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Advanced Medicaid Planning II: Asset Transfers

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The first part of this three-part article ("Advanced Medicaid Planning: Spousal Impoverishment," Vol. III, No. 1, July/August 1991) reviewed some of the nooks and crannies of the spousal impoverishment provisions of Medicaid law. Much of the potential for advancing client claims lies in the lack of precision of the federal statute or in the discrepancies between federal law and state implementation. This second part now turns to issues that, while important to married individuals, concern all present or potential Medicaid beneficiaries: transfers and trusts.

Transfers — and changes in ownership that do not constitute transfers — are important for married individuals seeking to qualify one spouse for Medicaid benefits where the community spouse's resources are at issue. They are even more important for single individuals, whose resources are always at issue, as the primary mechanism for advancing eligibility.

The Basic Transfer Rule

The transfer rules put into place by the Medicaid provisions of the Medicare Catastrophic Coverage Act of 1988 are relatively straightforward, but there are wrinkles.

A person who gives away a resource (without getting something of value in return) to qualify for Medicaid is subject to a waiting period for long-term-care benefits. Transfers *solely* for another purpose do not result in a waiting period, but that is not very useful in the planning context. Eligibility for hospital and physician services, home care, and other medical services is not subject to a waiting period following transfers.

Subject to a maximum of 30 months, the waiting period is the number of months equal to the "uncompensated value" of the resource given away divided by the average private pay cost of care in the state or community (states have the option to choose the latter) at the time of admission. The period begins with the first day of the month when the transfer was made. Thus, in a state with an average private pay cost of care of $3,000 per month, a gift of $18,000 made on January 30, 1991, results in ineligibility for six months (18,000 ÷ 3,000 = 6) — through June 30, 1991.

Transfers by the Community Spouse

Before December 19, 1989, the future community spouse was not restricted from disposing of property for the purpose of qualifying his or her spouse for Medicaid benefits, and after admission, the community spouse was free to retransfer assets that were transferred to him or her. A change in the Omnibus Budget Reconciliation Act of 1989 signed and effective that date (and applying only to transfers after that date) required states to deny eligibility for transfers by the spouse of the applicant, as well as by the applicant, while still permitting transfers to the spouse, community or otherwise. Many states have not amended their plans to reflect that change, however, so whether it applies is uncertain.

Changes in Form or Ownership That Are Not Transfers

SSI joint bank account rule. A number of states follow the Supplemental Security Income rule that provides that a withdrawal by a nonapplicant co-owner of funds in a joint bank account is not a transfer by the applicant co-owner. This rule may be restricted to accounts that have been joint for a minimum period of time, for example, 30 months. However, funds tranferred from a sole account of the applicant co-owner into the joint account, with the nonapplicant then taking them out, would not benefit from this rule; the deposit into the joint account itself constitutes a transfer.

States following this rule should also apply it to bank-like accounts, for example, money market accounts held at a

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An Update on Spousal Impoverishment

The first part of this series ("Advanced Medicaid Planning: Spousal Impoverishment," Vol. III, No. 1, July/August 1991) reviewed a few of the issues in seeking an increased community spouse resource allowance (CSRA) based on the spouse's need for income from those resources to earn his or her monthly needs allowance. Maryland has since taken a very restrictive position that makes this approach more difficult to use.

The community spouse can obtain the monthly needs allowance from three sources: his or her own income (including pension and annuity income and income generated from his or her savings and investments), the spouse's income under the spousal income allowance (42 U.S.C.A. §1396r-5(d)(1)(B)), and income from the additional resource allowance. At issue is whether the community spouse must look to the institutionalized spouse's income before seeking a higher resource allowance to generate sufficient income to meet his or her income allowance.

An attorney for the Maryland Department of Health and Mental Hygiene argued at a recent fair hearing that the community spouse is required under the federal statute to accept income from the nursing home spouse's income before claiming the right to a higher resource allowance. The administrative law judge agreed.

There are two reasons why this is not in the community spouse's interest. First, liquidity is lost: there is a difference between having $100,000 in the bank generating $500 per month in income and having a $500-per-month annuity. Second, the income benefit terminates when the nursing home spouse dies; this will often leave the community spouse with less than his or her monthly allowance. This would be so if, for example, a couple's only income was Social Security, with the husband in the nursing home receiving $600 per month and the wife $400. While this would be sufficient to generate the basic allowance of $984 in 1991-1992 (but not after July 1, 1992, when the formula changes again in favor of community spouses, 42 U.S.C.A. §1396r-5(d)(3)(B)(iii)), the wife's income would drop to $600 (or less) on the husband's death.

Maryland derived its authority from the Health Care Financing Administration (HCFA) State Medicaid Manual, adopted in New York. The HCFA provision cited states, curiously, only with respect to redeterminations:

There are no substitutions [higher resource allowances] when institutionalized spouses do not make available monthly income allowances to community spouses.

California and Maine, both, like Maryland, with no more regulatory guideline than the federal statute, have come to the opposite conclusion. After an adverse fair hearing decision, Tim Vogel of Portland, Maine, secured written confirmation from the state attorney general that the community spouse is permitted to elect a higher resource allowance even if her husband's "income is sufficient to meet [her] maintenance needs allowance. . . ."

