

VOLUNTARY IMPOVERISHMENT TO OBTAIN GOVERNMENT BENEFITS

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For I have known them all already, known them all:
Have known the evenings, mornings, afternoons,
I have measured out my life with coffee spoons;
I know the voices dying with a dying fall
Beneath the music from a farther room.
So how should I presume?¹

INTRODUCTION

Increasingly, middle-class and upper middle-class elderly Americans voluntarily impoverish themselves in order to obtain the government benefit known as Medicaid. "Medicaid planning," as this widely discussed estate planning technique is known, has several variations and is highly controversial.² Congress was so incensed by the practice of

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¹ THOMAS STEARNS ELIOT, *THE LOVESONG OF J. ALFRED PRUFROCK*, lines 49–54, in *PRUFROCK AND OTHER OBSERVATIONS* (1917).

² Searches of Westlaw and Lexis produce hundreds of relevant documents. The Practising Law Institute, the American Law Institute, and various state bar associations have published dozens of "how to" publications in this area. *E.g.*, MASSACHUSETTS CONTINUING LEGAL EDUCATION, INC., *ESTATE PLANNING FOR THE AGING OR INCAPACITATED CLIENT IN MASSACHUSETTS: PROTECTING LEGAL RIGHTS, PRESERVING RESOURCES, AND PROVIDING HEALTH CARE*, (2002). Likewise, lawyers, scholars and students have written reams about the topic. For a sampling of the leading treatments, see ERIC M. CARLSON, *LONG-TERM CARE ADVOCACY* (Matthew Bender & Co. 1999); Cynthia M. Brubaker, *Medicaid Eligibility: Planning for the Elderly Client*, 26 U. BALT. L.F. 15 (1995); Joel C. Dobris, *Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance*, 24 REAL PROP. PROB. & TR. J. 1 (1989); Hal Fliegelman & Debora C. Fliegelman, *Giving Guardians the Power to Do*

voluntary impoverishment to obtain Medicaid that it made it a crime both for citizens to practice it and for lawyers to advise their clients how to do so.³ Anger over this “Granny Goes to Jail” Act led Congress to amend the statute, specifically repealing the portions that targeted the elderly.⁴ Likewise, courts have rejected the statute as it targets lawyers.⁵ There remains, however, a variety of moral, legal, and policy controversies surrounding the practice of voluntary impoverishment.

The primary reason for the emergence of voluntary impoverishment as an estate planning technique is the increasing likelihood that one’s life will end in a lengthy stay in a nursing home or with the use of skilled

Medicaid Planning, 32 WAKE FOREST L. REV. 341 (1997); Jason A. Frank, *The Necessity of Medicaid Planning*, 30 U. BALT. L.F. 29 (1999); A. Frank Johns, *Legal Ethics Applied to Initial Client-Lawyer Engagements in Which Lawyers Develop Special Needs Pooled Trusts*, 29 WM. MITCHELL L. REV. 47 (2001); Harry S. Margolis, *A Proposal for Reform of Medicaid Rules Governing Coverage of Nursing Home Care*, 9 STAN. L. & POL’Y REV. 303 (1998); Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy*, 12 J.L. & POL. 195 (1996); Joseph A. Rosenberg, *Supplemental Needs Trusts for People with Disabilities: The Development of a Private Trust in the Public Interest*, 10 B.U. PUB. INT. L.J. 91 (2000); Michael Wytychak III, *Payment of Nursing Home Bills Through the Medicaid Program*, 36 IDAHO L. REV. 243 (2000); Michael Farley, Note, *When “I Do” Becomes “I Don’t”*: *Eliminating the Divorce Loophole to Medicaid Eligibility*, 9 ELDER L.J. 27 (2001); Kenneth Hubbard, Note, *The Medicaid Cost Crisis: Are There Solutions to the Financial Problems Facing Middle-Class Americans Who Require Long-Term Health Care?*, 43 CLEV. ST. L. REV. 627 (1995); Kristin A. Reich, Note, *Long-Term Care Financing Crisis—Recent Federal and State Efforts to Deter Asset Transfers as a Means to Gain Medicaid Eligibility*, 74 N.D. L. REV. 383 (1998); see also Ralph J. Moore, Jr. & Ron M. Landsman, *Planning for Disability*, 816 TAX MGMT. (BNA) (2000) [hereinafter *Planning for Disability*], and the sources cited therein at C-4 to C-8.

³ See Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, § 217, 110 Stat. 2008 (codified as amended at 42 U.S.C. § 1320a-7b(a) (1996)); Balanced Budget Act, Pub. L. No. 105-33, § 4734, 111 Stat. 522. (codified as amended at 42 U.S.C. § 1320a-7b(a) (1997)).

⁴ See *Planning for Disability*, *supra* note 2 and the sources cited therein for a more detailed discussion of these provisions. See also Lisa Schreiber Joire, *After New York State Bar Association v. Reno: Ethical Problems in Limiting Medicaid Estate Planning*, 12 GEO. J. LEGAL ETHICS 789, 801 (1999).

⁵ N.Y. State Bar Ass’n v. Reno, 999 F. Supp. 710, 716 (N.D.N.Y. 1998). Though Attorney General Reno declared that the Department of Justice would not enforce the statute, the court nonetheless granted plaintiff’s motion for a preliminary injunction, enjoining the Attorney General from acting on the statute. *Id.* at 713, 716. In a letter dated March 11, 1998 to the Speaker of the House, Newt Gingrich, Attorney General Reno advised that the provision “is plainly unconstitutional under the First Amendment.” Letter from Janet Reno, U.S. Att’y Gen., to Newt Gingrich, Speaker of the U.S. H.R. (March 11, 1998), at <http://www.seniorlaw.com/reno.htm> (last visited Aug. 24, 2003). For further discussion of *Reno*, see Joire, *supra* note 4, at 803.

nursing care in the home.⁶ The costs of these forms of “long-term care”⁷ are so great that they can easily consume one’s entire savings during the last years of life.⁸ This poses two problems for the elderly. First, they may finish their lives utterly impoverished and completely dependent on the government or their families for their support. This problem may be especially acute for married couples, as the healthy spouse may be impoverished by the costs of caring for an ailing partner many years in advance of the healthy spouse’s death.⁹ Second, despite a lifetime spent building an estate of some consequence, these elderly persons may die with nothing to leave to their loved ones.¹⁰

Voluntary impoverishment can ameliorate both of these problems. By giving one’s fortune to family members or by putting one’s property in specially designed trusts, the now-impoverished person may qualify for Medicaid, a means-tested government subsidy of long-term health-care needs.¹¹ Family members or the trust may provide additional support (from the transferred resources) to the impoverished person in order to help him or her maintain a reasonable quality of life.¹² For this reason, some commentators describe this as “artificial impoverishment.”¹³ Most of the voluntarily impoverished person’s assets eventually pass to his or her loved ones.¹⁴ Thus, when planned successfully,¹⁵ voluntary

⁶ This has been attributed to “the aging of America, the technological revolution, the commodification of health care, spiraling health care costs and the atomization of the family unit.” Jan Ellen Rein, Book Review, 31 McGEORGE L. REV. 771, 771 (1999–2000). People are living longer and “[t]he prevalence of disability rises steeply with age.” ALICE M. RIVLIN & JOSHUA M. WIENER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? 5 (The Brookings Inst. 1988) [hereinafter CARING FOR THE DISABLED ELDERLY].

⁷ “The need for long-term care is often measured in terms of the extent to which an individual requires assistance in performing basic ‘activities of daily living’ (ADLs) such as bathing, dressing, toileting, or eating. . . .” Mark Merlis, *Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles* 3 (1999), at <http://www.cmf.org> (last visited Aug. 23, 2003).

⁸ See *infra* Part III.

⁹ Rochelle Bobroff, *Judicial Deference to Federal Government Erodes Medicaid Protections for Elderly Spouses Impoverished by the High Costs of Nursing Home Care*, 29 WM. MITCHELL L. REV. 159, 161–66 (2002). As will be discussed *infra* Part II, Congress has made some minimal effort to insulate the healthy spouse from the costs associated with the long-term care needs of the unhealthy spouse.

¹⁰ See *infra* Part III.

¹¹ See *infra* Part IV.

¹² But see *infra* Part V for a discussion of the problems and risks this may entail for the elderly person.

¹³ Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can It Be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 WM. MITCHELL L. REV. 111, 131 (2002) [hereinafter *Medicaid Planning Justified*]. Other, more cynical, terms that have been used are “the false poor,” “the fake poor” and “paper paupers.” Rein, *supra* note 2, at 230.

¹⁴ See *infra* Part IV.

¹⁵ Careful planning will include an effort to evade the government’s attempts to recover from the estate or the trust of the beneficiary any Medicaid benefits paid on the deceased’s behalf. See *infra* Part IV.

impoverishment can preserve the disabled elderly person's quality of life, while also preserving her estate, by shifting most of the person's long-term health care costs to the government.¹⁶

This article considers the practice of voluntary impoverishment to obtain government benefits from both practical and policy perspectives. It proceeds to suggest some resolutions to the controversies surrounding the practice and some ways to improve the situation for our nation's elderly. Finally, it advocates that Congress adopt a well-documented middle path between the present law and universal elder health care.¹⁷ This middle path would continue means testing eligibility for long-term healthcare subsidization but limit the means testing to a set period of approximately two years after the person has entered long-term care. After the means testing period has expired all elderly persons in need of long-term health care would be eligible for government assistance without regard to their means. Under this approach many, if not most, middle and upper middle class persons would elect to maintain control over their life savings despite bearing substantial medical costs because they would be assured that a lengthy nursing home stay will not consume all of their income and savings and have the effect of impoverishing them and disinheriting their survivors. This article posits that most persons would elect to bear the costs of their long-term care for a limited period because most people find the idea of voluntary impoverishment repugnant and shameful and because the practice imposes a high cost on personal financial security. The cost to the government of the middle path would be relatively modest because most nursing home stays do not last much more than two years and because the path would weaken the incentives for voluntary impoverishment. Moreover, the middle path would encourage the practice of purchasing bridging, or mid-term, health care insurance policies to cover nursing home costs for the means testing period. Mid-term care insurance would be less costly than long-term care insurance and, thus, would be more successful in obtaining favor with the buying public. Finally, the middle path preserves the values of self-reliance and self respect for many of our nation's elderly without forcing them to sacrifice all of their lives' savings to do so.

