safety net for persons who are old, poor, and unfortunate to be exploited by those who are affluent."); *Meyer v. S.D. Dep't. of Soc. Services*, 581 N.W.2d 151, 156-58 (S.D. 1998); see also *Johnson v. Guhl*, 166 F. Supp. 2d 42, 51 (D.N.J. 2001) ("HCFA's position does not frustrate Congress' intent in enacting the MCCA to enable the community spouse to live above the poverty level. Instead, it ensures that Medicaid, as it was intended, helps the truly needy and furthers the legislature's intent to 'require couples to bear a reasonable amount of the costs of institutionalized care and thus preserve Medicaid resources.'").

125. Impoverishment of applicants under the current system will encourage future Medicaid applicants to purchase long-term care insurance. See JOSHUA M. WIENER, CONGRESSIONAL RESEARCH SERVICE, STATE COST CONTAINMENT INITIATIVES FOR LONG-TERM CARE SERVICES FOR OLDER PEOPLE CRS-21 (2000), <http://newfederalism.urban.org/pdf/lcicare-initiatives.pdf>; see also GRUBER, *supra* note 60 (analyzing the economic decision-making process for consumers); CUTLER, *supra* note 32, at 75 ("[People] might drop their private insurance coverage if they are eligible for the public program.").

accused of “gaming the system” for their undeserving and overprivileged clients.

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

We do not address each of these objections in detail. All objections are trumped by our conclusion that the ethical implications these objections raise are irrelevant as long as Medicaid planning is practiced in an amoral health care market, in which the only ethics that count are those of the marketplace.

C. Identifying the Stakeholders

Many stakeholders in the long-term care arena have an interest in Medicaid planning. They include: (1) the Medicaid applicant or recipient; (2) the applicant’s healthy spouse, still living in the community; (3) the applicant’s heirs; (4) the government, which funds the Medicaid program; (5) health care providers; and (6) the insurance industry.

1. The Applicant’s Interests

Surveys show that the general population, which includes the pool of potential Medicaid applicants, has a strong aversion to nursing home care.¹²⁶ One study, which surveyed seriously ill persons over age seventy, found that twenty-nine percent would rather die than go to a nursing home.¹²⁷ Improving quality of life in nursing homes therefore should be viewed as imperative. Where relocation to a long-term care facility is required, older persons

126. Robert L. Kane & Rosalie A. Kane, *What Older People Want from Long-Term Care, and How They Can Get It*, 20 HEALTH AFFAIRS, Nov.-Dec. 2001, at 114-115.

127. *Id.* at 115.

value kindness, caring, compatibility and responsiveness.¹²⁸ They value private accommodations, as well as control and choice on aspects of their daily lives. Good care furnished in the most appropriate setting is a nonnegotiable necessity.¹²⁹

But how do they get it? “Long-term care” includes a broad range of *expensive* health and social services. Choice in settings in which long-term care is delivered is a luxury reserved for the wealthy, however, as long as health care remains a commodity rather than a right. After the United States Supreme Court’s *Olmstead* decision,¹³⁰ home health care options are expanding; nonetheless, the Medicaid program remains focused on nursing home care as the long-term care option of choice.¹³¹ Preserving choice for the middle class, to the extent possible, is one interest served through effective Medicaid planning.

Likewise, nursing home residents are concerned about retaining enough assets once they leave the nursing home and return home.¹³² In *The Changing Profile of Nursing Home Residents: 1985-1997*, researchers found that nursing home residents are returning home in increasing numbers. In 1985, 18% of residents were discharged from nursing homes back into the community. By 1997, data showed that thirty percent of residents were discharged

128. *Id.* at 116.

129. *Id.*

130. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” *Id.* at 592. The federal government has embarked on a major initiative to facilitate states’ efforts to comply with the ADA and the *Olmstead* decision. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICANS WITH DISABILITIES ACT/OLMSTEAD DECISION, at <http://www.cms.hhs.gov/olmstead/> (last modified May 10, 2002).

131. NAELA WHITE PAPER, *supra* note 48, at 5. “Despite some recent improvements, long-term care continues to pose major challenges: People who need long-term care often do not get the care they need or prefer, and families’ caregiving and financial burdens are often heavy.” Feder, *supra* note 44, at 41. In many states, neither Medicare nor Medicaid will pay for assisted-care living services, or the eligibility criteria is so strict that as a practical matter public benefits are unavailable to residents of any long-term care facility other than a nursing home. Medicare-funded home health is generally limited to persons who are “confined to the home.” 42 C.F.R. § 409.42(a) (2001); STEIN & CHIPLIN, *supra* note 45, § 4.02[A].

132. “Persons who are discharged alive after depleting most of their life’s savings may not be able to be financially independent in the community and may subsequently become eligible for Medicaid or other forms of public assistance (e.g. SSI or food stamps).” ALEXI & KENNEL, *supra* note 10, at 8.

because they had recuperated or stabilized.¹³³ There is, however, little value in returning home if medical costs, including Medicaid “spend down,” have rendered independent living economically impossible. Preserving assets is necessary to enable the individual to return home.

Presumably, everyone has a right to continue living.¹³⁴ The prevailing view, however, is that health care resources are limited and, therefore, must be rationed.¹³⁵ When health care necessary to sustain life is rationed (withheld), the effect is *passive euthanasia*.¹³⁶ In a market economy, care is rarely withheld from those with means; most commentators agree that ability to pay is a primary function of access to health care services.¹³⁷

For those who are unable to pay, and the State has promised to provide them health care services,
the demands quickly exceed the ability of the State to

133. NADINE R. SAHYOUN, ET AL., THE CHANGING PROFILE OF NURSING HOME RESIDENTS: 1985-1997 3 (2001), <http://www.cdc.gov/nchs/data/agintrends/04nursin.pdf>. From October 1998 to September 1999, 834,000 residents were discharged (thirty-three percent of all discharges during that period) after recovery or stabilization. See U.S. Dept. of Health and Human Services, *The National Nursing Home Survey: 1999* VITAL & HEALTH STAT. 4 (2002), http://www.cdc.gov/nchs/data/series/sr_13/sr13_152.pdf. This *should* come as no surprise. The stated purpose of nursing home care is to attain and maintain the highest practicable level of physical, mental and psycho-social well-being possible. 42 C.F.R. § 483.25 (2001); see also GA. CODE ANN. § 31-8-108(a) (5) (2001) (stating a goal is to return residents home or to a less restrictive environment).

134. JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT 15 (J.W. Gough ed., Basil Blackwell 3d ed. 1966) (1690). One author explores a different viewpoint in John Hardwig, *Is There a Duty to Die*, 27 HASTINGS CTR REP., Mar.-Apr. 1997, at 34. He states “[w]e fear death too much. Our fear of death has led to a massive assault on it. We still crave after virtually any life-prolonging technology that we might conceivably be able to produce. We still too often feel morally impelled to prolong life – virtually any form of life – as long as possible. As if the best death is the one that can be put off longest.” *Id.* at 40.