And in California, Gregory Wilcox of Oakland, California, has secured two fair hearings decisions, approved by the California Department of Health Services, wherein the community spouse could have received her income from the nursing home spouse deduction, but elected not to.

Notwithstanding the HCFA state manual, careful statutory analysis and the limited legislative history indicate that Congress intended that community spouses be permitted to elect higher resources rather than the spousal income deduction to secure their future income. In providing for higher resources because of inadequate income, the statute refers only to the community spouse's income without allusion to augmentation from the nursing home spouse: "[i]f . . . the community spouse resource allowance . . . is inadequate to raise *the community spouse's income* to the minimum monthly maintenance needs allowance," 42 U.S.C.A. §1396r-5(e)(2)(C) (emphasis added). Moreover, the only reference in the legislative history says that the community spouse is entitled to the higher resource allowance after "taking into account any other income attributed to" him or her. "Attribution" is, of course, a familiar notion in Medicaid, akin to deeming. It refers to income that is considered to belong to a spouse aside from the "name on the instrument" rule, and the rules for attribution of income — under that title — are spelled out in the statute. 42 U.S.C.A. §1396r-5(b)(2) ("Attribution of income").

The statute's careful delineation of what is income to each spouse, supported by the pointed inclusion of attributed income and nothing more, puts the burden on advocates of the more restrictive approach. The flaw in their position is highlighted when the surviving spouse cannot otherwise meet his or her needs, for this is most plainly at odds with Congress's purpose.

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brokerage house. The key is whether each co-owner has a right to make withdrawals.

Division of jointly owned property. Investments in real property and securities that are jointly owned, and where joint action is required for sale or transfer, can usually be divided between the joint owners, each taking his or her aliquot share.

Purchase of income (annuities). Purchase of an annuity for the community spouse appears to be a perfectly appropriate way to use his or her postassessment assets. Maryland has informally taken the illogical position that an annuity purchase prior to admission is not a transfer, while purchase afterward is a transfer. But in each case there is no "uncompensated value," so there should be no period of ineligibility. This is especially clear with annuities purchased from insurance companies in the open market, as opposed to private arrangements, and with simple life annuities without a "years certain" benefit.

The community spouse should not, however, purchase an annuity without weighing the possible consequences, such as a reduced income allowance, a reduced resource allowance if it would otherwise be increased under the "adequacy of income" standard, and lack of liquidity.

Purchase of exempt resources. Cash in a bank account is counted against the resource allowance, but equity in a home, household goods, clothing, and one car are not. The issue as always is whether there is "uncompensated value" transferred when the noncountable resource is purchased. If what is received is valuable but exempt, no waiting period should result. It is important to keep in mind that the intent to qualify for Medicaid is irrelevant. The restriction on transfers is against gifts made for the purpose of qualifying for Medicaid, not other steps taken to qualify. And as a matter of policy, buying a house in part because one's spouse can then qualify for Medicaid is achieving, not thwarting, the congressional goal of insuring that community spouses will be protected in their old age.

Payment of debts and purchase of services for either spouse. Paying off existing debts of either spouse, including a home mortgage, should not be treated as a transfer, for there is full consideration or compensation. The assets-only analysis that Medicaid utilizes — that is, disregarding liabilities no matter how onerous or burdensome so long as they are not secured — makes the payment of debts an appropriate eligibility strategy.

Exempt Transfers

Some actions that are transfers are nonetheless exempted from penalty in order to further specific congressional goals. Among these are providing for the spouse or disabled or minor children of the applicant, protecting the interests of siblings, and encouraging adult children to care for their parents.

Transfer of home to certain individuals. 42 U.S.C.A. §1396p(c)(2)(A)(i)-(iv):

- *The applicant's spouse.* This will not usually affect eligibility but may enable the community spouse to avoid post-eligibility recovery at the cost of forgoing a step-up in basis on the earlier death of the nursing home spouse.
- *The applicant's minor or blind or permanently disabled child.*
- *The applicant's co-owner resident sibling.* The sibling must have resided in the home for a year prior to the applicant's institutionalization. The sibling must also have an equity interest in the home, but there is no time requirement; the first transfer of an equity interest, if without consideration, might constitute a transfer, while the second would not. Presumably the sibling could first be given a 1 percent interest, resulting in almost no period of ineligibility.
- *Adult child who provided care.* 42 U.S.C.A. §1396p(c)(2)(A)(iv). One interesting question is what degree of proof state Medicaid agencies will require for the applicant to establish that the care "permitted [the applicant] to reside at home rather than in such an institution or facility." Maryland accepts a physician's written verification that the applicant's "Medical and physical condition was such that he/she needed Long Term Care over the 24 month period."

Another interesting question is whether the parent who moved into the child's home for two years can utilize the exemption by transferring the parent's former home to the child. The federal statute refers to transfer of "a home" (not "the individual's home") and requires that the son or daughter "resided in such individual's home." In terms of policy, it should not matter much in whose home the parent lived, but it is admittedly somewhat forced, if not without reason, to fit that case within the statutory terms.

