DON'T WANT TO PAY FOR YOUR INSTITUTIONALIZED SPOUSE? THE ROLE OF SPOUSAL REFUSAL AND MEDICAID IN FUNDING LONG-TERM CARE

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At a time when the cost of nursing home care is exceptionally high, a portion of America's rapidly growing elderly demographic is struggling to foot the bill for the care they require. As a result, Medicaid-planning strategies that seek to mitigate the high costs of nursing home care have grown in importance. In this note, Andrew Wone explores the landscape surrounding a Medicaid-planning strategy called "spousal refusal" and the implications of its use. He first details the various factors that have contributed to the importance of spousal refusal. He then analyzes

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The author would like to thank the following: his family and friends, especially Lucy New, William and Aimee Won, Katherine Wone, and Carol Wong, for their continued support and encouragement; Professor Richard Kaplan for being a great mentor and guiding the development of this note; John Ford, Chester McLaughlin, Garvin Reiter, René Reixach, Marc Shok, and Mark Tapper for their research contributions; and *The Elder Law Journal* for its work throughout the editorial process. This note would not have been possible without the efforts and perseverance of those listed above.

Finally, this note is dedicated to the author's brother, Robert Eric Wone. Robert exemplified hard work, modesty, patience, and commitment to his family and community. His memory is a blessing, and he will always be a true inspiration to the author.

Wilson-Coker v. Morenz, *a federal appellate decision that upheld the utilization of spousal refusal. Mr. Wone next explains the implementation of spousal refusal, examines how several states have confronted the issue both legally and practically, and ultimately concludes that spousal refusal should exist, but in a modified form. Specifically, he argues for a "Modified Spousal Refusal" system and for amending federal Medicaid statutes to disallow the practice of spousal refusal by default. Modified Spousal Refusal would grant states the option to opt in and become eligible for spousal refusal pursuant to a clearly defined exception. Mr. Wone asserts that such a system would strike the appropriate balance between the ample need for nursing home care and the need for a cost-effective solution.*

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I. Introduction

Can an elderly husband really refuse to support his wife in a nursing home by shifting the financial burden to Medicaid? Yes, says the U.S. Court of Appeals for the Second Circuit, by employing a Medicaid-planning strategy called "spousal refusal."[1]

Due to the high cost of nursing home care,[2] elderly people and their families have increasingly turned to Medicaid-planning strategies to qualify for Medicaid benefits and ease their financial burden.[3] Medicaid planning involves taking measures to preserve one's assets in order to gain Medicaid eligibility by meeting the program's financial criteria.[4] One such Medicaid-planning strategy is spousal refusal, under which a healthy spouse refuses to financially support a spouse in need of nursing home care.[5] Spousal refusal has been in existence since 1988, following Congress' attempt to fix the Medicaid system to prevent spousal impoverishment, which is when a healthy spouse ends up poor after paying for an ailing partner's care.[6]

In *Morenz v. Wilson-Coker*,[7] decided in July 2005, the U.S. Court of Appeals for the Second Circuit affirmed the district court's decision to uphold the right of spousal refusal.[8] Until *Morenz*, reported case law involving the availability of spousal refusal had been limited to state courts.[9] Although spousal refusal has been limited in practice to a few

1. Morenz v. Wilson-Coker, 415 F.3d 230, 237 (2d Cir. 2005).

2. Jane Gross, *The Middle Class Struggles in the Medicaid Maze*, N.Y. TIMES, July 9, 2005, at B1 (noting that nursing home costs average $61,685 nationwide and more than $90,000 in a state such as New York).

3. Saul Friedman, *Gray Matters: Asset Transfers and Medicaid Planning*, NEWSDAY (N.Y.), Dec. 15, 2005, at B09.

4. 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).

5. Gross, *supra* note 2.

6. *Id.*; Thomas B. Scheffey, *Elderly Spouses Gain Assets Protection*, LEGAL INTELLIGENCER, Aug. 5, 2005, at 4.

7. 415 F.3d 230 (2d Cir. 2005).

8. *Id.*, *aff'g* 321 F. Supp. 2d 398 (D. Conn. 2004).