I. A BRIEF DESCRIPTION OF MEDICAID

Medicaid came into existence in 1965 as part of the Social Security Act of that year.¹⁸ It is "a cooperative federal-state program funded in

¹⁶ See *infra* Part IV.

¹⁷ See *infra* Part VII.

¹⁸ Medicaid was established by Title XIX of the Social Security Act on Medical Assistance, 79 Stat. 343 (codified as amended 42 U.S.C. § 1396a-v (1964)). The statute was subsequently amended in 1973 and 1984. A description of the events leading up to the enactment of

large part by the federal government and administered by the states.”¹⁹ Medicaid pays for long-term care²⁰ for needy elderly and disabled persons. The federal bureaucracies that oversee Medicaid and its sister program, Medicare,²¹ are known as the Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS).²² Because the states are the primary administering bodies, there is considerable variation in the program across the country. There are, however, federal regulatory guidelines which must be met.²³ Chiefly, an applicant must be at least age sixty-five,²⁴ continuously confined to a medical institution for more than 30 days, and financially needy in order to qualify for Medicaid.²⁵

Financial eligibility for Medicaid assistance is determined by reference to assets and income.²⁶ In many states, an applicant’s income cannot exceed 300% of the Supplemental Security Income (SSI) benefit amount.²⁷ In other states, one can qualify for Medicaid assistance if one’s income is less than one’s medical costs even if one’s income exceeds the guideline just described.²⁸ The applicant’s assets “must not exceed those applicable to SSI applicants.”²⁹ Not all of an applicant’s assets are counted for SSI or for Medicaid purposes, however. Excluded assets include the applicant’s home, car, and household goods.³⁰ The applicant’s non-excluded or “countable” assets must be “spent down” to

Medicare and Medicaid may be found on the website of the federal agency that oversees both programs, the Centers for Medicare and Medicaid Services (CMS), at <http://cms.hhs.gov/about/history/ssachr.asp>. CMS is a division of the Department of Health and Human Services (HHS).

¹⁹ *Medicaid Planning Justified*, *supra* note 13, at 123 (citing *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985)).

²⁰ As used throughout this article, long-term care includes both nursing home type care and skilled nursing care in the recipient’s home.

²¹ Medicare is the acute care analogue to Medicaid, but with some notable differences. The principal difference is that Medicare is not means tested. Instead it is universally available to the elderly, though Part B of Medicare involves payment of a fee. For a description of Medicare, see KATHRYN G. HENKEL, *ESTATE PLANNING AND WEALTH PRESERVATION*, ¶ 42.02 (1997 & Supp. 2003).

²² This agency’s website may be found at <http://cms.hhs.gov/>.

²³ *Planning for Disability*, *supra* note 2, at A-63.

²⁴ Non-elderly disabled persons may also qualify for Medicaid support. Their circumstances are outside the scope of this article.

²⁵ *Medicaid Planning Justified*, *supra* note 13, at 126–27 (citing 42 U.S.C. § 1396a(a)(10)(A)(ii)(V) (1994); 42 C.F.R. § 416.1005 (2001)).

²⁶ *Planning for Disability*, *supra* note 2, at A-63.

²⁷ *Id.* (citing 42 C.F.R. § 416.1005 (2001)). Three times the SSI benefit amounts to approximately \$1600 a month.

²⁸ Rein, *supra* note 2, at 214–15.

²⁹ *Medicaid Planning Justified*, *supra* note 13, at 127.

³⁰ *Id.* (citing 42 C.F.R. § 416.1210 (2001)).

Medicaid's resource limit in order to qualify for Medicaid benefits. Medicaid's resource limit in most states is about \$2,000.³¹

If, instead of spending down his assets, an applicant chooses to voluntarily impoverish himself by gratuitously transferring his assets to his children or other loved ones, the applicant will encounter various "look back period" rules.³² These rules impose periods of ineligibility based on the dollar value of those gratuitous transfers that occurred during the look back period.³³ The general look back period is thirty-six months.³⁴ For transfers to a trust, however, the look back period is usually sixty months.³⁵ There are exceptions to the Medicaid ineligibility penalties imposed by the look back period rules.³⁶ The most important exception for planning purposes is for certain transfers to or for the benefit of a spouse.³⁷ Because of the complexity of the look back period rules, voluntary impoverishment to obtain Medicaid benefits without the assistance of a lawyer has been likened to "walking through a minefield blindfolded."³⁸ The rules governing transfers into trusts are particularly complex and are intended to severely limit the utility of such transfers from a Medicaid eligibility standpoint.³⁹ Those trusts that do permit the applicant to qualify for Medicaid eligibility are typically subject to provisions that require that the trust assets remaining after the applicant's death be used to pay back the government for the Medicaid expenditures on behalf of the decedent.⁴⁰

Various provisions were enacted by Congress in 1988⁴¹ and refined in 1993⁴² to minimally protect the healthy spouse, or "community spouse," from being impoverished by the long-term care costs of the unhealthy spouse, or "institutionalized spouse."⁴³ These spousal protection rules create some exceptions to the general Medicaid income rules and

³¹ *Id.*

³² 42 U.S.C. § 1396 (c) (2000).

³³ These and related rules were tightened considerably in the Omnibus Budget Reconciliation Act of 1993 in an effort to reduce the opportunities to use voluntary impoverishment to qualify for Medicaid. *See Planning for Disability*, *supra* note 2, at A-79; *see also* Omnibus Budget Reconciliation Act of 1993, Pub.L. No. 103-66, 107 Stat. 312 § 13611(e) (1993); Reich, *supra* note 2, at 389.

³⁴ 42 U.S.C. § 1396p(c)(1)(B)(i) (2000).

³⁵ *Id.*

³⁶ For a comprehensive list of the exceptions see *Medicaid Planning Justified*, *supra* note 13, at 127-28.

³⁷ *See id.* at 128.

³⁸ *Id.* at 127.

³⁹ *See Planning for Disability*, *supra* note 2, at A-70-74.

⁴⁰ *Id.*

⁴¹ Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988).

⁴² Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993).

⁴³ Bobroff, *supra* note 9, at 169-70.

the spend down rules. In general, these rules protect the community spouse's separate income and one half of the spouses' joint income from factoring into the Medicaid eligibility of the institutionalized spouse.⁴⁴ The rules guarantee the community spouse a minimum amount of income known as the minimum monthly needs allowance (MMNA).⁴⁵ These rules also allocate the spouses' countable assets between them on a 50–50 basis without regard to who holds actual title. As with joint income, the community spouse is entitled to a minimum amount of assets known as the Community Spouse Resource Allowance (CSRA).⁴⁶ The CSRA also has a limit.⁴⁷ The community spouse's share of the countable assets in excess of the CSRA limit and the institutionalized spouse's half of the countable assets must be spent down before Medicaid eligibility is attained.⁴⁸ On the whole, these rules are not particularly generous.⁴⁹

Upon the death of an elderly Medicaid recipient, federal law requires the state to seek to recover some of the Medicaid payments made on the decedent's behalf from the decedent's estate.⁵⁰ This "estate recovery" can be made against assets that were not counted to determine Medicaid eligibility, including the decedent's home.⁵¹ Several states have resisted engaging in estate recovery actions. At least one state has unsuccessfully argued in court that the estate recovery law is unconstitutional.⁵² As a result of the estate recovery rule, even a Medicaid recipient who owns substantial excluded assets may have nothing to leave to his or her heirs once the government has recovered its payments. By

⁴⁴ *Id.* at 171–72; *Planning for Disability*, *supra* note 2, at A-65.

⁴⁵ In 2002 the minimum MMNA was \$1,493 and the maximum MMNA was \$2,232. *Planning for Disability*, *supra* note 2, at B-2201. *Planning for Disability*, *supra* note 2, at A-65.

⁴⁶ Bobroff, *supra* note 9, at 171–72; *Planning for Disability*, *supra* note 2, at A-68. In 2003, the minimum CSRA was \$18,132. *Planning for Disability*, *supra* note 2, at B-2201.

⁴⁷ See *Planning for Disability*, *supra* note 2, at A-68. In 2003, the maximum CSRA was \$90,660. *Id.* at B-2201.

⁴⁸ 42 U.S.C. § 1396r-5(c) (2000); see *Planning for Disability*, *supra* note 2, at A-68; see also Farley, *supra* note 2, at 37.

⁴⁹ See Rein, *supra* note 2, at 217–19. In 2002 the minimum MMNA was \$1,493 and the maximum MMNA was \$2,232. In 2003 the minimum CSRA was \$18,132 and the maximum CSRA was \$90,660. *Planning for Disability*, *supra* note 2, at B-2201.

⁵⁰ *Medicaid Planning Justified*, *supra* note 13, at 129 (citing 42 U.S.C. § 1396p(b)(1)(B) (1994)). For a useful description of these rules and the cases interpreting them, see Janel C. Frank, *How Far is Too Far? Tracing Assets in Medicaid Estate Recovery*, 79 N.D. L. REV. 111, 117–38 (2003).

⁵¹ But estate recovery cannot be brought against the home if the decedent's spouse or underage child still resides there. Brubaker, *supra* note 2, at 22.

⁵² *W. Va. ex rel. McGraw v. U.S. Dep't of Health and Human Serv.*, 289 F.3d 281 (4th Cir. 2002).

some accounts, estate recovery rules have caused many poor people to decline to seek Medicaid assistance for fear of losing their homes.⁵³

Given the difficulty of qualifying for Medicaid through voluntary impoverishment and the draconian effects of the estate recovery rules, one might wonder why people nonetheless engage in the practice. The answers lie in the punishing costs of long-term care and in the planner's sleight of hand.

