

Protecting Assets During Catastrophic Illness Through Financial Planning: The Physician's Role

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Abstract: Patients requiring long-term institutional care face major financial dislocations that affect their families as well. While the issue of who should pay for long-term care, society or the individual, is still unsolved and controversial, lawyers specializing in welfare law can assist individuals in obtaining pub-

The problem of financing long-term care for chronic illness continues to generate considerable public debate as the plight of patients and families who must deal with this problem receives increased public attention.¹⁻³ In large part because of the generally acknowledged absence of a satisfactory societal approach to this problem, lawyers specializing in welfare law have directed their attention to assisting individuals in coping with the intricacies of obtaining public entitlements for long-term care. The expressed purpose of such legal advocacy is to maximize benefits received and minimize the expenditures of private assets. With respect to benefits for chronic illness care, this purpose translates into an effort to protect private assets and shift the financial burden from the individual to society as a whole. It is analogous to the tax planning that has become so much a part of life for middle- and upper-income families.

The purpose of this article is to describe the more important legal options based on our experience in the state of New York, with the understanding that the principles involved in this jurisdiction apply with some modification throughout this country. We also advance the proposition that physicians should inform chronically ill patients and even those at high risk from chronic illness (such as the elderly) that long-term care has major financial consequences, that choices exist with respect to paying for such care, and that patients should consider availing themselves of expert

lic entitlements and preserving private assets. Public awareness of such planning services is uneven. Physicians can make an important contribution to the welfare of their patients who are at risk by informing them of such services and of the problems they seek to address (JABFP 1988; 1:46-9.).

legal guidance. We have not found previous reference to such a role for the physician in the literature on geriatrics and the law.⁴

The Problem

Only the very wealthy can afford the costs of nursing home care without public assistance. In New York State, for example, the average yearly cost of such care is \$42,000. While the Medicare program may pay a portion of such costs for a maximum of 100 days, provided that skilled nursing treatment is involved, it is primarily to the Medicaid program that the institutionalized patient must turn for assistance.

Eligibility for Medicaid exists when an individual's income and resources fall below the poverty level established by a state. To qualify for Medicaid, a patient whose income or resources exceed the eligibility criteria must in most cases first "spend down" excess income or resources until the Medicaid-defined poverty level is reached. (In some states there is no provision for the "spending down" of excess income, and excess income precludes eligibility for Medicaid.) Obviously, resources so "spent down" are no longer available for use by a spouse, giving rise to the often tragic consequences described in the media references cited previously.

Long-Range Financial Planning to Protect Assets

The financial crisis precipitated in families by the imminent need for nursing home care often leads to a desperate search to protect assets from use for

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nursing home expenses and to shift this burden as quickly as possible to Medicaid, a topic discussed later in this article. However, this problem can be largely avoided if the possibility of catastrophic illness is anticipated by making use of the Transfer of Assets provisions of the state Medicaid laws. These provisions often exempt from consideration in the Medicaid eligibility determination process those resources transferred more than two years prior to the date of application for Medicaid. Assets transferred within two years of application are generally presumed to have been transferred for the specific purpose of achieving eligibility. This presumption is subject to rebuttal if it can be proven that the transfer was made exclusively for some purpose other than qualifying for Medicaid.

The Transfer of Assets law provides at risk individuals with the opportunity to preserve their financial resources for the use of their families and to qualify earlier for Medicaid should the need for custodial care or treatment arise. Transferring assets includes making gifts to trusted family members, creation of joint bank accounts, and establishment of trusts and life estates in real property. It should be emphasized that the details regarding the exempt status of these various arrangements vary from one state to another, making expert legal consultation essential.

While transfer of assets is tantamount to loss of control over them, a major drawback for some individuals, such transfer does not preclude the receipt of gifts for the original donor's use as the occasion arises. For example, a child who receives gifts from a parent donor is free to make gifts to the parent in turn.