9. Searches of Westlaw and LexisNexis revealed no reported federal cases involving spousal refusal besides *Morenz v. Wilson-Coker*. *See also* Note, Morenz v.

states prior to *Morenz*,[10] the issue is of national importance due to the financial implications of Medicaid, which is substantially supported by federal funding.[11]

Moreover, elderly couples, especially those in the middle class, face the increasing burden of nursing home expenses,[12] as governments have taken measures to restrict Medicaid planning and control costs.[13] As a result, elder law attorneys and their clients will look for alternative Medicaid-planning strategies to qualify for Medicaid benefits.[14]

This note explores the tensions surrounding spousal refusal and Medicaid, the legal rationale behind the *Morenz* decision, and the need for a balanced solution. The Background section briefly discusses the current state of Medicaid and long-term care, with a focus on nursing

Wilson-Coker, 1 NAT'L ACAD. ELDER L. ATT'YS J. 327, 328 (2005) [hereinafter NAELA].

10. John A. Miller, *Voluntary Impoverishment to Obtain Government Benefits*, 13 CORNELL J.L. & PUB. POL'Y 81, 95 (2003) (mentioning Maryland as a place where spousal refusal is legal); Ctr. for Long-Term Care Reform, NAELA Presentation Excerpts and CLTCF Comments, http://centerltc.com/bullets/current/naela.htm (last visited Sept. 8, 2006) [hereinafter CLTCF] (mentioning New York, Florida, and Washington, D.C. as possible places where spousal refusal is allowed).

11. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 418 (2004).

12. Gross, *supra* note 2.

13. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 5 (2006); Saul Friedman, *Gray Matters: To Social Darwinists Poor Are Unfit to Live*, NEWSDAY (N.Y.), Mar. 19, 2005, at B08; Press Release, PR Newswire, President Bush Signs the Deficit Reduction Act of 2005 (Feb. 9, 2006), http://sev.prnewswire.com/health-care-hospitals/20060209/NYTH07309022006-1.html [hereinafter PR Newswire].

14. E-mail from Garvin Reiter, Attorney, Law Offices of Nay & Friedenberg, to Andrew Wone, Student, U. of Ill. Coll. of Law (Mar. 15, 2006, 18:10 CST) [hereinafter Reiter] (on file with author) (noting that spousal refusal has not actually been used in Oregon, but some attorneys may be considering its use due to the recent passage of the Deficit Reduction Act in 2006); E-mail from Marc Shok, Pub. Assistance Consultant, Conn. Dep't of Soc. Servs., to Andrew Wone, Student, U. of Ill. Coll. of Law (Feb. 16, 2006, 07:27 CST) [hereinafter Shok] (on file with author); E-mail from Mark Tapper, Attorney, Tapper Law Offices, to Andrew Wone, Student, U. of Ill. Coll. of Law (Nov. 7, 2005, 12:41 CST) [hereinafter Tapper] (on file with author) (noting that spousal refusal has not been extensively used in Vermont until recently, primarily due to more effective planning strategies). With the gap between private and Medicaid rates at approximately 40%, spousal refusal could receive greater consideration as a planning strategy. *Id.* The *Morenz* decision is law in Vermont, but it is unknown how the state will react or the future level of estate recovery efforts. *Id.* For a comparison of Vermont with other states in terms of Medicaid expenditures, see CTRS. FOR MEDICARE & MEDICAID SERVS., FISCAL YEAR 2003 NATIONAL MSIS TABLES 2 tbl.01 (2006), *available at* http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/MSISTables2003.pdf [hereinafter MSIS TABLE] (stating that Vermont expended more than $600 million in 2003, with a cost of $4149 per beneficiary, compared to the national average of $4487).

homes, then turns its attention to the historical context of the spousal refusal provision and the role of Medicaid planning. The Analysis section addresses why spousal refusal is important nationally and explains the *Morenz* court's rationale. This section also discusses the spousal recovery process, and its potential role in recouping Medicaid expenditures due to spousal refusal. To illustrate costs and benefits, this note compares the spousal refusal recovery process to Medicaid's general estate recovery process. Additionally, the Analysis examines several states where spousal refusal has been litigated. Finally, the Resolution advocates changing the federal statute and the administrative agency guidelines to create "Modified Spousal Refusal." This Resolution accounts for the social and political considerations of spousal impoverishment, the role spousal refusal plays, the discretion traditionally given to states under Medicaid, the growing fiscal pressure on government budgets, and the intent of Medicaid to be a service for those "whose income and resources are insufficient to meet the costs of necessary medical services"[15] while also preventing "pauperization" of the spouse.[16]