135. See Levy, *supra* note 23, at 116. “Rationing may be defined as the de facto or de jure allotment or limitation of medical care necessitated by a shortage of money available.” Gregory N. Rutecki, *Rationing Medical Care to the Elderly Revisited: Futility as a Just Criterion*, 7 J. BIBLICAL ETHICS IN MED., Summer 1993, <http://www.bmei.org/jbem/volume7/num3/ruteki.htm>. See generally, TIMOTHY L. TAKACS, HEALTH CARE RATIONING: CHALLENGES FOR THE ELDER LAW ATTORNEY, at <http://www.tn-elderlaw.com/rationing.html> (October 1996).

136. “Allowing to die – sometimes called ‘passive euthanasia’ – is already accepted as a humane and proper course of action in certain cases.” SINGER, *supra* note 17, at 209. For a discussion involving the difference between active and passive euthanasia, see *id.* at 202-13. The author notes that in traditional Eskimo communities, it was custom for a man to kill his elderly parents. *Id.* at 217. Obviously, the affected elder may wish to have a voice in this decision.

137. See e.g., BODENHEIMER & GRUMBACH, *supra* note 14, at 21.

supply these services. When demands exceed the supply, what do [policymakers do]? They limit services in subtle ways, such as by (1) requiring more “documentation,” (2) limiting the number of hospital beds, (3) demanding early discharge, (4) reducing payment for services and procedures, (5) requiring more out-patient procedures, (6) limiting the number of visits, (7) requiring “justification” before payment, (8) establishing stricter “Certificate of Need” requirements, (9) increasing taxes, (10) accusing the suppliers of services of waste, fraud and abuse, etc. The list is unending but there is never a hint that the system is fatally flawed and that the system has never worked as promised in any country in which it has been tried.¹³⁸

So as Medicaid’s fiscal crisis deepens, and one response to ameliorating the crisis is to limit services, the elderly have a substantial interest in preserving private funds that can be used to fund health care “reclassified” by public benefits programs and insurance entities as “futile” or “not medically necessary.”¹³⁹ The Medicaid safety net does not pay for those “quality of life” items that may make life in a nursing home a little more bearable. Medicaid recipients who want decent clothes, dentures, snacks, entertainment, books and magazines, and furnishings for their rooms have to pay for these things themselves.¹⁴⁰ For most, that is hardly possible out of the \$2000 Medicaid resource limitation and the Personal Needs Allowance that they can retain out of their monthly income (the remainder of which is paid to the nursing home, under Medicaid’s share-of-cost requirement).

138. William H. Tucker, *Social Security—Good Concept, Bad Execution*, 160 ARCHIVES OF INTERNAL MED. 2680 (2000).

139. See WESLEY J. SMITH, FUTILE CARE THEORY AND MEDICAL FASCISM: THE DUTY TO DIE, at <http://www.frontpagemag.com/archives/miscellaneous/futile.htm> (Apr. 9, 2002); CENTER FOR BIOETHICS, UNIVERSITY OF MINNESOTA, DISTRIBUTING LIMITED HEALTH CARE RESOURCES 2 (1997) (discussing that “health care resources are scarce relative to needs” and failure to place limits on delivery of health care services would limit other national priorities), http://www.bioethics.umn.edu/publications/Limited_Resources.pdf. Futile treatment is treatment that secures biologic survival, but not meaningful recovery or reversal of the condition being treated. Rutecki, *supra* note 135.

140. 42 C.F.R. § 483.10(c)(8)(ii) (2001). “Nursing home residents also value control and choice on aspects of the daily lives, particularly with reference to leaving the facility from time to time and telephone and other communication with those outside the facility. . . . The majority [of nursing home residents] place a high value on privacy.” Kane & Kane, *supra* note 126, at 116. Medicaid does not fund these “luxuries.” See also BODENHEIMER & GRUMBACH, *supra* note 14, at 161.

Although a resident's means should not determine the quality of services received, it may. In July 2000 CMS released phase 1 of its report, *Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes*, which details substandard care in American nursing homes and pins the blame primarily on understaffing.¹⁴¹ Persons with means can afford to supplement services that nursing homes provide, in some instances, transforming substandard care to acceptable care. In other cases, preserved assets may provide residents and family members with the means to create a form of private quality enforcement; assets may pay for sitters, who can serve as private ombudsmen to ensure that essential services are provided.¹⁴²

In almost every case, when death occurs, the Medicaid applicant will want to pass wealth to his heirs, an impulse as old as the Bible itself.¹⁴³ Former President Jimmy Carter says the following about his own estate plan:

One of the most interesting and gratifying responsibilities at our age is to decide what to do with accumulated wealth and possessions. In all too many cases, couples fail to leave a will of any kind. Whether it's a few pieces of furniture and some personal items or broader holdings of stocks and real estate, we should decide what will happen to our belongings. We must remember that, no matter what we do, the Internal Revenue Service will be one of our major heirs. How much of our estate will go for taxes can be greatly affected by whether or not we plan for the future. . . . We are leaving a substantial portion of our estate to the Carter Center. . . . We have retained an interest in some of our bequests, amending the arrangements to accommodate changing circumstances and sometimes for sentimental reasons. For instance, we have a special feeling about our property around Plains.

141. Phase I of the Report, at <http://www.cms.hhs.gov/medicaid/reports/rp700hmp.asp> (July 2000); Phase II, at <http://www.cms.hhs.gov/medicaid/reports/rp1201home.asp> (March 2002); see also MINORITY STAFF, SPECIAL INVESTIGATIONS DIVISION, COMMITTEE ON GOVERNMENT REFORM, U.S. HOUSE OF REPRESENTATIVES, ABUSE OF NURSING HOME RESIDENTS IS A MAJOR PROBLEM IN U.S. NURSING HOMES (2001), http://www.house.gov/reform/min/pdfs/pdf_inves/pdf_nursing_abuse_rep.pdf.

142. This can be particularly important in areas where local Ombudsmen, for whatever reason, are indifferent to substandard care.

143. The concept of inheritance is ancient. Without detailing the breadth of the Hebrew notion of "birth-right," suffice it to say that the notion of passing one's substance to the next generation is also ancient. See *Genesis 27:27*.

Both Rosalynn's and my ancestors who were born in the 1700s are buried there, and most of the land that we own was acquired several generations ago. . . . [W]e wish to keep intact and owned by our direct descendants.¹⁴⁴

Former President Carter's description of his estate plan underscores the natural inclination we all have toward directing how our assets will be distributed (which runs counter to the position espoused by critics of Medicaid planning).¹⁴⁵ Beyond personal and sentimental reasons for controlling the disposition of assets, the social significance of inheritance laws was recognized by Alexis de Tocqueville in *Democracy in America*. Those who control the direction wealth takes as it passes to the next generation have immense power.¹⁴⁶ Tocqueville observed: "What is called family pride is often founded upon an illusion of self-love. A man wishes to perpetuate and immortalize himself, as it were, in his great-grandchildren."¹⁴⁷ 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.¹⁴⁸ No rational person would enter such a lottery voluntarily.¹⁴⁹

2. *The Applicant's Healthy Spouse*

Failure to plan can impoverish the Medicaid applicant's healthy spouse. A Medicaid applicant is not eligible to receive

144. CARTER, *supra* note 20, at 129-30; *see also In re Labis*, 714 A.2d 335 (N.J. Super. Ct. App. Div. 1998) (authorizing Medicaid planning transfer in substituted judgment/guardianship context because ward would have wanted to provide for his wife for life and benefit his children thereafter).