II. THE COSTS OF LONG-TERM CARE

As with any discussion of medical costs in this country, we must begin by recognizing that we are talking about a moving target. This is especially true with respect to medical costs for the elderly, which for decades have routinely increased at rates far above the general rate of inflation.⁵⁴ Moreover, the number of elderly persons needing long-term care is growing rapidly.⁵⁵ The Congressional Budget Office (CBO) estimates that "inflation-adjusted expenditures for long-term care for the elderly will grow annually by 2.6 percent between 2000 and 2040. Those expenditures are projected to reach \$207 billion in 2020 and \$346 billion in 2040."⁵⁶ There are many reasons for these cost increases and also many feasible approaches toward limiting costs.⁵⁷ For present purposes, however, what this means for each individual is that the costs of long-term health care pose the single greatest financial risk of old age.⁵⁸

In 2003, the average annual cost for a nursing home stay in this country was estimated at approximately \$60,000.⁵⁹ Based on past expe-

⁵³ See, e.g., Rein, *supra* note 2, at 225–27.

⁵⁴ *Medicaid Planning Justified*, *supra* note 13, at 119 n.38 (citing Mark P. Doescher et al., *Supplemental Insurance and Mortality in Elderly Americans*, 9 ARCHIVES OF FAMILY MEDICINE (2000), at <http://archfami.ama-assn.org/issues/v9n3/full/foc9054.html>).

⁵⁵ "The large number of baby boomers will begin to reach age 65 in 2011, swelling the ranks of the elderly. In addition, more elderly people will reach advanced ages (85 and older) than in the past because of declining mortality rates. Those trends will cause the proportion of the population that is elderly, which was just under 13 percent in 1995, to rise to 20 percent in 2040. More important, the population over age 85—the segment most likely to require long-term care—will grow to over three times its current size by 2040." CONG. BUDGET OFFICE, PROJECTIONS OF EXPENDITURES FOR LONG-TERM CARE SERVICES FOR THE ELDERLY 1 (March 1999) [hereinafter PROJECTIONS OF EXPENDITURES], at <http://www.cbo.gov>. See also Janice Cooper Pasaba & Alison Barnes, *Public-Private Partnerships and Long-Term Care: Time for a Re-Examination?*, 26 STETSON L. REV. 529, 532 (1996).

⁵⁶ PROJECTIONS OF EXPENDITURES, *supra* note 55, at 4.

⁵⁷ See Rein, *supra* note 2, at 306–11 (describing some of the reasons for escalating costs, including increased number of patients, inflation, fraud, provider control of the cost structure, federal mandates, and rising reimbursement levels).

⁵⁸ Marshall B. Kapp, *Options for Long-Term Care Financing: A Look to the Future*, 42 HASTINGS L.J. 719, 719 (1991).

⁵⁹ Kelly Greene, *Nursing Home Costs are Climbing*, WALL ST. J. 9 Aug. 5, 2003, at D8. This article reports on two recent national cost surveys, one by MetLife Inc. and the other by General Electric Co. The MetLife survey estimated average annual nursing home costs at

rience, that figure can be expected to grow rapidly over time. To illustrate, between 1977 and 1999 the average annual charge for a nursing home stay rose from \$8,268 to \$46,692, *an almost six-fold increase*.⁶⁰ The income of elderly persons does not match up well against these costs. In 1999, more than half of all households headed by persons over the age of sixty-five had less than \$25,000 in annual income.⁶¹ Even when we focus on the wealthier segment of the elderly population, the cost of a lengthy nursing home stay represents a formidable and potentially disastrous expense.⁶² In 1999, among those persons aged fifty-five to seventy-four who owned stocks and other securities, the median level of income was \$53,000 and the median value of their financial assets was \$200,000.⁶³ For those equity owners aged seventy-five and over, the median income was \$30,000 and the median value of their financial assets was again \$200,000.⁶⁴ Because the risk of entering a nursing home increases with age while household income generally decreases with age, it is apparent that most elderly persons will not be able to cover the full costs of a nursing home stay with income alone.⁶⁵ Instead, spend-down of savings will likely begin right away. This is particularly true if there is a spouse or other family member who must share the income and other resources in question. In such circumstances even a person with \$40,000 or \$50,000 of annual income and a home that is paid for could reasonably anticipate spending down \$25,000 to \$35,000 or more each year that

\$66,000. The GE Survey estimated those costs at \$57,700. The article also reports that home care costs \$18 an hour. At that rate, constant care at home for a year would cost \$183,960. *See also* Bobroff, *supra* note 9, at 162 (estimating average annual nursing home costs at over \$50,000 in 2002). The costs of nursing home stays vary by geographic region and by institution size but are always substantial. *See also* NAT'L. CENTER FOR HEALTH STATISTICS, HEALTH, U.S. Table 124 (2001), at <http://www.cdc.gov/nchs/data/hu.PDF> (hereinafter CENTER FOR HEALTH STATISTICS). Even in the early nineties, nursing homes cost as much as \$100,000 annually in places such as New York City. Rein, *supra* note 2, at 210.

⁶⁰ NAT'L. CENTER FOR HEALTH STATISTICS, *supra* note 59, at Table 123.

⁶¹ U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS: CONSUMER INCOME Table 13 (1999) (Income Distribution Measures by Definition of Income), at www.census.gov/prod/2000pubs/p60-209.pdf (hereinafter U.S. CENSUS BUREAU). There are many ways to define and measure income. I have used here one of the higher measures, money income less taxes but including capital gains and earned income credit. Other measures yield similar but lower numbers for median household income of those over age 65. *See id.* at Table 7 (Median Income of People by Selected Characteristics: 1999, 1998, and 1997) (calculating median income for 1999 at \$19,079); *see also* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE U.S. Table 663 (2001) (Money Income of Households—Distribution by Income level and Selected Characteristics: 1999) (calculating median income at \$22,812).

⁶² *See* Frank, *supra* note 2, at 30–32 (1999).

⁶³ U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE U.S.: INCOME, EXPENDITURES, & WEALTH No. 663 (2001) (Money Income of Households—Distribution by Income Level & Selected Characteristics), at <http://www.census.gov/prod/2002.pdf>.

⁶⁴ *Id.*

⁶⁵ *See* CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 9–11.

they are in long-term care⁶⁶ if they do not find some way to qualify for Medicaid.⁶⁷

That spend-down begins immediately for most people is supported by the fact that “[a]pproximately seventy percent of nursing home residents rely on Medicaid to help pay for their nursing home care.”⁶⁸ This represented more than one million people in 1996.⁶⁹ Since these persons, by definition, must be impoverished in order to qualify for Medicaid, we can deduce one of three things about each of these persons: (1) they were poor to begin with; (2) they spent down their assets; or, (3) they voluntarily impoverished themselves in order to qualify for Medicaid. Unfortunately we do not know how many fall into that last category.⁷⁰

⁶⁶ This simple estimate is much more optimistic than other projections along this line. In one such projection the authors posit spend down at the rate of \$65,000 a year for a retired couple with \$500,000 in assets, \$30,000 of income and long-term care costs of \$45,000. See Mark E. Battista & Brigitte Emmons-Touchette, *Covering the Financial Risk of Long-Term Care: Responding to the Myths*, 1 QUINNIPIAC HEALTH L.J. 175, 183 (1997) (emphasizing the need for long-term care insurance, though it is noteworthy that the authors appear to be involved in the business of selling such insurance).

⁶⁷ The income and resources of the nursing home elderly have been depicted as dramatically less than the circumstances described *supra* notes 53–55 and accompanying text. See Rein, *supra* note 2, at 255–56 (arguing that Medicaid planning could not have been rampant in the 1980’s and early 1990’s since the people who occupy nursing homes have little in the way of income or assets to shelter). The generations approaching old age now are wealthier than their predecessors. Moreover, Medicaid planning is rational behavior, even for those with relatively few assets. Thus, even if Medicaid planning was not widespread in the past, it is likely to become so in the future.

⁶⁸ Bobroff, *supra* note 9, at 162. Another source states that, in 1999, 60% of expenditures for nursing home care came from government, mostly from Medicaid (47%) and Medicare (10%). NAT’L. CENTER FOR HEALTH STATISTICS, *supra* note 59, at Table 118 (Personal Health Care Expenditures, According to Type of Expenditure & Source of Funds).

⁶⁹ Bobroff, *supra* note 9, at 162. According to another source, 4.7 million Medicaid recipients in 1996 were over the age of sixty-five. This includes Medicaid recipients not in nursing homes. See John M. Broderick, *To Transfer or Not to Transfer: Congress Failed to Stiffen Penalties for Medicaid Estate Planning, but Should the Practice Continue?*, 6 ELDER L.J. 257, 262–63 (1998).

⁷⁰ It has been estimated that 20% of Medicaid nursing home expenditures arise from the voluntary impoverishment, but few efforts seem to have been made to quantify the breadth of the practice. See Broderick, *supra* note 69, at 272–73. One finds scattered comments in the literature, often without authority, either asserting it is widespread or that it is not widespread. See, e.g., Marilyn Moon, *Long-Term Care in the United States*, THE URBAN INSTITUTE 4 (Feb. 1996), at www.cmf.org/programs/medfutur/moonlt.asp (“While this abuse may not be widespread, it is substantial enough to create considerable concern about fairness. And, in some areas of the country, such as New York, the feeling is that the abuses are large and come from those with very high incomes.”). See also Joshua M. Wiener & David G. Stevenson, *State Policy on Long-Term Care for the Elderly*, 17 HEALTH AFFAIRS 81, 86 (May/June 1998) (“Although the rhetoric surrounding the issue is passionate and all states acknowledge it is somewhat of a problem, Massachusetts, New Jersey, and New York were the only ANF states [a group of 13 states] in which asset transfer was thought to be a major policy issue. It is of particular concern in New York, where there are approximately 1,200 elder-law attorneys and

Although we do not know the precise numbers of those who voluntarily impoverish themselves, we can reasonably judge that the number is substantial and growing.⁷¹ This is because knowledge of the practice among lawyers and their clients is becoming more pervasive.⁷² The middle class elderly have more to lose than they did in earlier times,⁷³ and the practice is a rational adaptation to a system that is likely to leave many people destitute in any event.