II. Background

A. Medicaid

In 1965, Congress created Medicaid with the passage of the Social Security Act.[17] The goal of Medicaid is to provide medical assistance to people in need.[18] Jointly funded by federal and state governments, Medicaid is the "payor of last resort" for people who are otherwise unable to pay for necessary medical services.[19] Medicaid provides extensive coverage for nursing homes and other long-term care services with substantially fewer restrictions than Medicare.[20]

15. 42 U.S.C. § 1396 (2005). This note does not directly address the ethical implications of Medicaid planning. See Takacs & McGuffey, *supra* note 4, at 114–15, for a discussion of potential ethical considerations.

16. Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 480 (2002).

17. EARL DIRK HOFFMAN, JR. ET AL., DEP'T OF HEALTH & HUMAN SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID 3 (2005), *available at* http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2005.pdf.

18. *Id.*

19. 42 U.S.C. § 1396; Eve Green Koopersmith, *DSS May Recover Medicaid Expenses from Community Spouse*, 5 N.Y. HEALTH L. UPDATE (1998).

20. Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 65. Medicare is the federal government's

The Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services (DHHS), is responsible for regulating Medicaid.[21] However, states have broad latitude in administering the program by determining their own eligibility standards, level and scope of coverage, and service rates.[22]

Medicaid expenditures are expected to continue growing.[23] Currently, Medicaid is 1.5% of gross domestic product (GDP), and this figure is estimated to grow to 2.6% by 2035 and 4.8% by 2080.[24] The elderly comprise 9% of all Medicaid beneficiaries but have a higher expenditure rate per person and account for more than 20% of overall Medicaid expenditures.[25]

B. Nursing Home Costs and Rising Demand

The couples that use spousal refusal are most commonly in need of nursing home services, and Medicaid shoulders a substantial portion of the nation's nursing home costs.[26] In 2003, Medicaid paid for 48% of the nation's long-term care expenses,[27] almost half of which covered nursing home expenses totaling approximately $41 billion.[28] Overall costs for nursing home care were approximately $110 billion nationally in 2003.[29] The average cost for individual nursing home

heath care program for people ages sixty-five and older. Most elderly people are covered by Medicare, but Medicare covers skilled nursing care only under specific conditions. *Id.* at 60. Most notably, the recipient must stay in a hospital for at least three days prior to going to the skilled nursing facility and must receive skilled nursing care while in the facility. *Id.*

21. Ctrs. for Medicare & Medicaid Servs.; Statement of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed. Reg. 35437 (July 5, 2001).

22. HOFFMAN ET AL., *supra* note 17, at 15 (noting that a person who qualifies for Medicaid in one state may not necessarily qualify in another state); *see also* Kaplan, *supra* note 20, at 64.

23. KATHRYN G. ALLEN, GOV'T ACCOUNTABILITY OFFICE, MEDICAID: LONG-TERM CARE FINANCING: GROWING DEMAND AND COST OF SERVICES ARE STRAINING FEDERAL AND STATE BUDGETS 8 fig.2 (2005), *available at* http://energycommerce.house.gov/108/hearings/04272005Hearing1487/Allen.pdf [hereinafter GAO FINANCING].

24. *Id.* at 7.

25. HOFFMAN ET AL., *supra* note 17, at 22 (providing a breakdown of the Medicaid budget expenditures by group, cost per person, and aggregate total).

26. GAO FINANCING, *supra* note 23, at 10–11.

27. *Id.* at 5.

28. *Id.* at 5–6.

29. CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME CARE EXPENDITURES AGGREGATE AND PER CAPITA AMOUNTS AND PERCENT DISTRIBUTION, BY SOURCE OF FUNDS: SELECTED CALENDAR YEARS 1970–2004 tbl.8,

care is approximately $70,000 a year for a private-pay patient,[30] but these costs vary widely by geographic area or by facility.[31] As a result of these high costs, Medicaid has become a common source of financing for nursing home care because it provides more extensive coverage and imposes fewer restrictions than other options such as Medicare.[32]