145. Indeed, since the natural response of virtually everyone is self preservation, one can legitimately question the moral justification, to the extent they urge some "higher law," of the position taken by Medicaid planning critics.

146. 1 ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 50-51 (Phillips Bradley ed., Alfred A. Knopf 1966) (1835).

147. *Id.* at 49.

148. The social effect of injecting income into poor families is beyond the scope of this article. However, low income is related to poor material conditions. *See* Michael Marmot, *The Influence of Income on Health: Views of an Epidemiologist*, 21 *HEALTH AFFAIRS*, Mar.-Apr. 2002, at 31, 32. Marmot speculates that a threshold exists below which material conditions such as clean water, good sanitation, adequate nutrition, adequate housing and warmth are not accessible. Above the threshold, although there are still differing opportunities for social participation, the differences in material conditions no longer have a plausible connection with pathology. For additional information on the status of poor families, *see* POLICY ANALYSIS FOR CALIFORNIA EDUCATION, *NEW LIVES FOR POOR FAMILIES?*, at http://pace.berkeley.edu/pace_new_release.html (2002).

149. *See* Levy, *supra* note 23, at 114-15.

Medicaid if his countable resources exceed \$2,000.¹⁵⁰ Those assets, however, may have been necessary to support his spouse during her retirement. In 1988, Congress enacted the Medicare Catastrophic Coverage Act (MCCA) “to protect the elderly and disabled population from the financial disaster caused by catastrophic health care expenditures not currently reimbursed under the Medicare and Medicaid programs.”¹⁵¹ Included in MCCA was a special section that pertains to Medicaid and the treatment of resources and income for spouses.¹⁵² Under prior law, nearly all of a couple’s assets had to be depleted before a spouse institutionalized in a nursing home (the “institutionalized spouse”) could become eligible for Medicaid, often resulting in the impoverishment of the spouse remaining at home (the “community spouse”). The purpose of MCCA “is to end this pauperization by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available to her while her spouse is in a nursing home at Medicaid expense.”¹⁵³

To meet the Congressionally-mandated goal of avoiding impoverishment of the community spouse, MCCA provides special allowances of assets and income for married couples where one spouse resides in a nursing home. At the time of institutionalization, a “snapshot” of the couple’s resources is taken.¹⁵⁴ The couple’s resources are separated into one of two categories, countable and exempt, and a total value of the couple’s countable resources is determined. Countable assets include checking and savings accounts, certificates of deposit, money market funds, stocks and bonds, and other similar assets, whether held by them separately or jointly.¹⁵⁵

Of the countable assets, the community spouse is permitted to retain what is termed the “community spouse resource allowance.”¹⁵⁶ Assets that are exempt, such as the couple’s home, are not considered when the community spouse resource allowance is set. Of the total countable resources, the community spouse

150. 42 U.S.C. § 1382 (1994).

151. H.R. REP. NO. 100-105, pt. 2, at 65-68 (1998), *reprinted in* 1988 U.S.C.C.A.N 803, 888.

152. 42 U.S.C. § 1396r-5 (1994).

153. H.R. REP. NO. 100-105, *supra* note 151, at 888.

154. 42 U.S.C. § 1396r-5(c)(1)(A) (1994).

155. 42 U.S.C. § 1396r-5(c) (1994).

156. 42 U.S.C. § 1396r-5(f)(2) (1994).

resource allowance is the greatest of (1) \$17,856 (in 2002, adjusted annually); (2) the lesser of one-half of the total countable resources or \$89,280 (in 2002, adjusted annually); (3) an amount established pursuant to a fair hearing; or (4) an amount transferred under court order.¹⁵⁷ All other countable resources above this amount are attributed to the institutionalized spouse.¹⁵⁸ When the countable resources attributed to the institutionalized spouse have been appropriately reduced to the Medicaid resource limitation (\$2,000 in most states), the institutionalized spouse is eligible for Medicaid nursing home benefits.

Once eligibility for Medicaid is established, a determination is made of the allocation of income to the community spouse. MCCA provides that a community spouse is entitled to a minimum monthly maintenance needs allowance ("MMMNA") to be set by the states at 50% above the poverty level for a family of two.¹⁵⁹ Post-eligibility, the income allowance may be deducted from the institutionalized spouse's income that would otherwise be paid to the nursing home.

157. *Id.* It is worth noting that the elderly often live on accumulated assets because income declines when they leave the workforce. See ALEXI & KENNEL, *supra* note 10, at 6. If this is true, one can argue that the CSRA is woefully inadequate. The 2002 HHS Poverty Guidelines set the poverty level for single persons residing in the forty-eight contiguous States at \$8,860. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2002 HHS POVERTY GUIDELINES, at <http://aspe.hhs.gov/poverty/02poverty.htm> (last updated Apr. 24, 2002). The life expectancy for females attaining age 65 is 19.2 years; for males it is 16.3 years. NATIONAL CENTER FOR HEALTH STATISTICS, FAST STATS A TO Z, at <http://www.cdc.gov/nchs/fastats/lifexpec.htm> (last updated June 13, 2002). At age 65, a community spouse who retains the maximum CSRA to pay her living expenses at the 2002 poverty level will outlive her money by more than nine years. If she requires assisted living (which is not covered by either Medicare or Medicaid), the average cost of care is \$2,159 per month, or \$25,908 per year. METLIFE, GENERAL NEWS: 2002 AND 2001 PRESS RELEASES, ASSISTED LIVING AVERAGES \$2,159 PER MONTH IN U.S. METLIFE MATURE MARKET INSTITUTE STUDY FINDS, at <http://www.metlife.com/Applications/Corporate/WPS/CDA/PageGenerator/0,1674,P250%257ES356,00.html> (May 29, 2002). Even with the maximum CSRA, the community spouse will not have sufficient assets to fund assisted living care for four years at current rates. If she requires nursing home care herself, she will have insufficient assets to pay for two years of care in virtually all states and, in some areas, would have insufficient assets to fund a single year of care. By way of contrast, the CSRA is slightly over one-half the average annual income of physicians for one year. See THE HENRY J. KAISER FAMILY FOUNDATION, TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE, 2002, at 77 (2002), http://www.kff.org/content/2002/3161/marketplace2002_finalc.pdf.

158. 42 U.S.C. § 1396r-5(f).

159. 42 U.S.C. § 1396r-5(d)(3)(A)(i), (B)(iii) (1994).

Medicaid planning, therefore, takes on special urgency, where a principal goal of the planning is to preserve assets for the benefit of the community spouse. Arguably, then, any planning within the ambit of the rules that results in protecting assets and income for the community spouse ought to be largely free from controversy. In fact, however, it is not.