Trust among family members is an essential requirement for the kind of planning proposed here, especially as it relates to gifts to be made by the family members back to the individual at risk. Unscrupulous relatives can effectively cheat elderly or ill individuals out of their assets under the guise of preserving them, as well as on other grounds. When there is inconsistency in trustworthiness among family members, a workable alternative is the transfer of assets to an irrevocable trust that is not available for medical payments and that is under the trusteeship of one or more relatives.

A mentally incompetent individual is legally prohibited from transferring assets. When such a patient's family cannot be trusted, the preferred action is the appointment of a conservator to use the patient's assets in the patient's best interests,

even though medical payments cannot be excluded through this route.

Shifting the burden of long-term care to Medicaid is worthwhile only if Medicaid-supported nursing homes in a particular state are of adequate quality. When they provide care of inferior quality, as is true in many states, sheltering assets makes sense primarily when transfer of the patient to another state with high-quality, Medicaid-supported nursing homes is possible. This circumstance would only be desirable if there are close family members who are residents of such a state.

Acute Financial Planning When Custodial Care Is Required

The concern with protecting assets, whether or not long-range planning has occurred, also commonly arises simultaneously with the acute need for nursing home care. All too often this is the circumstance in which the question first arises, when it is too late to take full advantage of the Transfer of Assets law and thereby limit the resources that may be protected. However, options still exist in the acute situation both for speeding the eligibility of the patient for Medicaid benefits and maximizing resources that can be retained by the family.

A common problem encountered by families is that of the distribution of assets when one spouse requires nursing home care and the other does not. Most states provide that spouses are responsible for the support of each other, which affects the resources of the noninstitutionalized spouse. However, as of 1983 the Federal "deeming" regulation (42 C.F.R. Section 433.723, entitled: Financial Responsibility of Spouses) provides that if only one spouse applies for Medicaid and the spouses have lived apart one month or longer by reason of institutionalization, the local Department of Social Services (DSS) may consider in its determination of eligibility only the income and resources of the noninstitutionalized spouse that are actually contributed to the patient. The noninstitutionalized spouse may accordingly limit the level of support paid to the patient to permit qualification for Medicaid that cannot be denied on administrative grounds under the new law. A possible response by the DSS to such action is bringing a lawsuit in Family Court (or its equivalent) against the noninstitutionalized spouse for an Order of Support. In the meantime, the patient's extensive medical bills would

be paid by Medicaid, and the burden of proof shifts to the state. Sometimes a DSS may simply deny the Medicaid application on arbitrary grounds. Such a denial would clearly be erroneous and can be remedied by pursuing the administrative appeal process known as a Fair Hearing.

In the case in which most of the marital income belongs to the institutionalized spouse, little may be left after medical expenses for the spouse still at home. Here, an effective remedy for the "well" spouse is to bring suit in Family Court for an Order of Support against the custodial spouse. If the court awards this support, the DSS must deduct the amount of the award from the institutionalized spouse's income in determining the level of Medicaid benefits.

When the DSS does take notice of the new legal regulations pertaining to interspousal liability for medical care, it may apply them incorrectly. A common example presented in the state of New York is the misuse of the Table of Support Obligations provided in state regulations. This table is provided for instances in which a spouse voluntarily wishes to contribute support to a spouse from whom he/she is separated. The table sets a recommended amount of support. However, we have found that often the DSS will erroneously take a figure from this table and count it as income for the institutionalized spouse whether or not the noncustodial spouse makes such payments. Such an action may be remedied by means of a Fair Hearing. The remedy available to the DSS, in turn, is to bring suit in Family Court for an Order of Support.

Another common problem arises when custodial care is required and can be provided at home. In general, the "well" spouse's resources will be taken into consideration for determining Medicaid eligibility. In this situation, an option, admittedly distasteful, is for the couple to achieve a divorce with provision for no spousal support or alimony. The "ill" ex-spouse stands on his or her own with respect to Medicaid eligibility.