Furthermore, CMS expects the need for long-term care, which includes nursing home services, to increase and to contribute to a rise in Medicaid's expenditures.[33] There are approximately 1.6 million nursing home residents nationally,[34] and although the nursing home population has increased every year since 1994, the proportion of elderly people in such facilities has decreased due to the growth of services such as assisted living and home care.[35] However, as life expectancy continues to increase, so will the chances of elderly people needing such services.[36] While less than 2% of the elderly population between the ages of sixty-five and seventy-four live in nursing homes, approximately 20% of people age eighty-five and older live in nursing homes.[37] In addition, the aging baby boomers will have a dispropor-

available at http://new.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

30. GOV'T ACCOUNTABILITY OFFICE, MEDICAID: TRANSFERS OF ASSETS BY ELDERLY INDIVIDUALS TO OBTAIN LONG-TERM CARE COVERAGE 2 (2005), *available at* http://www.gao.gov/new.items/d05968.pdf [hereinafter GAO TRANSFERS].

31. Gross, *supra* note 2. For example, New York's average is $93,600 a year, while some high-quality nursing homes in other major metropolitan areas can be more than $200,000. *Id.*

32. Kaplan, *supra* note 20 (stating that Medicaid is more extensive than Medicare because Medicaid: covers chronic conditions that require less-than-skilled nursing level of care; includes health aide services, medical supplies and equipment, and personal care services; and does not have duration-of-stay limits for nursing homes).

33. HOFFMAN ET AL., *supra* note 17, at 22; DAVID M. WALKER, GOV'T ACCOUNTABILITY OFFICE, MEDICAID: LONG-TERM CARE: AGING BABY BOOM GENERATION WILL INCREASE DEMAND AND BURDEN ON FEDERAL AND STATE BUDGETS 12 (2002), *available at* www.gao.gov/new.items/d02544t.pdf [hereinafter GAO AGING].

34. Am. Geriatrics Soc'y, The AGS Foundation for Health in Aging, Aging in the Know, Nursing Home Care, http://www.healthinaging.org/aginginthe know/questions_ch_trial.asp?ch=15 (last visited Sept. 8, 2006).

35. *Id.*; Press Release, Univ. of Cal. S.F. News Office, Assisted Living and In-Home Care Increase as Nursing Home Beds Decline (Aug. 4, 2005), http://pub.ucsf.edu/newsservices/releases/200508051/.

36. GAO AGING, *supra* note 33, at 10; Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. MED. 1409, 1411 fig.1 & tbl.1, 1412 fig.2 (2000).

37. Am. Geriatrics Soc'y, *supra* note 34.

tionate effect on the demand for long-term care services.[38] By 2040, the number of elderly people ages eighty-five and older will increase 250% from the year 2000 to a total of 15.4 million, and some commentators have estimated that conditions such as dementia will double the number of elderly people living in nursing homes by the year 2020.[39] Thus, it is likely that a rapidly growing population of elderly people with increasingly longer life spans will spur greater demand for Medicaid benefits and more widespread use of strategies like spousal refusal to qualify for these benefits.

C. The Medicaid Catastrophic Coverage Act (MCCA)

In 1988, Congress passed the Medicare Catastrophic Coverage Act (MCCA),[40] which created new eligibility rules to prevent spousal impoverishment for couples with one "institutionalized spouse."[41] An "institutionalized spouse" is someone who is "likely to reside in a medical institution and/or nursing facility for a continuous period of institutionalization" while a "community spouse" is someone who is "not living in a medical institution or nursing facility."[42] Prior to the MCCA, the community spouse had to expend a large portion of the couple's resources to qualify the institutionalized spouse for Medicaid, and then the couple had to reduce its posteligibility income to minimize Medicaid's contribution for institutional care.[43] The MCCA attempts to "protect the community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance."[44]

38. GAO AGING, *supra* note 33, at 13.
39. GAO FINANCING, *supra* note 23, at 11; Am. Geriatrics Soc'y, *supra* note 34.
40. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683. MCCA was modified by the Omnibus Budget Reconciliation Act of 1993, but the spousal impoverishment provisions still exist. Miller, *supra* note 10, at 86 n.33.
41. Ctrs. for Medicare & Medicaid Servs., Spousal Impoverishment, http://www.cms.hhs.gov/MedicaidEligibility/09_SpousalImpoverishment.asp (last visited Sept. 8, 2006) [hereinafter CMS Spousal Impoverishment].
42. CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE MEDICAID MANUAL CH. 3—ELIGIBILITY § 3260.1 (2005) [hereinafter STATE MEDICAID MANUAL] (on file with The Elder Law Journal).
43. Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 480 (2002).
44. *Id.*

D. Medicaid Eligibility

When an institutionalized spouse applies for Medicaid, the appropriate state agency examines the couple's resources and income.[45] In order to qualify for Medicaid, the applicant must satisfy both income and resource requirements. This subsection describes the underlying policies of these two eligibility criteria.