Moreover, dramatic upward Medicaid spending trends at the federal level support the supposition that voluntary impoverishment is growing.⁷⁴ Between 1980 and 1990 federal Medicaid spending increased from 14.3 billion dollars to 43.3 billion dollars, a three-fold increase. From 1990 to 2000, expenditures leapt to 119.4 billion dollars and are projected to reach 265.4 billion dollars by 2010.⁷⁵

The aggregate costs of long-term care in this country are enormous and growing. In part this is due to the growing numbers of elderly in our society, but even the costs measured on an individual basis are frightening in scope. Even people who are presently well-off in our society have good reason to fear that a lengthy nursing home stay could destroy them financially. It is only natural that such people turn to a Medicaid planner for help, and the planners have been busy devising techniques to assist the disabled elderly.

III. THE PLANNER'S LEGERDEMAIN

Planning, as that term is used by lawyers in the tax, trusts and estates, and business fields, is the art of achieving the client's goals in the

where newspaper and magazine advertisements relating to asset transfer are said to be ubiquitous.”).

⁷¹ Joire, *supra* note 4, at 800 (citing a 1995 publication estimating that 20% of Medicaid nursing home expenditures arose from Medicaid planning).

⁷² See Lawrence A. Frolik, *The Developing Field of Elder Law Redux: Ten Years After*, 10 ELDER L.J. 1, 3–4 (2002) (noting expansion and diversification of the field of elder law).

⁷³ It was argued a few years ago that, on balance, the elderly did not have enough assets to justify substantial Medicaid planning. See Rein, *supra* note 2, at 256. But the last two decades have seen a rise in wealth and financial investment in this country as evidenced by the median value of stock portfolios and mutual fund holdings. See U.S. CENSUS BUREAU, *supra* note 61, at No. 1214 (Characteristics of Equity Owners: 1999); No. 1209 (Stock Ownership by Age of Head of Family and Family Income: 1992 to 1998); No. 1213 (Characteristics of Mutual Fund Owners: 1998) (2002). The elderly also own homes, cars, and other nonfinancial assets in very high percentages. See U.S. CENSUS BUREAU, *supra* note 61, at No. 763 (Nonfinancial Assets Held by Families by Type of Asset: 1998). The baby boom generation is moving into retirement and bringing lots of assets with them. If Medicaid planning has not been pervasive up to now, that will likely change.

⁷⁴ One writer contends that the rapid rise in Medicaid costs is due to “rampant fraud on the part of some health care providers” and extensive use of Medicaid by the middle class “due to so-called ‘divestment planning,’ whereby middle-class citizens deliberately impoverish themselves in order to become eligible for Medicaid benefits.” Hubbard, *supra* note 2, at 630.

⁷⁵ Betty W. Su, *The U.S. Economy to 2010*, MONTHLY LAB. REV. Table 6 (Nov. 2001).

face of rules designed to obstruct the path.⁷⁶ Medicaid planning “helps an applicant preserve assets, while fitting within the financial criteria for Medicaid eligibility.”⁷⁷ This often involves gratuitous transfers of property interests to others or transfers into trust, but it can also involve transmuting countable assets into excluded assets and avoiding the estate recovery rules for retained assets.⁷⁸ As noted at the outset, the goals are two-fold: first, to preserve assets in order to supplement Medicaid and thereby maintain the elder person’s quality of life until the very end, and, second, to assure that the person’s life savings are passed on to loved ones rather than consumed by long-term health care costs. Achieving one goal or the other is relatively easy but achieving both goals together is more difficult. In all events this is an area where foresight, resources, and access to good legal advice are rewarded. Thus, wealthier and more financially sophisticated persons are likely to enjoy considerable advantage over persons with less wealth and sophistication.⁷⁹ It is one of the perversities of the rules intended to close Medicaid planning loopholes that they are certain to be most effective against the poorest members of the class at which they are directed. The estate recovery rules, for example, are more likely to capture the cottages of the poor than the stately manors of the upper middle class.⁸⁰

Outright gifts more than three years before application is made for Medicaid are disregarded for eligibility purposes. Thus, one of the simplest and most widely used techniques of voluntary impoverishment is simply to give substantial assets to one’s children or other loved ones well in advance of the actual application for Medicaid assistance in order to avoid the look back and estate recovery rules.⁸¹ Again, this technique favors the more affluent person who can afford to give away assets early on before there is any immediate concern about long-term care. A foresighted variation on this technique is to purchase long-term care insurance for a term that complies with the look back period rules and later, when institutionalization looms on the horizon, to engage in aggressive

⁷⁶ For an elaboration of this view, see John A. Miller, *Indeterminacy, Complexity and Fairness: Justifying Rule Simplification in the Law of Taxation*, 68 WASH. L. REV. 1, 13–16 (1993).

⁷⁷ *Medicaid Planning Justified*, *supra* note 13, at 131; see also Fliegelman, *supra* note 2, at 359 (Medicaid planning means “the process of lawfully rearranging an individual’s assets so that the individual qualifies for Medicaid under the law while the assets are sheltered for use by a spouse, children or others.”).

⁷⁸ See *Planning for Disability*, *supra* note 2, at A-90.

⁷⁹ It should be recognized, however, that at some indefinite level of wealth, Medicaid planning might become more trouble than it is worth to the client.

⁸⁰ As this last remark implies, it is my view that everyone ought to be permitted to leave something to one’s kith and kin. Perhaps this could take the form of a homestead exemption from the estate recovery rules if those rules cannot be abolished entirely.

⁸¹ *Planning for Disability*, *supra* note 2, at A-90.

gifting away of assets.⁸² The insurance, thus, serves as a funding bridge until the look back period has expired. Another approach available to an affluent person is to make gifts of assets while retaining enough property to pay for long-term care until the look back period rules no longer apply.⁸³

The outright gift approach meets the asset protection goal, but may fail to meet the quality of life goal unless the donee cooperates or unless the donor or her spouse has other assets. For this reason, some people prefer to make transfers into trusts, the terms of which continue to make the assets or income available to the trust's grantor or the grantor's spouse.⁸⁴ These trusts must be carefully drawn to limit the Medicaid applicant's access to the trust assets; otherwise the assets will be deemed to be owned directly by the applicant for Medicaid eligibility purposes and may disqualify the applicant.⁸⁵ Certain trusts, called Miller trusts,⁸⁶ are often used to divert income away from the Medicaid applicant when the applicant's income is otherwise over the eligibility limit.⁸⁷ Other trusts may be used to create an income stream to the settlor while depriving him of any right to the principal. These income-only trusts cause the principal to be disregarded for Medicaid eligibility purposes.⁸⁸ One of the difficulties with the use of trusts is avoidance of the estate recovery rules. The statutorily authorized trusts, collectively known as the safe harbor trusts, are required to have a Medicaid payback provision.⁸⁹

Sometimes the transfers described above may be carried out by the holder of the Medicaid applicant's power of attorney rather than the applicant himself.⁹⁰ The making of gifts by the power holder, especially to him or herself, has been the subject of some controversy and abuse, especially in the tax context.⁹¹ Although there are variations from state to state, the emerging general rule appears to be that the power to make

⁸² *Id.* at A-88.

⁸³ This is sometimes called the "half a loaf recipe" because that is roughly the amount that can be given. Rein, *supra* note 2, at 220. For a more refined, formulaic approach to this technique, see Fliegelman, *supra* note 2, at 360-61; see also Margolis, *supra* note 2, at 306.

⁸⁴ For a detailed discussion of the use of trusts for Medicaid planning, see *Planning for Disability*, *supra* note 2, at A-73 to A-78 & A-81 to A-82.

⁸⁵ *Id.*

⁸⁶ The trust has been so named in reference to the case establishing its viability as a Medicaid planning device. See *Miller v. Ibarra*, 746 F. Supp. 19 (D. Colo. 1990). The decision has been codified at 42 U.S.C. § 1396p(d)(4)(B).

⁸⁷ Dennis Voorhees, *Planning Medicaid Eligibility* in PRACTICAL MEDICARE AND MEDICAID SKILLS IN IDAHO III-9 (2003). Transfers to trusts must be irrevocable and must occur more than five years before the application for Medicaid to avoid being counted as assets belonging to the applicant.

⁸⁸ *Planning for Disability*, *supra* note 2, at A-77 to A-78.

⁸⁹ *Id.* at A-73-74, A-86.

⁹⁰ *Id.* at A-87 to A-88.

⁹¹ See, e.g., *Estate of Swanson v. U.S.*, 46 Fed. Cl. 388 (2000).

gifts on the power grantor's behalf must be expressly stated in the instrument.⁹² Given the potential for abuse, this is the appropriate direction in which the law should develop.

A commonly employed technique known as "asset repositioning" involves taking countable assets and turning them into excluded assets or into an excluded income stream.⁹³ Simple examples include buying a new car or making home repairs and improvements such as a new roof or furnace.⁹⁴ In some cases these assets may later be subject to estate recovery, but they at least temporarily preserve the applicant's savings.⁹⁵ In addition, asset repositioning contributes to the quality of life of the community spouse and may reduce her risk of later impoverishment without affecting Medicaid eligibility of the institutionalized spouse.⁹⁶ In this regard, the timing of these expenditures may be crucial in order to maximize the community spouse's CSRA. The best time to make the expenditures for this purpose is after admission to a nursing home and prior to application for Medicaid.⁹⁷ This illustrates how technically complex Medicaid planning is, and how important competent counsel has become.

Asset repositioning can be regarded as a form of spend down. Another spend down technique involves payment for services that will be rendered in the future, including some legal and accounting services and funeral and burial expenses.⁹⁸ Prepayment for services makes particular sense when the expenses are almost certain to arise at some point. Again, from the standpoint of the community spouse's CSRA, the best time to make the expenditures is after admission to a nursing home and prior to application for Medicaid.⁹⁹

There are many Medicaid planning techniques available to married persons, some of which are variations on asset repositioning.¹⁰⁰ The purchase of an annuity for the benefit of the healthy spouse of a potential Medicaid applicant is one specialized technique of asset protection.¹⁰¹ In effect, the applicant's resources are diverted to the spouse and converted

⁹² See *Planning for Disability*, *supra* note 2, at A-9; KATHRYN G. HENKEL, ESTATE PLANNING AND WEALTH PRESERVATION ¶ 43.02[1][b] (2003); Andrew H. Hook, *Durable Powers of Attorney*, 859 Tax Mgmt. (BNA), at A-24, A-27 to A-31 (2000).