Medicaid planners, seeking to provide community spouses with maximum protection, are sometimes accused of exploiting loopholes in the law.¹⁶⁰ Excess countable resources that would otherwise be at risk for the cost of the institutionalized spouse's nursing home care may be spent without limit on exempt resources for the community spouse. One strategy might be for the community spouse to purchase a new home—regardless of value. The community spouse could purchase a \$500,000 home to qualify her husband for Medicaid, and then sell or transfer the home post-eligibility, without affecting his continued eligibility.

Another popular strategy is to purchase an immediate, irrevocable annuity for the benefit of the community spouse.¹⁶¹ The financial services industry has caught on to this one, and a cottage industry of selling “Medicaid friendly” annuities has arisen.¹⁶² The practice has become so widespread and so apparently abusive that courts in New Jersey, Ohio, and Pennsylvania¹⁶³ have severely restricted the strategy, and at least one state (Alabama) known to the authors bans their use altogether as a strategy to qualify the institutionalized spouse for Medicaid. Rules that would limit or prohibit annuities are under consideration elsewhere.¹⁶⁴

A strategy that is popular in New York, but seldom used

160. See *In re Labis*, 714 A.2d 335 (N.J. Super. Ct. App. Div. 1998).

161. Thomas D. Begley, Jr., and Jo-Anne Herina Jeffreys, *The Use of Annuities in Medicaid Planning: An Update*, ELDERLAW REPORT 2001, at http://www.njelderlaw.com/library/article_display.asp?ID=43 (last visited July 20, 2002).

162. For an example, see “Medicaid Friendly” annuity, at <http://www.standardagents.com/product.asp?mid=261> (last visited July 20, 2002).

163. *Johnson v. Guhl*, 166 F. Supp. 2d 42, 58 (D.N.J. 2000); *McNamara v. Ohio Dep't. of Human Servs.*, 744 N.E.2d 1216, 1221 (Ohio Ct. App. 2000); *Bird v. Pa. Dep't. of Pub. Welfare*, 731 A.2d 660, 669 (Pa. Commw. Ct. 1999).

164. See, e.g., LEGISLATIVE SERVICES AGENCY, ADMINISTRATIVE RULE FISCAL IMPACT STATEMENT (2001) (discussing Indiana Proposed Rule 01-175), <http://www.in.gov/legislative/pdf/01175.pdf>; see also Sylvia Hsieh, *States Crack Down on Medicaid Planning*, LAW. WKLY., July 9, 2001, <http://www.lkrlaw.com/medicaid-planning.htm>.

elsewhere, is called “spousal refusal.” Under MCCA, Medicaid benefits may not be withheld from the institutionalized spouse should the community spouse refuse to make countable resources available to him. Instead, Medicaid has a right to sue the community spouse for support, under a theory of subrogation.¹⁶⁵ This results in a predictable *pas de deux* between the community spouse and the State Medicaid agency (at least as practiced in New York). Once institutionalization occurs, the community spouse in New York refuses to make the couple’s resources available to pay for her husband’s nursing home care; Medicaid pays and bills the community spouse at the Medicaid rate, which is usually considerably lower than the facility’s private pay rate. Married couples without the benefit of counsel pay the private rate, unless they know how spousal refusal works.

3. *The Applicant’s Heirs*

The interests of the applicant’s heirs are relevant only to the extent they support those of the elder.¹⁶⁶ About eighty-five percent of elders who need long-term care receive it from family and friends.¹⁶⁷ Today, “an estimated one [in] four U.S. households is involved in caring for a loved one aged fifty or older,”¹⁶⁸ over twenty-two million caregiver households nationwide.¹⁶⁹ “[Seven] million Americans are caring for a parent at any given time.”¹⁷⁰ The average caregiver age is forty-six, and more than seven of ten caregivers are female.¹⁷¹ While the average caregiver provides approximately eighteen hours of care each week, one in five provides forty or more hours of care each week.¹⁷²

165. 42 U.S.C. § 1396r-5(c)(3) (1994).

166. MODEL RULES OF PROF’L CONDUCT R. 1.14 cmt. 4, R. 1.2(d) (2002). We omit from this article a discussion of conflicts of interest that typically arise in an elder law practice. For a practical discussion of such conflicts, see any treatise on elder law.

167. BODENHEIMER & GRUMBACH, *supra* note 14, at 158.

168. FAMILY CAREGIVER ALLIANCE, FACT SHEET: WORK AND ELDERCARE, at http://www.caregiver.org/factsheets/work_eldercareC.html.

169. NATIONAL ALLIANCE FOR CAREGIVING & AARP, FAMILY CAREGIVING IN THE U.S.: FINDINGS FROM A NATIONAL SURVEY 8 (1997), <http://caregiving.org/content.reports.finalreport.pdf>.

170. FAMILY CAREGIVER ALLIANCE, *supra* note 168.

171. NATIONAL ALLIANCE FOR CAREGIVING, *supra* note 169, at 8.

172. *Id.* at 17. See also AARP, CAREGIVING & LONG-TERM CARE, at http://www.research.aarp.org/health/fs82_caregiving.html (December 2000).

Caregiving¹⁷³ is now “viewed as an unpaid extension of the public health system, providing [approximately] \$196 billion” in uncompensated care annually.¹⁷⁴ It should therefore be encouraged and supported. While running for President, then-Gov. George W. Bush stated:

A growing number of Americans are making the choice to care for loved ones at home. And many families have found that this enriches their lives together--connecting the generations...and making grandparents a daily encouragement to grandchildren, and a regular presence in the teaching of values. We will give extra help to those who care for elderly family members at home.¹⁷⁵

The question then is what can be done to support caregivers? Financial assistance would help. Unpaid caregiving is not “free.” Over the course of a caregiving career, caregivers can lose as much as \$650,000 in wages, Social Security benefits, and pensions.¹⁷⁶ The cost to employers is estimated at \$1,142 in lost productivity per year per employee; the Alzheimer’s Association estimates that Alzheimer’s disease alone will cost American business \$61 billion in 2002.¹⁷⁷ While it may be impossible to replace lost caregiver wages dollar-for-dollar, government could at least partially recompense the caregiver by recognizing an exception to

173. Caregiving is defined as

providing unpaid care to a relative or friend who is aged fifty or older to help them take care of themselves. Caregiving may include help with personal needs or household chores. It might be taking care of a person’s finances, arranging for outside services, or visiting regularly to see how they are doing. This person need not live with you.

NATIONAL ALLIANCE FOR CAREGIVING, *supra* note 169, at 6.

174. NATIONAL ALLIANCE FOR CAREGIVING, TOWARD A NATIONAL CAREGIVING AGENDA: EMPOWERING FAMILY CAREGIVERS IN AMERICA 2 (2001), <http://www.caregiving.org/content/reports%5ccaregiver%20summit-1241.pdf>.

175. GEORGE W. BUSH FACT SHEET, IMPROVING LONG-TERM CARE FOR SENIOR AMERICANS (quoting then-Governor George W. Bush), at <http://www.taxplanet.com/library/bush510/bush510.html> (May 10, 2000).