These examples of commonly encountered problems are presented to illustrate two points: (1) options exist for financial planning even when it is too late to act within the Transfer of Assets law; and (2) the local DSS, with its understandable interest in conserving public monies, should not necessarily be viewed as a reliable, unbiased source of advice. Competent legal guidance should be obtained.

The Physician's Role

Physicians have traditionally and rightfully been concerned with the financial impact on their patients of medical problems. They have recognized an obligation to inform patients about the costs of care and of steps that can be taken to ameliorate those costs. With respect to the costs of long-term care, this obligation should include providing both a warning about financial risk and an indication of preventive measures that can be taken.

The sharing of such cost information does not have to be either onerous or time consuming. The physician simply has to say to the elderly patient (or others at risk) that he or she has been making it a point to acknowledge the concern that most older patients have about an incapacitating illness ("Everyone has this fear in the back of his or her mind."); that although only a small minority eventually require such services, the families of those who do often face financial problems; that planning can help to avoid these problems; and that legal remedies are available.

A careful family assessment prior to the offering of any advice on this topic can help to identify those family settings in which financial planning of the type presented here could lead to exploitation rather than protection of the individual at risk. In this case, the physician as advocate for the patient can suggest legal counsel for the purpose of establishing a trust with a reliable relative or, in the case of incompetence, creating a conservatorship. The obvious risk for the physician in taking such action is the alienation of unscrupulous family members. Balancing the needs of the individual with those of the family is not always an easy task.

Discussion

Some physicians may agree with the general objectives of this discussion but will disclaim any personal responsibility on the grounds that information sharing of the kind proposed is not the duty of the physician. Our response to this objection is that the physician as a trusted professional with an important role in the lives of many elderly patients and others at risk for long-term illness is in a strategically unique position to raise the issue of financing long-term care. What is more, the raising of this issue is appropriate in terms of the natural concern that physicians have for the impact of the cost of care on their patients. Not to do so may needlessly expose patients and their

families to financial harm. That in all likelihood few physicians currently discuss this issue with patients is not itself an argument against doing so, but it can be viewed instead as an opportunity for providing a new service in response to the recognition of an important problem. Alerting patients to this problem and the availability of legal remedies can and should be separated from the broader policy question of who should pay for long-term care, a question about which physicians undoubtedly have various points of view.

Some physicians may object to financial planning for long-term care on the grounds that it smacks unsavorily of tax avoidance and taking advantage of "loopholes" in the public welfare laws. To this charge we have two responses. First (and foremost), we are not here advocating financial planning per se (even though we do believe in it) but the spreading of the message that financial planning in anticipation of possible nursing home care exists as a reasonable undertaking for interested at risk parties. It should then be the informed patients' decisions whether such services are applicable to their own situations.

The analogy, drawn in criticism, to tax avoidance is very much to the point. To the extent that our tax laws were inequitable, the remedy did not lie in denying tax advice to individuals (which was primarily undertaken for the expressed purpose of maximizing the benefit to the individual) but in recently accomplished tax reform. In this regard, our opinion, now shared by many in government, with respect to the welfare laws is that these, too, are out of date. However, we also believe that while awaiting reform individuals at risk should be able to avail themselves of the best advice for dealing with existing laws in ways consis-

tent with their own values. At the very least, they should know that there are services to provide such advice.

It is of interest that physicians themselves now face similar threats to family assets because of the crisis in malpractice suits and awards. They are increasingly seeking to protect their own assets through legal and financial planning as evidenced, for example, by the recent publication distributed by the Massachusetts Medical Society.⁵

It is probably true that in terms of income level those who now avail themselves of legal planning services to protect against financial loss during catastrophic illness least need them. That this is so and is in a sense unfair is precisely an argument for increasing the public's access to information about such services.

Finally, we would argue that by explicitly raising these issues with patients and their families we are encouraging greater public involvement in the debate about who should pay for long-term care, thereby increasing the pressure on government and other interested parties to face squarely a pressing societal problem.

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