Transfers of other resources to certain individuals. 42 U.S.C.A. §1396p(c)(2)(B). Any resource may be transferred to the spouse, and to a blind or disabled child. Transfers to another for the "sole benefit" of the spouse are also permitted.

Hardship. An exemption is provided for cases in which the denial of eligibility would work an "undue hardship." 42 U.S.C.A. §1396p(c)(2)(D).

Other Issues

Multiple transfers. The regulations in most states appear not to specify whether two or more transactions constitute a single transaction resulting in a single (longer) period of ineligibility or two separate transactions with overlapping periods of ineligibility. In the example given earlier, if the applicant had transferred an additional $15,000 on February 27, 1991, it is unclear whether his or her period of ineligibility would extend five more months to November 30, 1991, or would not extend at all since the two periods of ineligibility would run concurrently. Most state regulations fail to acknowledge that this is an issue at all. To the extent it is an issue of fact, transfers of different property to different individuals in different months are more likely to be con-

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sidered separately, with separate and overlapping periods of ineligibility, than, for example, two checks written the same day, drawn on the same bank account, and payable to the same person.

Rounding down. Some states, such as Virginia, round down to the next highest multiple of the average private pay cost of care, while others round up. With rounding down, the applicant would be able to dispose of $[(2 × cost) – 1] per month while incurring a waiting period each month only for that month. If the average cost were $2,000, he or she could thus dispose of $3,999 in separate transfers each month, or $119,970 over a 30-month period, and qualify for benefits in the thirty-first month.

Determination of average private pay cost of care. The statute refers to "the average cost, to a private patient at the time of application, of nursing facility services." 42 U.S.C.A. §1396p(c)(1)(B)(ii). States have the option of using a community average rather than the statewide average.

Average cost of care is a question of fact. Some states have determined this amount by regulation. Whether such regulatory determinations are rebuttable or subject only to the "arbitrary and capricious" standard, a state is not free to use a number not connected to reality.

If the average cost is to be challenged at a fair hearing, the following issues or considerations should help in attacking the state's regulation:

1. What is the average "at the time of application"? If the state's average was determined two years ago, to what extent has inflation in nursing home care costs rendered it obsolete?
2. What is the "average" an average of? If ten nursing homes quote rates that average $3,150 per month, does it matter that the three most expensive are also the three largest? The way the statute is phrased — "the average cost, to a private patient . . . of services," suggests that patient averages, rather than nursing home averages, should be used.
3. What constitutes "nursing facility services" for this purpose? Does this include only basic room and board, all Medicaid-compensated services, or all nursing home services subject to regulation? Should non-Medicaid nursing homes be included?
4. Who may act for the state in selecting the community-average option? In a state with significant urban/rural price disparities, and where the lower-cost areas are outside the region to which a hospital patient can be required to accept discharge, can an administrative law judge determine that a statewide average would be unreasonable?

In no known cases was the average determined at a fair hearing. In most situations, the planning choices may make the effort not worth the result. But the difference in waiting periods and savings can be significant. In Maryland, for example, where the state-promulgated average is $3,000 (issued in July 1988), the present actual average is about $4,000. Using the latter figure would shorten the waiting period for a $90,000 transfer from 30 to 23 months. If the patient's income is low, the savings could approach $28,000 (assuming that the nursing home is of average cost). As is always the case with caps, there is less benefit for a larger transfer; the benefit disappears at $120,000.

Disclaimers and elective shares. A disclaimer is a rejection by an individual of an interest in a trust or inheritance. The general common law rule provided that a disclaimer was not a transfer but a refusal to accept a gift. Thus it was not a fraud on creditors and, as a corollary, was not a transfer for Medicaid purposes. A number of state statutes and one or two decisions treat a competent Medicaid beneficiary or applicant's disclaimer as a transfer.

The more common and vexing problem is whether a state court will permit or authorize a fiduciary, such as a conservator or guardian, to disclaim on the ward's behalf. In that context, some state courts have denied authority, reasoning that such a disclaimer would be a transfer.

A statutory share is the obverse, an interest in a decedent spouse's estate that the surviving spouse must affirmatively elect to override a will that leaves less than the statutory share to the spouse. A few decisions find that failure to elect is a transfer.

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The Other Foot Drops:
United States Limits State Medicaid Funding Mechanism

The Bush Administration has issued new rules prohibiting states from using taxes and contributions from health care providers as part of the states' contribution to Medicaid. (See "OMB-HHS Task Force Reports Plan to Limit Medicaid Cost Increases," Vol. III, No. 2, September 1991.) The Department of Health and Human Services describes this practice as a "scam." States, however, say that this is the only way they can meet the growing costs of providing medical care for lower-income citizens.

Both Republican and Democratic governors have opposed the new restrictions and predict they will result in closed hospitals and reduced medical care for needy people. The restrictions also could force strapped state Medicaid programs into further financial disarray. The new rules are scheduled to go into effect January 1, 1992.