176. THE NATIONAL ALLIANCE FOR CAREGIVING, *supra* note 174, at 4.

177. FAMILY CAREGIVER ALLIANCE, *supra* note 168. The disease will cost corporate America \$36.5 billion in 2002 for workers who take off time to care for Alzheimer’s patients. That figure includes loss of productivity (\$18 billion), absenteeism (\$10 billion), and hiring temporary workers (\$2 billion), among other costs. Health care business costs and research will require an additional \$24.6 billion, according to the study. This annual cost is nearly twice as much as was estimated in 1998, says the Alzheimer’s Association. ROSS KOPPEL, ALZHEIMER’S ASSOCIATION, ALZHEIMER’S DISEASE: THE COST TO U.S. BUSINESSES IN 2002, at 2-5 (2002), <http://www.alz.org/media/newsreleases/current/062602ADCosts.pdf>.

the estate recovery rules for the benefit of an unpaid caregiver, in much the same way that states may not recover when there is a surviving spouse or a disabled child. Effective Medicaid planning offers a private solution.

4. *The Government*

On January 23, 2002, Dan L. Crippen of the Congressional Budget Office testified before the House Budget Committee. Long-term budget pressure is looming just over the horizon, said Crippen.

Those pressures result from the aging of the U.S. population (large numbers of baby boomers will start becoming eligible for Social Security retirement benefits in 2008 and for Medicare in 2011), from increased life spans, and from rising costs for federal health care programs. According to midrange estimates, if current policies continue, spending on Social Security, Medicare and Medicaid combined will nearly double by 2030, to almost 15% of GDP.¹⁷⁸

Federal and state governments have yet to shoulder the responsibility of *delivering*, as opposed to *financing*, health care. As Feder and her colleagues put it, "Medicare and Medicaid policy resembles a fiscal tug-of-war, rather than a concerted effort to address people's needs."¹⁷⁹ In 2030, 70 million Americans will be 65 years of age or older. Of that number, 8.5 million will have attained age 85.¹⁸⁰ Experts forecast as many as three million nursing home residents in 2030,¹⁸¹ an increase from 1,720,500 in 2000.¹⁸² Who is going to take care of the disabled elderly, and at

178. *The Budget and Economic Outlook: Fiscal Years 2003-2012: Before the House Comm. on the Budget*, 107th Cong. (2002) (statement of Dan L. Crippen, Director, Congressional Budget Office), <http://www.cbo.gov/showdoc.cfm?index=3276&sequence=0>.

179. Feder, *supra* note 44, at 48.

180. SAHYOUN, *supra* note 133, at 7.

181. *Id.* A fact statement produced by candidate George W. Bush, *Improving Long-Term Care for Senior Americans*, May 10, 2000, paints a more dire picture. Candidate Bush estimated that "between 2000 and 2030, the nursing home population will rise from 2.8 million to 5.3 million; total nursing home expenditures will rise from \$69 million to \$330 million." GEORGE W. BUSH FACT SHEET, *supra* note 175. The Bush estimate does not appear to differentiate between nursing home residents over 65 years of age, and those under that age.

182. See U.S. CENSUS BUREAU, QT-P12. GROUP QUARTERS POPULATION BY SEX, AGE, AND TYPE OF GROUP QUARTERS: 2000 (2000), http://factfinder.census.gov/servlet/QTTable?ds_name=D&qr_name=DEC_2000_SF1_U_QTP12&lang=en&

what cost?

One possible solution to government's long-term care financing crisis is to cap prices.¹⁸³ Another is to internalize the delivery of care. A third is to drastically tighten the criteria for Medicaid eligibility, forcing nursing home residents to apply more of their private resources to pay for their own care, including reliance on unpaid caregivers. The State of Connecticut, for example, has requested a "Section 1115 Medicaid Demonstration Waiver" that, if granted by CMS, would allow Connecticut to impose a period of Medicaid ineligibility for transfer of assets not from the date of the transfer but from the date that the individual would otherwise qualify for Medicaid nursing home benefits (that is, at the time of application when the applicant is a nursing home resident).¹⁸⁴ The avowed purpose of the waiver proposal is to frustrate those individuals who have the foresight to plan for Medicaid eligibility and force them instead to purchase long-term care insurance.

Assuming the U.S. health care system continues to function as a market, government could do more than it is presently doing. It could actively participate in the development of a national health care agenda (otherwise known as "goals"), and regulate both supply and demand to move market participants toward a more universal health care system. Still, government is not a panacea.¹⁸⁵ Governments and markets, according to some experts, work hand-

eo_id=01000US&_caller=bfri&_ts=45670541133.

183. See *U.S. v. Nazon*, 940 F.2d 255 (7th Cir. 1991) (affirming a Medicaid fraud conviction, thus illustrating government's ultimate power to control prices).

184. "Through this proposed Demonstration project, the behavioral changes of applicants would be evaluated with the expectation that the revised TOA [Transfer of Asset] policy would encourage personal responsibility and the use of LTC insurance, while also realizing substantial savings to the Medicaid program." For more information about the Connecticut waiver proposal, see the state's Department of Social Services Web site. STATE OF CONNECTICUT, DEPARTMENT OF SOCIAL SERVICES, TRANSFER OF ASSETS SECTION 1115 & DEMONSTRATION WAIVER PROPOSAL 2 (2002), http://www.dss.state.ct.us/pubs/TOA_proposal.pdf. Whether transferring assets adversely affects Medicaid financial stability and integrity has not gone unquestioned, however. Joshua Wiener, for one, who is widely acknowledged as an expert in the area of long-term care financing, wrote in 1998 that while almost all states regard transferring assets as a problem, only a few states have elevated it to a major policy concern affecting Medicaid's fiscal health. Joshua M. Wiener and David G. Stevenson, *State Policy on Long-Term Care for the Elderly*, 17 HEALTH AFFAIRS, May-June 1998, at 81, 97, <http://newfederalism.urban.org/html/haffairs/wiener.pdf>.

185. Thomas Rice et al., *Reconsidering the Role of Competition in Health Care Markets: Introduction*, 25 J. HEALTH POL. POL'Y & L. 863, 867 (2000).

in-hand and need each other. Government needs markets to help ensure that the services produced are the ones that are wanted and resources are not unnecessarily squandered. Markets need government to ensure that prices are fair, all segments of the population are served, and that objective information is disseminated. Determining the proper blend is the key.¹⁸⁶

5. *Health Care Providers*

Providers of health care—doctors, hospitals, and nursing homes—are in business. Health care in fact is a big business, consuming 13.2% of the nation's Gross Domestic Product in 2000.¹⁸⁷ Even a non-profit hospital must have a stable stream of revenue in order to keep the doors open. This profit-making, or revenue-enhancing, objective, founded on the profit motive, puts facilities at odds with elders who need health care and may or may not have sufficient resources to pay for it. Should they be entitled to it nonetheless, regardless of ability to pay?