⁹³ Voorhees, *supra* note 87, at III-8-9.

⁹⁴ *Planning for Disability*, *supra* note 2, at A-89; Voorhees, *supra* note 87, at III-8-9. Technically, asset repositioning is known as a "non-transfer transaction" because they are not treated as transfers under 42 U.S.C. § 1396p(c).

⁹⁵ *Planning for Disability*, *supra* note 2, at A-86.

⁹⁶ Voorhees, *supra* note 87, at III-8-9.

⁹⁷ See *Planning for Disability*, *supra* note 2, at A-93 to A-94.

⁹⁸ *Id.* at A-94.

⁹⁹ See *id.* at A-93 to A-94.

¹⁰⁰ *Id.* at A-94.

¹⁰¹ *Id.* at A-94-95.

into an income stream that is excluded from consideration for Medicaid purposes.¹⁰² This technique avoids the estate recovery rules and has become so widespread that it has drawn considerable fire from state and federal authorities, to the extent that its future is now in doubt.¹⁰³

Another asset protection technique involving the spouse of a potential applicant is the purchase of a new home.¹⁰⁴ It should be remembered that the home is an exempt asset and that transfers to spouses are exempt transfers.¹⁰⁵ According to one commentator, the home can be purchased by the spouse "to qualify her husband for Medicaid" and then transferred or sold by the spouse "post-eligibility" without affecting the applicant's continued eligibility.¹⁰⁶

A technique called "spousal refusal," in which the healthy spouse refuses to make community assets available to the institutionalized spouse in order for the latter to qualify for Medicaid, has gained some notoriety in New York and Maryland.¹⁰⁷ The state theoretically has a right of recovery against the refusing spouse, but enforcement has been lax.¹⁰⁸

Because of the exceptions to the transfer-of-assets rules for transfers to or for the benefit of the transferor's spouse, trusts for the benefit of a spouse offer planning opportunities not available for self-settled trusts.¹⁰⁹ Properly drawn trusts give the spouse access to income from the trust but not the principal, thereby avoiding inclusion of the principal in calculation of the spouse's Medicaid eligibility.¹¹⁰

There are also techniques for increasing the community spouse's community resource allowance (CSRA) or maximizing the community spouse's income that take advantage of certain aspects of the spousal impoverishment rules described earlier. One such technique involves using borrowing to increase the couples' combined assets temporarily for

¹⁰² *Id.*

¹⁰³ See *Medicaid Planning Justified*, *supra* note 13, at 143; Voorhees, *supra* note 87, at III-18.

¹⁰⁴ *Medicaid Planning Justified*, *supra* note 13, at 143.

¹⁰⁵ There are other exempt transfers that may be useful in specific circumstances. These include transfers to a disabled child or other disabled person, transfers of a home to a child who has lived with the transferor for two years and provided home health care during that period, and transfers of a home to sibling who has lived with the transferor for at least one year. See 42 U.S.C. § 1396(c)(2)(A); see also *Planning for Disability*, *supra* note 2, at A-84 to A-85, A-91, & A-95 to A-96.

¹⁰⁶ *Medicaid Planning Justified*, *supra* note 13, at 143.

¹⁰⁷ See *Planning for Disability*, *supra* note 2, at A-69 to A-70; see also *Medicaid Planning Justified*, *supra* note 13, at 143-44 and the authorities cited therein.

¹⁰⁸ For a more detailed discussion, see *Planning for Disability*, *supra* note 2, at A-69 to A-70; see also *Medicaid Planning Justified*, *supra* note 13, at 143-44 and the authorities cited therein.

¹⁰⁹ *Planning for Disability*, *supra* note 2, at A-76 to A-77.

¹¹⁰ *Id.*

purposes of computing the CSRA.¹¹¹ After the CSRA has been determined, the institutionalized spouse's share of the assets may be used to pay off the liability, thereby spending down his resources to qualify him for Medicaid.¹¹²

According to some commentators, divorce can also be an effective Medicaid planning technique.¹¹³ The strategy to follow, apparently, is to have the decree divide the couple's property heavily in the favor of the community spouse.¹¹⁴ Since the couple is no longer married, arguably the assets held by the now ex-spouse are not countable against the institutionalized spouse under the spousal allocation rules. Further, as the property passes by decree rather than by gift, presumably the look back period rules and the estate recovery rules should not apply either.¹¹⁵

There are likely many other more specialized techniques available for Medicaid planning that take advantage of particular attributes of clients or their property. For example, there may be techniques available to farmers and ranchers¹¹⁶ and small businesses that have not yet been exploited or that are being exploited by only a few. One might wonder, for example, what use could be made of discounted sales of minority interests in closely held entities to family members or to trusts as a means to avoid the look back period rules. For years these sorts of transfers have been used to great advantage in the gift tax area.¹¹⁷ The idea is that the interest transferred has a low fair market value relative to the value of the property held inside the entity.¹¹⁸ The "discount" value stems from the lack of control and marketability of the minority interest in the enterprise.¹¹⁹ Thus, one might sell a quarter interest in a partnership with assets worth \$1,000,000 for \$150,000 rather than for its proportionate value of \$250,000, and the sale price would be regarded as representing

¹¹¹ See *id.* at A-92 to A-93.

¹¹² *Id.* This technique works because the CSRA ignores liabilities even when they are incurred to acquire countable assets. It should be remembered, however, that the CSRA is subject to a maximum; the community spouse's assets in excess of that maximum must be spent down.

¹¹³ See Farley, *supra* note 2, at 28-34 (discussing *L.M. v. State Div. Of Med. Assistance & Health Servs.*, 659 A.2d 450 (N.J. 1995)); see also Wytychak, *supra* note 2, at 260 (suggesting this technique is appropriate where the community spouse has "significant separate property"); Fliegelman, *supra* note 2, at 364.

¹¹⁴ See Wytychak, *supra* note 2, at 260.

¹¹⁵ This is analogous to the rules that apply to the federal gift tax treatment of property transfers in divorce. Such transfers are generally not treated as gifts. See I.R.C. § 2546. See generally RICHARD B. STEPHENS ET AL., *FEDERAL ESTATE AND GIFT TAXATION* ¶ 10.06 (2002).

¹¹⁶ See Roger A. McEowen, *Estate Planning for Farm and Ranch Families Facing Long-Term Health Care*, 73 NEB. L. REV. 104 (1994) (describing several interesting techniques not widely discussed elsewhere).

¹¹⁷ See, e.g., RICHARD B. STEPHENS ET AL., *FEDERAL ESTATE AND GIFT TAXATION* ¶ 10.02[2][c] (2002).

¹¹⁸ *Id.*

¹¹⁹ *Id.*

full fair market value for the interest transferred.¹²⁰ No gift has occurred. In this way, \$100,000 of intrinsic value is transferred without being subject to gift tax. In the current context, \$100,000 of intrinsic value would be transferred away without triggering the look back period rules since the transfer was for fair value received.¹²¹ This approach also may serve to create liquidity to pay nursing home expenses during spend down.¹²² If there is a problem with family members having the resources to make the purchase outright, it could be structured as an installment sale.¹²³ Even if the transfer is structured as a gift, the amount of the gift is reduced by the discount and, thus, the period of ineligibility is reduced as well.¹²⁴

Successful planning involves staying ahead of the regulators. Moreover, planners are often loath to disclose their techniques to the prying eyes of their competitors.¹²⁵ Thus, the available literature about voluntary impoverishment probably does not give the complete picture of what is happening. In my experience with estate planning, I have often found that the literature is several years behind the practice. This likely holds true for the subject of Medicaid planning as well. Therefore, while this rough summary of the Medicaid planner's legerdemain shows something of what has been going on in the area of voluntary impoverishment, it should not be taken as exhaustive. It is clear that a great deal of time, money, and energy has gone into developing a broad array of voluntary impoverishment techniques. This is indicative of the growing pervasiveness of the practice and of its increasing fiscal impact on the Medicaid system. It also shows the pressure that middle-America is experiencing with respect to the costs of long-term care.

¹²⁰ *Id.* A combined discount of 40% for lack of marketability and control is not unusual. See KATHRYN G. HENKEL, ESTATE PLANNING AND WEALTH PRESERVATION, ¶ 16.03[1][c] (1997).

¹²¹ The look back period rules, and the penalties they can trigger, apply to gratuitous transfers. See *Planning for Disability*, *supra* note 2, at A-80.

¹²² This assumes the transferee makes payment in cash.

¹²³ For a discussion of the utility and mechanics of installment sales in the estate planning and income tax contexts, see KATHRYN G. HENKEL, ESTATE PLANNING AND WEALTH PRESERVATION, ¶ 30.01 et seq. (1997); Lisa Marie Starczewski, 565 T.M., *Installment Sales* (2002).

¹²⁴ A gratuitous transfer during the look back period delays an applicant's eligibility for Medicaid assistance. The length of the delay increases in proportion to the size of the gratuitous transfer. See Broderick, *supra* note 69, at 267-68. Thus, the larger the gift, the longer the delay in eligibility. Therefore, by structuring her gifts to obtain discounts in the gift's value, the donor reduces the length of delay in Medicaid eligibility engendered by the gift.

¹²⁵ Tax planners are well aware that whenever a tax avoidance plan becomes too well known the Treasury is likely to seek to shut it down. I know one prominent estate planner (who shall remain nameless) who is so averse to publicity about his techniques that he requires that his clients sign a non-disclosure agreement before he will plan their estates. He regards his estate plans as something akin to trade secrets.