1. INCOME ELIGIBILITY

Medicaid's standard eligibility process requires an individual assessment of each spouse's income.[46] The state agency takes into consideration an applicant's income from Social Security, pensions and Supplemental Security Income (SSI), and interest or dividends from investments.[47] The maximum income level varies by state.[48] Some states do not allow individual income to exceed 300% of the current SSI, while others allow qualification as long as an applicant's income is lower than the medical costs.[49] To satisfy Medicaid's income eligibility criteria, the institutionalized spouse's income cannot exceed the maximum level set by the state.[50]

Once an applicant meets Medicaid eligibility, the state agency reexamines the income level to determine how much of the institutionalized spouse's income must be contributed toward nursing home costs and whether any of it should be left available to the community spouse.[51] If the community spouse's income falls below the "minimum monthly maintenance needs allowance" (MMMNA), the agency allocates a portion of the institutionalized spouse's income to the community spouse.[52] The MMMNA is derived from the federal pov-

45. CMS Spousal Impoverishment, *supra* note 41.
46. *Id.*
47. Kaplan, *supra* note 20, at 66.
48. Miller, *supra* note 10, at 85.
49. *Id.*; *see also* Takacs & McGuffey, *supra* note 4, at 127. SSI is a welfare program that provides benefits to qualifying elderly and disabled. *See* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 320 (3d ed. 2003).
50. *See* CMS Spousal Impoverishment, *supra* note 41.
51. *Id.*; *see also* Kaplan, *supra* note 20, at 68 (stating that the minimum income standard for the community spouse, determined similar to the CSRA, is left to the discretion of the states, subject to a federally set range).
52. Sargent Shriver Nat'l Ctr. on Poverty Law, Supreme Court Affirms Use of "Income-First" Methodology for Determining Community Spouse's Resource Allowance When Calculating Institutionalized Spouse's Medicaid Eligibility, http://www.povertylaw.org/poverty-law-library/case/54400/54462 (last visited Sept. 11, 2006). See *Wisconsin Department of Health & Family Services v. Blumer*, 534 U.S. 473 (2002), for a full discussion of the Court's rationale.

erty level for a couple, then adjusted by a state-determined percentage.[53] Currently, the state must use a percentage of at least 150%.[54] Applying this state percentage to the federal poverty level, the MMMNA in 2006 is between $1,603.75 and $2,488.50.[55]

2. RESOURCE ELIGIBILITY

To determine eligibility based on resources, the state agency evaluates a couple's assets collectively regardless of ownership.[56] There are two categories of resources: countable and excludable.[57] The CMS State Medicaid Manual considers homes, automobiles, burial funds, and household goods to be excludable resources for married couples.[58] Homes and automobiles are excluded without any limitation to their value.[59] Following MCCA's passage in 1988, special resource allowance provisions were created for couples when one spouse was institutionalized.[60] After calculating the couple's countable assets, the community spouse is able to retain a "protected resource amount" (PRA), also commonly referred to as a "community spouse resource allowance" (CSRA).[61] This amount can vary by state and is adjusted annually for inflation.[62] For 2006, the CRSA was the greatest of the following amounts: (1) one-half of the couple's total countable resources up to $99,540; (2) an amount transferred to the community spouse due to a court order; (3) an amount designated by a state program administrator; or (4) the state spousal resource stan-

53. *Blumer*, 534 U.S. at 481.
54. *Id.*
55. CMS Spousal Impoverishment, *supra* note 41.
56. *Id.*
57. Takacs & McGuffey, *supra* note 4, at 141.
58. CMS Spousal Impoverishment, *supra* note 41.
59. Kaplan, *supra* note 20, at 68. Although the Deficit Reduction Act of 2005 put a cap of $500,000 on exempted home equity, this should not be an issue for community spouses as long as they live in the home. Francine Brevetti, *Own a Home, Lose Your Medi-Cal*, SAN MATEO COUNTY TIMES (Cal.), Mar. 18, 2006. States have the option of raising this limit to $750,000. *Id.*
60. Miller, *supra* note 10, at 86–87. Prior to the passage of MCCA in 1988, the institutionalized spouse was not eligible for Medicaid if the couple had more than $2000 in countable resources. Takacs & McGuffey, *supra* note 4, at 140–41. As a result, this forced couples to spend down and led the community spouse into poverty in order for the institutionalized spouse to receive Medicaid; some couples divorced rather than spend down. Gross, *supra* note 2; Takacs & McGuffey, *supra* note 4, at 141.
61. Takacs & McGuffey, *supra* note 4, at 141; CMS Spousal Impoverishment, *supra* note 41.
62. Kaplan, *supra* note 20, at 69.