In 1971, Dr. Robert M. Sade expressed the view that medical care is not a right. His argument, premised in free market economic theory, is that "the concept of medical care as the patient's right is immoral because it denies the most fundamental of all rights, that of a man to his own life and the freedom of action to support it."¹⁸⁸ Medical care is a service provided by doctors and others to people who wish to purchase it. According to Sade, now a cardiothoracic surgeon and director of the Institute of Human Values in Health Care at the Medical University of South Carolina, any contrary position would wrongly deprive doctors of the fruit of their labor.¹⁸⁹ Although Sade argues that his views mirror Locke's, Sade misapprehends Locke. It is true, as Locke said, that the labor of one's body is his own. No one compelled Sade to enter the healing profession, however. Sade's choice dictates that he must live with government's regulation of that profession, whatever form that may take. Sade's (unstated) view that medicine is a business rather than a profession is at the heart of concerns relating to the

186. *Id.* at 869.

187. Stephen Heffler et al., *Health Spending Projections for 2001-2011: The Latest Outlook*, 21 HEALTH AFFAIRS, Mar.-Apr. 2002, at 207.

188. See Robert Sade, *Medical Care as a Right: A Refutation*, in ETHICS IN MEDICINE 573-580 (Stanley Joel Reiser et al. eds., MIT Press 1977) (1971), available at <http://www.aapsonline.org/brochures/sademcr.htm>.

189. See LOCKE, *supra* note 134.

current Medicaid system. During the 1990s, as Medicaid (and other health care financing vehicles) moved from a fee-for-service system to a capitated payment system, the potential for profit due to increased personal labor evaporated. Instead, profit is now maximized through cost-savings, one method of which is by a reduction in services. This “less is more” approach will not reverse itself until professionalism, rather than profit, is paramount.

On June 14, 1999, the American Academy of Family Physicians issued a press release endorsing universal “coverage.”¹⁹⁰ This proposal, while positive, appears to be premised on continuation of the insurance financing model presently in place. On December 4, 2001, the House of Delegates of the American Medical Association adopted a “Declaration of Professional Responsibility: Medicine’s Social Contract with Humanity.”¹⁹¹ The AMA has committed itself to “advocate for social, economic, educational and political changes that ameliorate suffering and contribute to human well-being.”¹⁹² Nonetheless, a difference of opinion exists concerning what this entails.

6. *Insurers*

In theory, long-term care should be insurable.¹⁹³ “In fact, the need for long-term care is far from a necessary concomitant to aging.”¹⁹⁴ People in all age groups face a risk they will need long-term care, although the risk of requiring long-term care does increase with age.¹⁹⁵ Should this risk be spread through public (social) or private insurance, or through a publicly-financed, health care delivery system?¹⁹⁶ The answer depends in part on who should

190. See Press Release, American Academy of Family Physicians, All Americans Must Have Health Insurance: A Joint Statement (June 14, 1999), <http://www.aafp.org/news/990614nr.html>. The Statement was joined by the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians-American Society of Internal Medicine, the American College of Surgeons, and the American Medical Association.

191. <http://www.ama-assn.org/ama/upload/mm/369/decoprofessional.pdf>.

192. *Id.* Art. VIII.

193. NAELA WHITE PAPER, *supra* note 48, at 2.

194. Judith Feder, *Long-Term Care: A Public Responsibility*, 20 HEALTH AFFAIRS, Nov.-Dec. 2001, at 112.

195. *Id.*

196. Douglas Clement, *Beyond Supply and Demand*, FEDGAZETTE (May 2002) (“The only guaranteed means of dealing with adverse selection is compelling everyone to purchase insurance and insisting that everyone pays their share. But

pay for it, and how much they should pay. The sick want expansive insurance, while the healthy do not (until they get sick). Mandatory insurance, essentially a tax, forces the healthy to subsidize health care for the unhealthy.¹⁹⁷

The insurance industry, which is profit motivated, insists it can meet this need. It has developed long-term care insurance products to enable an individual, for a premium, to transfer the risk of the high cost of nursing home care to an insurance company. Medicaid and Medicaid planning pose a risk to the insurance industry, however. If potential policy purchasers can secure social insurance (i.e. Medicaid) for less than the cost of private insurance, they have no incentive to purchase long-term care insurance.¹⁹⁸

In fact, one of the policy issues now under debate is whether Medicaid and long-term care insurance can coexist. Encouraging people to purchase private long-term care insurance while working to strengthen the public safety net for those who cannot afford it probably are incompatible strategies, according to a 1999 study sponsored by The Commonwealth Fund. The Bush administration's policy of promoting the purchase of long-term care insurance by giving purchasers tax breaks would erode support for efforts to assure access to care for the poor through Medicaid or another system, the study's author contends.¹⁹⁹

Nonetheless, the federal government projects continued reliance on an insurance model as the means of providing access to health care services. The assumption underlying this policy is

such 'universal' insurance requires government intervention—the opposite of free markets — and substantial income redistribution. Aside from the political obstacles to such a policy, universal health insurance incurs the economic inefficiencies of taxation, transfers and administrative costs—deadweight losses that economists abhor.”), <http://minneapolisfed.org/pubs/fedgaz/02-05/supply.cfm>. All insurance contains a subsidy used to finance health care. The subsidy in private insurance is a transfer of resources from the healthy to the poor. Social insurance includes the former, but typically adds a transfer from the wealthy to the poor as well. BODENHEIMER & GRUMBACH, *supra* note 14, at 15.

197. BODENHEIMER & GRUMBACH, *supra* note 14, at 13, 163. Others argue, however, that no redistributive effect is realized so long as value is returned to taxpayers (or policy purchasers). See Levinson, *supra* note 33, at 553.

198. See CUTLER, *supra* note 32, at 75. See also CENTER FOR LONG-TERM CARE FINANCING, THE LTC TRIATHLON: LONG-TERM CARE'S RACE FOR SURVIVAL (2000), <http://www.centerltc.org/pubs/triathlon.pdf>.

199. See MARK MERLIS, FINANCING LONG-TERM CARE IN THE TWENTY-FIRST CENTURY: THE PUBLIC AND PRIVATE ROLES, at http://www.cimwf.org/programs/elders/merlis_longtermcare21st_343.asp (Sept. 1999).

flawed, however. Fundamentally risk-adverse, insurers are motivated to cover those persons who are low-risk health service users, not to provide universal access.²⁰⁰ If insurance is intended to serve as the point of access to long-term care, therefore, government must diligently oversee and set the ground rules by which insurance companies go about their business.²⁰¹ For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the use of preexisting condition clauses to exclude workers who change jobs. HIPAA does not regulate marketing, so insurers simply exclude those deemed undesirable risks through pricing and selling tactics.²⁰²

VII. BACK TO ETHICS

Elder law attorneys are uniquely positioned to counsel elders regarding this complex area of the law. If they fail or refuse to counsel elders regarding legally permitted options, elder law attorneys will have derogated their duty to their clients. From this narrow perspective—call it the legalistic perspective—a lawyer's failure to advise his client of all of his long-term care financing options is unethical. That is the lawyer's duty under the rules of professional conduct.²⁰³ Moreover, by failing to counsel elders who seek advice about how to qualify for benefits under the Medicaid program, the legal profession would tacitly concede that America's legal system, indeed its political system, no longer has room for, and no longer condones, divergent values.