IV. WHY IS THIS A PROBLEM?

Voluntary impoverishment is subject to a number of moral, philosophical, political, and practical objections. In an article that seeks to justify the practice of voluntary impoverishment, Timothy Takacs and David McGuffey set out eight common objections to the practice. A consolidated version of those objections is as follows:

1. Voluntary impoverishment defeats Medicaid's purpose of providing for the poor and will lead to diminished medical resources for "the truly needy." Thus, those who can afford to pay for their long-term care have a civic duty to do so in order to preserve Medicaid benefits for the truly needy.
2. Preserving peoples' inheritances is not a compelling public interest that justifies the diversion of government resources away from the truly needy.
3. Voluntary impoverishment, if unchecked, could bankrupt the system.
4. Children who use powers of attorney and other mechanisms to impoverish their parents are depriving their parents of good care and are engaging in "elder financial abuse."
5. Voluntary impoverishment discourages purchasing insurance to pay for long-term care costs.¹²⁶

Takacs and McGuffey sidestep these objections by asserting that "[a]ll 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."¹²⁷ They explain this view further by asserting, "[t]o 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. . . ."¹²⁸

This line of analysis recalls Judge Learned Hand's famous pronouncement in the taxation context that "[a]ny one may so arrange his affairs that his taxes shall be as low as possible; he is not bound to choose that pattern that will best pay the Treasury; there is not even a patriotic duty to increase one's taxes."¹²⁹ Takacs and McGuffey's point

¹²⁶ *Medicaid Planning Justified*, *supra* note 13, at 132–34.

¹²⁷ *Id.* at 135.

¹²⁸ *Id.* at 153.

¹²⁹ *Helvering v. Gregory*, 69 F.2d 809, 810 (2d Cir. 1934); *see also* Frank, *supra* note 2, at 29 (drawing on Judge Hand's views in *Gregory* to support the permissibility of Medicaid planning).

is that “there is not even a patriotic duty to increase one’s. . .”healthcare costs. Stated another way, when the question of who will pay for long-term health care is governed by a system of laws established by the government, the individual is entitled to structure his affairs so as to pay no more than the law requires.¹³⁰ After all, it is the government that wrote the rules. The government has the power, and the individual has his wits. To deny the individual the right to use his wits (or more likely the wits of the planner) to avoid paying for his long-term care would skew the odds in the government’s favor in what is already an uneven contest.¹³¹

At the present time, there is a certain irony in questioning the public benefit of preserving inheritances. Congress has recently repealed the estate tax, effective 2010, thus relieving the wealthiest members of the population from the burden of paying taxes on the part of their estates in excess of the \$1,000,000 that is already exempt.¹³² Meanwhile, it has raised the exemption levels to the point where by 2009 a married couple can leave \$7,000,000 to their heirs with no estate tax bill.¹³³ Obviously, Congress thinks the rich are entitled to pass their wealth on to their loved ones. This stands in stark contrast to the estate recovery rules that are intended to strip away every last vestige of the poor man or woman’s inheritance. This must be an especially bitter pill for an heir to swallow after, as is often the case, she¹³⁴ or he has devoted several years to giving unpaid care to the now deceased elderly person.¹³⁵

¹³⁰ Frank, *supra* note 2, at 36–38.

¹³¹ This is a paraphrase of something I wrote a decade ago in the tax planning context. See Miller, *supra* note 76, at 15. Mr. Frank’s article is a classic example of the planner’s point of view. Frank takes the rules that restrict eligibility and describes their limits. Because these rules have limits, he argues, they implicitly accept that Medicaid planning is a legitimate technique. He calls these implicit acceptances “de facto policies that militate in favor of Medicaid planning.” Frank, *supra* note 2, at 36–38. He also cites several cases in which the courts have approved Medicaid planning. *Id.* at 40. For a philosophical justification of practices like Medicaid planning, see Leo Katz, *Form and Substance in Law and Morality*, 66 U. CHI. L.REV. 566 (1999) (arguing that everyday morality is formalistic and, since law tracks everyday morality, it is formalistic also). “Lawyers who engage in . . . [such] shenanigans [as voluntary impoverishment planning] are simply capitalizing on the formality of the everyday morality that underlies the law. And by the standards of that same everyday morality they are acting perfectly defensibly.” *Id.* at 567. See also Dobris, *supra* note 2, at 25 (setting out three arguments justifying Medicaid planning: 1) a just America should not bankrupt its citizens as the price of admission to a nursing home; 2) disallowing Medicaid planning would discourage savings and encourage cheating; and 3) disallowing Medicaid planning undermines reasonable expectations of inheritance).

¹³² See I.R.C. § 2010(c) (2003); STEPHENS, *supra* note 117, at ¶¶ 1.05, 8.10[5]. The exemption for married couples is effectively \$2,000,000; however, with minimal planning, such as inter vivos gifting, much more can be passed tax free. See I.R.C. §§ 2503, 2513.

¹³³ See I.R.C. § 2010(c).

¹³⁴ Most often, caregivers to the elderly are women. See Pasaba & Barnes, *supra* note 46, at 536 n.40, and sources cited therein.

¹³⁵ See Rein, *supra* note 2, at 264–70 (describing the human and economic costs of providing elder care for family members).

The objections set out above may not overcome an individual's legal or moral right to engage in Medicaid planning, but at least some of them are good reasons why the government might seek to discourage voluntary impoverishment. After all, it is important that Medicaid be managed in a fiscally sound manner and that the truly needy be given adequate care. Thus, to deny the relevance of the objections from the applicant's or the applicant's heirs perspective only shifts the argument to a different question. Is there a fiscally prudent way to redesign Medicaid that reduces the incentive to engage in voluntary impoverishment? The urgency of this question stems not only from the strains on the Medicaid system imposed by voluntary impoverishment but also from the strains voluntary impoverishment imposes on those who engage in it.

The objections described by Takacs and McGuffey are, for the most part, impersonal objections. That is, these objections look at the practice of voluntary impoverishment from the perspective of one standing outside looking in. But there are other concerns one may articulate concerning voluntary impoverishment that look at its effect on the person who surrenders her wealth in this fashion or who considers doing so but chooses not to. This is viewing the act of voluntary impoverishment from the personal perspective. There are at least three objections that arise when voluntary impoverishment is viewed from the personal perspective.

First, the act of voluntary impoverishment leaves the person financially vulnerable and relatively defenseless.¹³⁶ For example, a person who voluntarily impoverishes himself by outright gifts before entering a nursing home and who is later discharged from a nursing home may be forced to live in poverty after discharge. Moreover, for those persons who remain institutionalized for the remainder of their lives, Medicaid provides only the bare minimum needed to go on living. Some of the planning devices described earlier can ameliorate some of these risks and discomforts. However, the essential thrust of voluntary impoverishment is to leave the person financially exposed and at the mercy of others. That is why there is some merit to the argument that the use by a child of a power of attorney to impoverish a parent for Medicaid eligibility purposes is a form of abuse. A person living on Medicaid is living on the edge of a financial precipice.

Second, to the average person the idea of ending up on the public dole is utterly repulsive. Voluntary impoverishment conflicts with the core American value of self reliance and, hence, it may feel shameful and opportunistic. Ours is a society that places a high value on material achievement and personal autonomy. People who have spent their whole

¹³⁶ For a discussion of these and other disadvantages, see *id.* at 220; see also Dobris, *supra* note 2, at 14–15.

lives seeking to establish and maintain their financial and personal independence are likely to suffer great loss of self regard after becoming impoverished and being placed in a program explicitly labeled as for “the needy.”

Third, not only does voluntary impoverishment impose high costs in terms of personal security and self-respect, but the spend down alternative may be just as personally destructive. This is because a person who chooses not to engage in voluntary impoverishment may experience a strong feeling that he has been a chump or a sucker. He may feel that only an idiot would choose to spend his life’s savings to buy something he can have at substantially lesser cost or, possibly, for free. This sense of having played the fool must be especially bitter for those persons who, as is likely, spend down their assets and end up impoverished, humiliated, and stigmatized anyway.¹³⁷ When the choice is between becoming impoverished through spend down and becoming impoverished by gifting to loved ones, the person who chooses to spend down may regard himself as having been stupidly honorable at the expense of those who matter most to him or her.¹³⁸ Moreover, by gifting away assets that are destined to be lost anyway, the donor can at least hope to gain the donee’s goodwill. By engaging in spend down, however, that opportunity is lost. Thus, the person who chooses to spend down may end up believing that he has deprived both himself and his loved ones out of mere stubborn pride, and his family may feel the same way. The person who engages in spend down pays a heavy price emotionally as well as financially.

Thus, the present structure of the law offers a choice between being a freeloader and an uncaring fool. In both cases, one is likely to approach life’s end in circumstances of dire financial peril.¹³⁹ This is hardly a desirable state of affairs.

Both the Medicaid system and the persons who practice voluntary impoverishment are harmed by the practice. Both would benefit from fiscally sound rules that make the practice unnecessary. Before setting out a proposal that approaches this goal, it will be useful to provide some context by briefly describing various proposals that have been offered to finance the cost of caring for the nation’s disabled elderly.

V. LONG-TERM CARE: PROPOSALS FOR REFORM

A number of proposals have been put forward to address the problem of funding long-term care for this country’s elderly. Thus far, no

¹³⁷ See Rein, *supra* note 2, at 269–72.

¹³⁸ For a discussion of elderly America’s ambiguous feelings toward Medicaid, see Dobris, *supra* note 2, at 19–20.

¹³⁹ See Rein, *supra* note 2, at 272–73.

comprehensive plan has been adopted by Congress, though in 1996 it did make an indirect effort to improve the situation by creating tax incentives for the purchase of long-term care insurance.¹⁴⁰ Thus far, these incentives seem to have had little impact.¹⁴¹ As noted at the beginning of this article, another significant reform effort by Congress has been its failed attempt to suppress the practice of voluntary impoverishment by imposing criminal sanctions.¹⁴² Congress has been more successful in limiting, but not eliminating, the utility of trusts as Medicaid planning devices.¹⁴³ Given the urgency of the problem and the creativity of the planners, suppression of voluntary impoverishment is not a promising course to follow. Instead what is needed is a fiscally responsible course that creates a better alternative than voluntary impoverishment.