dard, which can be between $19,908 and $99,540.[63] As with other areas of Medicaid, states have wide latitude to set the CSRA. A state can select the minimum, the maximum, or create its own formula that results in a midrange dollar amount.[64]

An elderly couple with resources above the CSRA must spend down its assets until they are within the CSRA to qualify for Medicaid coverage.[65] While there are some risks to Medicaid planning, elderly couples may find it beneficial.[66]

E. Medicaid Planning

Medicaid planning allows applicants to become eligible for services and avoid spending down even if their current asset levels exceed the CSRA.[67] Some observers criticize the use of Medicaid-planning strategies like spousal refusal as an abuse of Medicaid and a loophole that wastes the program's resources.[68] However, others view spousal refusal as a planning strategy codified by Congress in order to avoid spousal impoverishment and argue that it is an equitable approach because it does not simply reject applicants on the basis of a bright-line mathematical formula.[69] For these proponents, spousal re-

63. *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net: Hearing Before the S. Comm. on Finance*, 109th Cong. 7 (2005) [hereinafter *Medicaid Waste*] (statement of Julie Stone-Axelrad, Specialist in Social Legislation, Congressional Research Service); CMS Spousal Impoverishment, *supra* note 41; *see also* OFFICE OF ASSISTANT SEC'Y FOR POL'Y EVALUATION, DEP'T OF HEALTH & HUMAN SERVS., SPOUSES OF MEDICAID LONG-TERM CARE RECIPIENTS 6 (2005), *available at* http://aspe.hhs.gov/daltcp/reports/spouses.pdf [hereinafter DHHS, SPOUSES] (stating that in 2004, the CSRA minimum was $18,552, and the maximum was $92,760).

64. Kaplan, *supra* note 20, at 68.

65. CMS Spousal Impoverishment, *supra* note 41.

66. CLTCF, *supra* note 10.

67. Miller, *supra* note 10, at 92.

68. Friedman, *supra* note 3 (noting Stephen Moses' view that Medicaid planning exploits the system and confers benefits on undeserving recipients).

69. G.M. Filisko, *Medicaid Family Can Hold on to More Assets*, A.B.A. E-REPORT (2005) (on file with The Elder Law Journal) ("[T]he sad thing about this case is that it had to be brought at all, that states have to be compelled to follow what this court indicated was a statute that was pretty clear . . . . If a statute isn't working, states should go to Congress and ask that it be changed. You don't just not follow it." (quoting Rene Reixach, Attorney, Woods Oviatt Gilman LLP, Rochester, N.Y.)); Scheffey, *supra* note 6.

fusal is a necessary and socially beneficial option in light of the high cost of nursing home care.[70]

Without spousal refusal and other Medicaid-planning strategies, a substantial segment of elderly households would be unable to cover the full cost of long-term care for even a one- or two-year period based on nonhousing resources or average annual income.[71] A DHHS study estimated that virtually no elderly couples could pay for nursing home care without using their assets, and only 40% to 50% could afford a single year without depleting all financial resources.[72] Thus, for much of the elderly population, nursing home costs pose a significant burden.

Couples constitute 46% of all elderly households, and they typically have higher asset levels than single elderly persons; the median annual income for elderly couples is almost $40,000, and their median nonhousing resources are slightly less than $125,000.[73] Many elderly couples find that spending down their assets to meet the CSRA is risky given the uncertainty in the length of nursing home stays and the large unpredictable costs associated with such care.[74] The CSRA can be as low as $19,908, and couples may be wary of spending down to such a low level rather than preserving a more comfortable financial safety net.[75] When one spouse is institutionalized, a couple needs to preserve assets for the financial security of the community spouse.[76]

Furthermore, household income typically decreases with advancing age.[77] Approximately 80% of elderly people have an annual income of $50,000 or less, with a median income of $24,200, and about half of elderly households have $50,000 or less in nonhousing re-

70. Jay Gallagher, *Billions of Dollars Leak Through Loopholes*, GANNETT NEWS SERVICE, Mar. 29, 2003, *available at* http://content.gannettonline.com/gns/newyork/p3_6.html.