But that still does not answer our question: in a broader sense, is it ethical for the lawyer to advise the client to engage in Medicaid planning? Conversely, why might it be unethical to advise a client who wishes to engage in Medicaid planning? Needless to say, the lawyer cannot advise the client to do something that would result in harm to the client—not, in any event, without the client's consent. Under this standard, there may be an ethical duty on the lawyer to advise his client of the potentially adverse consequences to the client that may flow from Medicaid planning (such as harm to the Medicaid program, limits on access to nursing home care, and the

200. See generally, CUTLER, *supra* note 32, at 5; see also Rice, *supra* note 185, at 866.

201. See Stone, *supra* note 31, at 955.

202. *Id.* at 956.

203. MODEL RULES OF PROF'L CONDUCT R. 1.1, 2.1 (2002).

like).²⁰⁴

But what about harm that the client could not realistically expect to happen to him personally, but harm that may result to others, such as those we will call the “truly poor”—that is, those who are Medicaid eligible without planning? An elder who has money has options: he can plan for Medicaid eligibility, but if he needs care that Medicaid cannot or will not pay for, he can arrange his affairs so that resources may be legally unavailable to him, for Medicaid purposes, but nonetheless informally available to him (such as by transferring assets to a trusted relative who will hold the money for him in case he needs it). The truly poor do not have that option.

Does the lawyer have a duty not to harm the truly poor, a duty that derives from the duty to his client, as we discussed earlier?

Whether they are rich or poor, elders are participants in an amoral health care market. Medicaid (like its companion, Medicare) is not a health care delivery system. It is a health care financing system that addresses interests in the market place.²⁰⁵ For an elder who is “lucky” enough to develop an acute illness, such as myocardial infarction or a stroke, Medicare will pay the bill. For persons who are unlucky and develop a chronic illness such as Alzheimer’s disease that requires years of costly long-term care, the American health care market place forces them to “spend down” to Medicaid eligibility. This acute/chronic dichotomy can be explained only as an artifact of the American long-term care financing system, as opposed to a long-term care delivery system. No one *intends* to get sick. No moral opprobrium should therefore attach to efforts by the sufferer and his family to engage in Medicaid planning to minimize the financial impact chronic illness imposes on them.²⁰⁶

Participants in a free market, including elders who need long-term care, are under no obligation to pay more than the going rate

204. See ROTUNDA, *supra* note 6, at 433 (comparing the MRPC with the Rules of Model Conduct, and quoting from EC 7-8). “It is often desirable to point out those factors which may lead to a decision that is morally just as well as legally permissible.” *Id.* Of course, this returns us to the question, “Is there a higher law?”

205. It cannot be a coincidence that until the name was changed in 2001, the federal agency that oversees Medicare and Medicaid was called the Health Care Financing Administration.

206. Morality must be doable. MAYO, *supra* note 8, at 59-60. Of course, one may still consider the effect of moral hazard and take appropriate measures to limit overuse of medical services.

for any commodity. In the desert, the person who controls the water supply is under no obligation to sell at any price. The price is therefore set by fiat rather than through negotiation. Health care can be similarly viewed. The sick and frail are frequently in no position to bargain for a better deal.²⁰⁷ To suggest that purchasers of health care services should pay more than the minimum net cost to secure those services, merely because they have the resources to do so, is as absurd as criticizing wealthy persons for shopping at the discount store, whose lower prices are driving other merchants out of business.²⁰⁸ Where the market permits planning which results in a reduced net price, a purchaser cannot be faulted for availing himself of the lower price even if he could pay more.²⁰⁹ In a health care system in which the commodity known as *health* is bought and sold, there is no reason why any market participant should value another person's property (that is, health) more than his own. Until the United States elevates health care to a moral right, instead of a property right, Medicaid planning is morally and ethically justified.

207.

This information asymmetry [resulting from the consumer's lack of knowledge concerning the complexities of medical care diagnosis or treatment] gives physicians market power. Physicians recommend to people what services are appropriate and often provide those services after they are recommended. Physicians also have leeway in pricing, at a time when consumers have little ability to price shop. Unless physicians have objective functions looking out for patient welfare, inefficient outcomes will result.

CUTLER, *supra* note 32, at 26.

208. If patients are relegated to a competitive market, then what is good for the goose must also be good for the gander. "An increasingly competitive health insurance market is likely to treat people less as patients and more as consumers who must protect themselves from error and exploitation." Wendy K. Mariner, *Patients Must Have Rights*, NAT'L L. J., Feb. 19, 2001, at A21, available at www.patient-rights.org/publications/pdfpublications/NLJpatie.pdf. Patients must be allowed to protect themselves.

209. Indeed, self-interest is often viewed as fostering market efficiency because, in theory, each market participant responds appropriately to prices for the purpose of maximizing profit. Jeremy Waldron, *Private Property*, in A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY 3, 13 (Dennis Patterson ed., 1996). Although it is tempting to do so, we cannot lose sight of the fact that even impoverished American elders seldom confront absolute poverty. See SINGER, *supra* note 17, at 218-22 (defining absolute poverty). Does that mean Medicaid planning is unimportant? Quite the contrary. With many elders, "it's not just his money at stake, but his pride and self-worth." MORRIS, *supra* note 10, at 244.

VIII. REFORM PROPOSALS

Before meaningful reform can take place, the federal and state governments must decide which objectives and stakeholder interests merit priority. If health care should be viewed as a right, reform proposals should be universal. If health care is not a right, reform may be unnecessary; markets exist to meet the long-term care needs of consumers. Even if reform did include universal health care, should the middle class status of the elderly be protected, or should elders who are struck with chronic disease be required to impoverish themselves before they receive assistance?

Any long-term care reform proposal must address the major issue of moral hazard: whether social insurance creates a sufficient incentive (or disincentive) to pay for one's own health care.²¹⁰ Health security may or may not be a right for all citizens—that is certainly a debatable proposition—but no one contends that the community owes malingerers a free ride. Any reforms must include sufficient checks and balances to ensure that each recipient of health security has an incentive to carry his portion of society's cumulative burden.²¹¹

A solution put forward in 1998 by the Center for Long-Term Care Financing is called "LTC Choice."²¹² The authors of this report deal with the "moral hazard" problem posed by the current system of long-term care financing (that is, Medicaid), namely that the system punishes those persons who are frugal and rewards those who are profligate, by eliminating Medicaid's "loopholes" and requiring individuals who attain age sixty-five either to present proof of financial responsibility or to register their assets and income with the government.

The tough choice is whether or not they will insure privately or rely on the *LTC Choice* program. If they insure privately, or earmark sufficient assets permanently for

210. "The principal of justice is linked to . . . fairness." BODENHEIMER & GRUMBACH, *supra* note 14, at 217 (discussing distributive justice). Even if it is inappropriate to define access in terms of dollars held by the person needing care, arguably there is nothing unfair about linking access to labor, at least for persons who are not disabled.