Congress' failure to comprehensively address the problem of financing long-term care for the elderly has been attributed mainly to "the apprehension of uncontrollable public expenditures if entitlement to eligibility is materially expanded."¹⁴⁴ This "apprehension" rests upon the reasonable assumption that if government-financed long-term care were more available more people would use it.¹⁴⁵ This phenomena, which is a familiar one in the insurance industry, is called induced demand or "moral hazard."¹⁴⁶ Sensible reform must avoid carte blanche entitlement to publicly financed long-term care in order to avoid bankrupting the system.¹⁴⁷ Thus, the central challenge of any long-term care finance plan

¹⁴⁰ See Merlis, *supra* note 7, at 21–22; see generally A. Mark Christopher, *New Law Provides Ways to Reduce Tax Burdens Relating to Long-Term Care Expenses*, 86 J. TAX'N 20 (1997); David M. English, *New Legislation on Long-Term Care and Other Issues Affecting the Elderly*, 23 EST. PLAN. 494 (1996).

¹⁴¹ In 1985, 3.4% of nursing home care expenditures were paid by private insurance. By 1995, the year before Congress created new incentives for purchasing long-term care insurance, the number had risen to 7.5%. In 1999, that number nudged up less than one percent to 8.4%. NAT'L CENTER FOR HEALTH STATS., REPORT ON HEALTH: U.S. 2001, 333, Table 118 (2001) (Personal Health Care Expenditures). Other sources put the contributions of private insurance at much lower levels (around 1%). See, e.g., Merlis, *supra* note 7, at 5.

¹⁴² See *supra* note 3 and accompanying text.

¹⁴³ *Planning for Disability*, *supra* note 2, at A-70 to A-78.

¹⁴⁴ Kapp, *supra* note 58, at 733.

¹⁴⁵ *Id.* at 734. Despite the heavy expenditures made by the government, it is estimated that most of the costs of long-term care for the elderly are borne by family members and friends. See *id.* at 729; CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 5–6; see also Pasaba & Barnes, *supra* note 55, at 536–38 (noting the insufficiency of current options for financing long-term care). On the whole, research supports the notion that there is pent up demand for publicly financed long-term health care for the elderly.

¹⁴⁶ See CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 57, 66; *Medicaid Planning Justified*, *supra* note 13, at 154.

¹⁴⁷ See CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 12. Rivlin and Wiener set out three other objectives of reform: (1) it should reduce uncertainty about how people will pay for long-term care; (2) it should enable people to remain at home as long as possible; and, (3) it should encourage efficiency, flexibility and experimentation in the delivery system. *Id.* at 13.

is to find the right balance between private and public expenditures in order to control costs while seeing that care is available to all who need it. On one hand, if public monies for long-term care are too freely available, then induced demand will likely cause the overall costs to skyrocket out of control.¹⁴⁸ On the other hand, if public support is eliminated in favor of private support, then many persons will go without care. Finally, if public support is limited but still available to the needy, then devices such as voluntary impoverishment are likely to proliferate as people struggle with the two concerns described at the beginning of this article, the fear of *involuntary* impoverishment and the fear of disinheriting one's loved ones.

Since the late 1980s, there have been a number of ideas put forward directed at reforming long-term care financing in the private sector. The possibility of individual medical accounts (IMAs), a variant on the individual retirement account, has been raised.¹⁴⁹ Continuing Care Retirement Communities (CCRCs) have established a niche market.¹⁵⁰ Most prominently, the idea of private long-term care insurance as the chief fix for the problem has been debated.¹⁵¹

Individual Medical Accounts would give tax advantages to those who save for long-term care.¹⁵² Studies indicate that this mechanism is seriously flawed as a vehicle for funding the costs of long-term care for three main reasons. First, the amount of savings must be quite substantial and must begin at an early age for those persons who end up in long-term care.¹⁵³ Second, most of those who do save will never need the savings since they will not enter long-term care.¹⁵⁴ Third, those persons most likely to fully fund such accounts are those who have the least financial need for them.¹⁵⁵ Nonetheless, the idea continues to draw support in Congress.¹⁵⁶

Continuing Care Retirement Communities are "residential campuses" that usually combine a range of living circumstances and health services, typically including a nursing home.¹⁵⁷ These graduated living

¹⁴⁸ One reason for this is because "the predominate provider of long-term care in the United States is the family." *Id.* at 5. If many or all of these family members instead seek public assistance for long-term care, the government's costs may become unmanageable.

¹⁴⁹ *Id.* at 17, 109–22.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 59–82.

¹⁵² *Id.* at 109.

¹⁵³ *Id.* at 112, 122.

¹⁵⁴ *Id.* at 112–13, 122.

¹⁵⁵ *See id.* at 110, 113–15.

¹⁵⁶ *See* Warren Rojas, *House Clears Bill to Create New Tax-Preferred Savings Tools*, 99 TAX NOTES 1875 (June 30, 2003) (describing a bill, passed by the House, creating Health Savings Accounts (HSAs) that could be rolled over into Individual Retirement Accounts (IRAs) at age sixty-five).

¹⁵⁷ CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 83.

environments have many lifestyle advantages for the elderly, but they are costly.¹⁵⁸ While they can be designed as risk pooling enterprises, this has not been the trend.¹⁵⁹ Instead the move from assisted living to nursing home care usually involves a large monthly cost hike.¹⁶⁰ Thus, CCRC's are not primarily a financing mechanism for long-term care; rather, they are service providers. Like IMAs, they are most likely to be utilized by wealthier persons.¹⁶¹

It appears that the most promising private-sector option for long-term health care reform is long-term care insurance.¹⁶² More specifically, one aspect of long-term health care for the disabled elderly makes it particularly appropriate to address through insurance; that is, the fact that most people will never need substantial long-term care. Though about one in four will reside in a nursing home at some point, fewer than five percent of our nation's elderly are in nursing homes at any one time.¹⁶³ This means that long-term care lends itself to risk pooling "whereby many people contribute to a fund to cover the extraordinary expenses of the few."¹⁶⁴ This fact might cause one to conclude that private insurance could solve the problem. The difficulty with relying exclusively on private insurance, however, is that its affordability depends on its purchase many years in advance of the remote possible need because the risk of needing long-term care rises steeply with age.¹⁶⁵

A pattern of purchasing insurance well in advance of need contradicts human nature, as people are more likely to buy it only once the need becomes more immediate.¹⁶⁶ At that point, "those people likely to need long-term care insurance may buy it disproportionately, and insurance companies tend to react by screening out disabled applicants."¹⁶⁷

¹⁵⁸ See *id.* at 83–90.

¹⁵⁹ *Id.* at 83–84.

¹⁶⁰ *Id.* at 83–85.

¹⁶¹ *Id.* at 84, 94, 96.

¹⁶² *Id.* at 81–82, 238–39.

¹⁶³ *Id.* at 13, 122.

¹⁶⁴ *Id.* at 13.

¹⁶⁵ See Merlis, *supra* note 7, at 4–5 (estimating that 36% of individuals aged forty-five in 1995 can expect to spend time in a nursing home and that, while the average stay is estimated at 2.7 years, 7–8 % will require five or more years of nursing home care). Pasaba and Barnes argue that 43% of individuals aged sixty-five and older will reside in a nursing home, nearly a quarter of whom will reside there for more than four years. Pasaba & Barnes, *supra* note 55, at 536. See also Merlis, *supra* note 7, at 19–20, for a useful discussion of the nature of long-term care insurance.

¹⁶⁶ Merlis, *supra* note 7, at 13–14; Pasaba & Barnes, *supra* note 55, at 541. Moreover, Rein contends that long-term care insurance is unaffordable for most people and suffers from other problems including limited coverage, high lapse rates, inability to upgrade as policies improve, and sales and marketing abuses. See Rein, *supra* note 2, at 279–92.

¹⁶⁷ CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 210–11; see also Pasaba & Barnes, *supra* note 55, at 541–43. This is known as the problem of "adverse selection." Kapp, *supra* note 58, at 742.

Perhaps with sufficient time and marketing, the need for early purchase of long-term care insurance can be impressed upon the general population; to date, however, this has not been the case. Moreover, one author argues that “even the most optimistic estimates of the market for long-term care insurance would still leave more than half of all seniors uninsured.”¹⁶⁸

There have also been a number of public-sector reform proposals.¹⁶⁹ Several of these sought to increase the government subsidy for long-term care with an emphasis on skilled nursing care in the person’s home.¹⁷⁰ The emphasis on home health care comports with the preferences of the elderly¹⁷¹ and may also prove less expensive than institutional care.¹⁷² These approaches are akin to simply liberalizing the existing Medicaid system which has “the political advantage that it can be accomplished incrementally.”¹⁷³

Other proposals focused on public insurance for long-term care similar to that already provided by Medicare for acute care.¹⁷⁴ Many variations are possible, but the essential features are public financing with private cost sharing and broad entitlement to benefits.¹⁷⁵ As discussed earlier, substantial private cost sharing is essential in order to provide incentives not to abuse or over use the care system.¹⁷⁶ The need for private cost sharing implies the need for continued means tested aid for those too poor to bear any significant part of their long-term care expenses. Public financing could take the form of a payroll tax like Social Security and Medicare but need not do so.¹⁷⁷ The most promising of the public sector solutions to the problem of paying for the care of the disabled elderly involves a substantial private component.¹⁷⁸ For this reason, it is called the middle path.

¹⁶⁸ Margolis, *supra* note 2, at 304.

¹⁶⁹ Kapp, *supra* note 58, at 736–40.

¹⁷⁰ *Id.*

¹⁷¹ CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 148.

¹⁷² See A.E. Benjamin, *Consumer-Directed Services at Home: A New Model for Persons with Disabilities*, 20 HEALTH AFFAIRS 81 (Nov./Dec. 2001).

¹⁷³ CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 205. Margolis argues for a number of incremental changes. See Margolis, *supra* note 2, at 305–09.

¹⁷⁴ Kapp, *supra* note 58, at 736; see also CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 26, 210–34; see *Medicaid Planning Justified*, *supra* note 13, at 156; see also Dobris, *supra* note 2, at 25–27 (arguing for “compulsory, government sponsored insurance”).

¹⁷⁵ See CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 211.

¹⁷⁶ See Part VI *supra*.

¹⁷⁷ See Kapp, *supra* note 58, at 742 (“A myriad of different revenue options exist.”). Our tax system has become increasingly regressive over the past two decades and another payroll tax would only add to this problem. Revival of wealth taxation would be a reasonable approach in this author’s view. Kapp views revival of wealth taxation to be a reasonable approach.

¹⁷⁸ See generally, CARING FOR THE DISABLED ELDERLY, *supra* note 6, at ch. 3 (concluding that private sector options are appealing because, among other things, they have the poten-

VI. THE MIDDLE PATH

The main features of the middle path are set out in a book published by The Brookings Institution entitled *CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?*¹⁷⁹ The lead authors are economists Alice M. Rivlin¹⁸⁰ and Joshua M. Wiener. Rivlin and Wiener develop economic models for a number of different approaches to long-term care reform, including private insurance, individual medical accounts, home equity conversions,¹⁸¹ and continuing care retirement communities. Their announced objective was to delineate an approach that met four main goals: 1) "reduc[ing] the uncertainty and anxiety that now surround paying for long-term care;" 2) enabling the elderly to remain at home as long as possible; 3) enhancing the quality, flexibility and efficiency of the delivery system; and 4) not "greatly exacerbat[ing] the expected rise in long-term care expenditures or add to the inflationary pressures on the long-term care industry."¹⁸²

After analyzing various approaches, Rivlin and Wiener concluded that the optimal approach to achieve their goals was a blend of public and private insurance that supported home health care as well as institutional care.¹⁸³ Some of their recommendations for incremental reform have already been adopted. These include tax incentives for purchase of long-term care insurance and liberalized home health care rules for Medicaid eligibility.¹⁸⁴ But the key thrust of their proposal, a national public insurance program for catastrophic loss, remains to be enacted. The essence of this proposal is to provide public subsidy of long-term care after a long deductible period of one to two years.¹⁸⁵ It is implicit in

tial to reduce catastrophic health care costs, but would be most successful if combined with a public program).

¹⁷⁹ *CARING FOR THE DISABLED ELDERLY*, *supra* note 6.

¹⁸⁰ Ms. Rivlin served as Director of the White House Office of Management and Budget from 1994 to 1997, prior to which she was Director of the Congressional Budget Office.

¹⁸¹ I have not addressed this topic here. Despite some technical and social reasons why the government should not require people to use their home equity to fund long-term care, home equity conversions are plausible. *See, e.g.*, *CARING FOR THE DISABLED ELDERLY*, *supra* note 6, at ch. 8.

¹⁸² *Id.*

¹⁸³ *Id.* at 238–40.

¹⁸⁴ *See id.* at 238–44; Benjamin, *supra* note 130, at 91 (discussing the shift in responsibility for health care for people with disabilities, including the elderly, from professionals to recipients and how it changes the traditional home care agency model).

¹⁸⁵ *CARING FOR THE DISABLED ELDERLY*, *supra* note 6, at 245. Though I do not develop it in this article, Rivlin and Wiener set out a second option that they find plausible: a basic long-term care benefit, universally available to the elderly and with no deductible period. *Id.* at 245–46. Those persons who want additional benefits would have to pay for them privately. *Id.* at 245. I decline to develop this model for two reasons. First, Rivlin and Wiener indicate that this approach would be more expensive for the public than the middle path. *Id.* at 246. Second, this two-tiered approach introduces an overt class system of care that I do not find

this plan that there would be no estate recovery rules imposed.¹⁸⁶ Like Social Security and Medicare, this revamped version of Medicaid¹⁸⁷ could be funded by a payroll tax, with the existing Medicaid funding base covering much of the cost and personal savings or private insurance funding the deductible.¹⁸⁸ The deductible period would discourage excessive reliance on the public subsidy of long-term care.¹⁸⁹ Moreover, private insurance on this term-limited basis would likely be more affordable than is presently the case even when purchased later in life. As a result, more people would be likely to enroll. It would still be necessary to have a means-tested subsidy for those who could not afford long-term care during the deductible period, but the economic and psychological disadvantages of voluntary impoverishment described in this article would deter significant abuse of the means testing rules for such a limited advantage.¹⁹⁰

A serious potential problem with this approach is that it may continue to force spend down to poverty level by those middle-class people who are already fairly poor and, thus, unable to afford insurance.¹⁹¹ One way to address this problem would be to raise the resource levels for Medicaid eligibility so that spend down does not leave people so impoverished.¹⁹² This relief could be combined with repeal of the estate recovery rules in this context as well.¹⁹³ The denial of a poor person's right to leave a modest inheritance to his loved ones at a time when the super wealthy are being excused from paying estate taxes is simply uncon-

consonant with the ideal of equality. I recognize, however, that differences in economic status will almost inevitably produce disparities in treatment.

¹⁸⁶ The estate recovery rules have arguably impeded the development of public-private partnerships similar to those described by Rivlin and Wiener. See Pasaba & Barnes, *supra* note 55, at 550–52 (describing the negative effect of the OBRA '93 requirements of asset recovery programs by the states on emerging public-private partnership long-term care projects while maintaining that such partnerships remain viable).

¹⁸⁷ Rivlin and Wiener prefer to call this new insurance program an expansion of Medicare. See CARING FOR THE DISABLED ELDERLY, *supra* note 6, at 244.

¹⁸⁸ *Id.* at 246. Rivlin and Wiener assert that a three percent payroll tax would finance a public insurance program for long term care and that “continuing the current Medicaid program would cost at least half that much.” *Id.* They argue that other sources of revenue should be considered, including “state revenues, estate taxes, ‘sin’ taxes and reduction in other medicare spending. *Id.* at 219 The problems with relying on payroll taxes to pay for publicly financed long term care reform are that we already have a surfeit of payroll taxes and such taxes are regressive. *Id.* at 218–19.

¹⁸⁹ *Id.* at 212–14

¹⁹⁰ See *supra* Part V.

¹⁹¹ See Rein, *supra* note 2, at 293–94 (describing this problem in the context of partnership programs used in Connecticut and New York).

¹⁹² *Id.* (citing evidence that modest increases in the exempt resource level would create only minor increases in Medicaid expenditures).

¹⁹³ Margolis, *supra* note 2, at 308 (“Estate recovery should be eliminated as unfair, ineffective, and a waste of administrative resources.”).

scionable.¹⁹⁴ Another avenue that could be available to everyone but which is likely to be utilized most by the lower middle class is family home care during the deductible period. In effect the family could avoid spend down by providing the care themselves during the deductible period. Obviously, strict policing mechanisms would be needed to prevent abuse of the rule.¹⁹⁵ Recurring certification by the person's physician of continuing disability is one mechanism that might work.

CONCLUSION

Voluntary impoverishment to obtain government benefits degrades the elderly population.¹⁹⁶ Some people even consider the practice dishonest or discreditable. Nonetheless, proponents of the practice contend that voluntary relinquishment of one's property is simply rational behavior. It is seen as simply bowing to the inevitable.¹⁹⁷ Whether we accept the practice or deplore it, we must recognize its existence as a fact and understand that, in the absence of intervention, the practice will probably expand. While the rules could be tightened to make the practice more difficult, it is unlikely to go away as long as our system spreads the costs associated with chronic illness among the elderly so unevenly. Moreover, it is unlikely that the rule makers can outsmart the planners. As our tax system has shown, planners are amazingly adaptable and creative in deflecting and exploiting whatever rules the government develops. In the end the ones who are penalized are the "unlucky, the meek, and the lawyer averse. . . ."¹⁹⁸ The solution lies in leveraging the inherent disadvantages of involuntary impoverishment by reducing the risk of catastrophic loss in the event long-term care is required.

It is a commonly accepted truth that America is a society for the young. The realities of aging, decline, and death are often hidden from view in our society. To the extent that we address the topic of death and dying we prefer the image of the graceful death after a brief illness. Sadly, the truth is that many people die by inches. They cling to what appears a meager life well past the point where a disinterested observer might conclude that death is preferable. They cling to life with a fear-

¹⁹⁴ See Dobris, *supra* note 2, at 29 ("[M]any of the arguments in favor of allowing people to retain some assets while qualifying for Medicaid are similar to arguments against death taxation.").

¹⁹⁵ *Id.* ("The key problem with funding home care is the concern that vouchers would be used to pay family members for home care they have been providing for free.").

¹⁹⁶ The same has been said of spend down rules. See Kapp, *supra* note 58, at 743. ("Forcing older persons to achieve wealth and then prove poverty deprives them of a measure of basic human dignity, and society should not condone such mean-spirited public policy.").

¹⁹⁷ Frank, *supra* note 2, at 29.

¹⁹⁸ Dobris, *supra* note 2, at 28. Dobris also asserts that "any government system that yields to legal manipulation by distinguishing between those who obtain sophisticated counsel and those who do not is socially unwholesome." *Id.* at 31.

some tenacity that is also an expensive proposition. Is there fault in this? Should the sickly old people in this country surrender to death more readily? Who can judge this? The simple fact remains that at present they do not wish to “go gentle into that good night.”¹⁹⁹ In time, the practice of voluntary euthanasia may replace the practice of voluntary impoverishment as a means for addressing life’s last phase. For today, however, the reality is that old people want to live even if they appear to not live well. They “rage against the dying of the light.”²⁰⁰ Our health care system must address this passion for life in some more direct and rational fashion than is presently the case.

The practice of voluntary impoverishment to obtain Medicaid is too degrading, too unevenly available, and too expensive to receive our continued countenance. But the problems it addresses cannot be swept aside by mere government fiat. Indeed, the rise of the practice of voluntary impoverishment is clear testimony to the seriousness and intransigence of the problem of paying for long-term care for the disabled elderly. A solution must be crafted to give the middle-class elderly the incentive to bear much of their long-term care costs while limiting their risks of catastrophic loss. There is a middle path that achieves this end. Whether we have the political will to take this path remains an open question. If we do not, the practice of voluntary impoverishment to obtain government benefits will become as American as apple pie.

¹⁹⁹ Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

DYLAN THOMAS, *Do Not Go Gentle into that Good Night*, in *IN COUNTRY SLEEP AND OTHER POEMS* 18 (1952).

²⁰⁰ See *id.*