211. One of the basic tensions in the delivery of health care services is between caring for the individual and caring for the community at-large. BODENHEIMER & GRUMBACH, *supra* note 14, at 292.

212. See STEPHEN A. MOSES & DAVID M. ROSENFELD, LTC CHOICE: A SIMPLE, COST-FREE SOLUTION TO THE LONG-TERM CARE FINANCING PUZZLE 27-30, at <http://www.centerlrc.com/pubs/CLTC.F.R.eport.pdf> (Sept. 1, 1998).

long-term care, their problem is solved. If they choose to rely on the government-backed *LTC Choice* program, they must report annually on their income and assets in order to secure their estates as collateral and to eliminate the problem of artificial self-improvement which has plagued the Medicaid program.²¹³

No one who could afford to purchase insurance would elect to make his assets and income available to the government instead. That of course seems to be the goal of the Center's proposal—to stimulate demand for private long-term care insurance.

Another solution, put forward by the National Academy of Elder Law Attorneys (NAELA), is to federalize social insurance for long-term care.²¹⁴ Specifically, the NAELA White Paper proposes the creation of Medicare Part D, which would transfer responsibility for most long-term care financing from the states to the Centers for Medicare & Medicaid Services. Medicare Part D would be financed through payroll deductions and would provide each beneficiary with a pool of money to be used for any form of long-term care.²¹⁵ NAELA proposes that the pool be \$200,000 in 2000, indexed to inflation. There would be a \$10,000 deductible, after which Medicare would pay 80% of the cost of care.²¹⁶ Eligibility would be decided in a manner similar to Social Security disability determinations, with coverage triggered at the loss of two activities of daily living.²¹⁷ Eligibility would be presumed, with the government having the burden of proof if benefits are denied.²¹⁸

Both proposals are coercive, as any proposal must be to guarantee coverage and access to care. *LTC Choice* relies on the private market place to provide coverage and benefits and on the government to deny benefits to those who are profligate; but it retains Medicaid as a safety net for persons who are able to prove they are indigent through no fault of their own. The NAELA proposal relies on the social insurance model. Individuals are forced to participate in the risk pool through the tax system and

213. *Id.* at 29.

214. NAELA WHITE PAPER, *supra* note 48, at 6. The NAELA proposal is similar to the system Germany implemented in 1994. See Alison Evans Cuellar & Joshua M. Wiener, *Can Social Insurance for Long-Term Care Work?: The Experience in Germany*, 19 HEALTH AFFAIRS, May-June 2000, at 8. Germany's experience is described as a success. *Id.* at 22.

215. See NAELA WHITE PAPER, *supra* note 48, at 21-22.

216. *Id.*

217. *Id.* at 22.

218. *Id.* at 25.

payroll deduction.

As Mark Merlis points out, *LTC Choice* is not only “draconian” but impracticable. “By the time people need long-term care, there is no way to determine why some people have resources and others do not.”²¹⁹ Someone must make the decision on whether the applicant for Medicaid has been profligate during his lifetime or suffered a bad break and is deserving of public benefits. Who wants to step up to the plate and tell Grandma she is not deserving of help?

Moreover, both proposals suffer from the same defect: each is a long-term care financing system, rather than a long-term care delivery system. What happens to the elder who exhausts his insurance benefits or lifetime pool of money? Will he be guaranteed access to care nonetheless?

Although it is a demand-side proposal, two features in particular make the NAELA proposal attractive: (i) it retains autonomy, a value critical to many consumers, who would retain the right to choose the setting in which long-term care will be delivered; and (ii) it increases the bargaining power of long-term care purchasers through utilization of a national risk pool. By contrast, a system of private insurance has the potential of leaving the purchasing system disconnected in a manner that allows health care providers to dictate prices, unless the federal government tightly regulates the long-term care insurance industry. Where, as demographics make clear, demand for long-term care exceeds the system’s current supply, cost management (if done at all) must take place on the supply side. A strong purchaser can impose a pricing structure on health care providers.²²⁰

We believe members of society who are beyond what society marks as retirement age should be provided necessary health care without attaching any litmus test to its provision. At least, that should be the case with respect to today’s elders who could not

219. MERLIS, *supra* note 199.

220. Among other notable proposals is that put forward by Physicians for a National Health Program in 1991. See *A National Long-Term Care Program for the United States: A Caring Vision*, 266 J. AM. MED. ASS’N 3023 (1991), reprinted in *PNHP*, http://www.pnhp.org/publications/JAMA12_4_91.htm (last visited June 22, 2002). To compare how other Western nations, including Great Britain, the Netherlands, Spain, and Germany, finance long-term care costs, see generally 324 *BRIT. MED. J.* (June 29, 2002), discussing within various articles how certain Western nations finance long-term care, <http://bmj.com/content/vol324/issue7353>.

have anticipated the devastating cost of long-term care. What about tomorrow's elders? They have time to plan and contribute toward their own care. Society cannot allow them to consume their resources and then expect social assistance when need arises. To do so, ultimately, would allow health care recipients to consume their own labor and the labor of other persons. No society can afford to cover unlimited health care needs for very long without insisting upon contribution. An approach such as that advanced by NAELA would require everyone to contribute a portion of his or her labor to the risk pool.

IX. CONCLUSION

As we stated when we began, we do not expect to resolve all ethical questions relating to how long-term care is delivered in the United States. In this article, perhaps we ask as many questions as we answer. Controversies surrounding how to finance and deliver health care (and other social programs, such as Supplemental Security Income, public housing, and food stamps) will continue to abound so long as some persons have access to essential life-sustaining goods and services and others do not. Furthermore, even if the government provides universal health care, controversy will continue as stakeholders debate who should be covered and the scope of coverage.²²¹ Medical care presents one of "the most (melo)dramatic examples of the problems" associated with any program that, potentially, has a redistributive effect.²²²

Nonetheless, our primary goal as elder law attorneys should be to improve the lives of our clients. Having explicitly acknowledged that this is our goal, we would do well to consider the future. As the NAELA White Paper says, "[t]he current system in our country for addressing long-term care is a non-system, a hodgepodge of services that fails to meet the needs of the elderly and disabled in the variety of long-term care settings. It is economically inefficient and it fails to assure the quality of services which are provided."²²³ Even if controversy continues to surround questions of coverage and scope, a case can be made that moving America's health care system toward a universal right is a moral imperative of the elder law attorney.

221. Levinson, *supra* note 33, at 560.

222. *Id.*

223. NAELA WHITE PAPER, *supra* note 48, at 5.

Until we attain that goal, although it is controversial and legitimately subject to criticism, Medicaid planning is ethical and defensible. Despite what our critics say about us, elder law attorneys do acknowledge a place for differing ethical views. Where one stands on a particular issue usually depends on where one sits, however. Yes, stakeholders do have differing interests, which cause each participant in the health care market to approach the Medicaid program and Medicaid planning differently. These differing interests do not invalidate the wishes of clients who choose to engage in legally permissible asset protection strategies. And these differences do not make Medicaid planning “unethical,” but they do force clients and their lawyers to recognize that their acts have consequences for the American long-term care system.