71. GAO TRANSFERS, *supra* note 30, at 2, 14, 15.

72. LISA ALECXIH & DAVID KENNELL, DEP'T OF HEALTH & HUMAN SERVS., THE ECONOMIC IMPACT OF LONG-TERM CARE ON INDIVIDUALS (1994), *available at* http://www.aspe.hhs.gov/daltcp/Reports/ecoimpes.htm.

73. *Id.*

74. Miller, *supra* note 10, at 82–84.

75. Scheffey, *supra* note 6; CMS Spousal Impoverishment, *supra* note 41.

76. ALECXIH & KENNELL, *supra* note 72. The death of a spouse can lead to poverty for the surviving spouse, an outcome that is especially common among women. *Id.* Elderly widows often become poor due to the loss of a spouse's pension, the partial loss of Social Security benefits, and the expenses related to the spouse's death. *Id.*

77. Miller, *supra* note 10, at 89.

sources, with an overall median of $51,500.[78] Among the wealthier segment of the elderly population, the median income for people ages fifty-five to seventy-four who own equity investments is $53,000, with a median asset level of $200,000.[79] However, the median income drops to $30,000 for equity owners older than seventy-five, while the asset level remains constant.[80] The wealthier segment of the elderly population would still be unable to pay for nursing home costs with annual income alone; to qualify for Medicaid they would need to spend down resources of at least $25,000 per year until reaching the CSRA.[81]

Disabled elderly households have even lower average income and resource levels than other elderly households.[82] In disabled elderly households, which account for approximately 20% of the elderly household population, the median income is less than $20,000, and the median nonhousing resource level is even lower.[83] These disabled elderly also face a substantially higher chance of needing long-term care than the general elderly population.[84]

Medicaid planning is not without its consequences.[85] Some elderly people dislike the notion of relying on a government "welfare" program or feel uncomfortable about giving away their assets to their spouse.[86] Even if an institutionalized spouse is able to qualify for Medicaid, many long-term care facilities accept only a limited number of Medicaid patients.[87] Relying on Medicaid could restrict a person's initial facility choices and reduce mobility should it later become necessary to switch facilities.[88] Despite these factors, many elderly couples, especially in the middle class, face rising nursing home costs with limited incomes at their disposal. In this difficult situation, elderly couples turn to Medicaid-planning strategies such as spousal re-

78. GAO TRANSFERS, *supra* note 30, at 13–14.
79. Miller, *supra* note 10, at 89.
80. *Id.*
81. *See id.*
82. GAO TRANSFERS, *supra* note 30, at 15.
83. *See id.* at 16 fig.3; *see also* ALECXIH & KENNELL, *supra* note 72.
84. GAO TRANSFERS, *supra* note 30, at 15.
85. Kaplan, *supra* note 20, at 71.
86. *Id.* at 71–72.
87. *Id.* at 72.
88. *Id.*

fusal as a solution for these "ruinously expensive, but absolutely essential" costs.[89]

F. Overview of Spousal Refusal

Spousal refusal generally involves similar steps in all states that allow it.[90] First, the institutionalized spouse assigns his or her support rights to the state.[91] This removes the legal obligation of support between spouses, which is present in most states and determined by local law.[92] The community spouse often completes the assignment for the institutionalized spouse through a durable power of attorney.[93]

Next, the community spouse effectively takes sole ownership of all marital resources and makes these resources, along with his or her income, unavailable to the institutionalized spouse.[94] In most instances, the community spouse submits a letter to the state agency clearly expressing his or her refusal to contribute income or resources toward the cost of the Medicaid applicant's care.[95] If the institutionalized spouse does not have the capacity to assign his or her rights to

89. *In re* Shah, 257 A.D.2d 275, 283 (N.Y. App. Div. 1999); ELDER LAW SECTION, N.Y. STATE BAR ASS'N, REPORT OF THE LONG-TERM CARE REFORM COMMITTEE (2005), *available at* http://www.nysba.org/Content/Microsites53/Elder_Law_Section1/2005_Long_Term_Care_Reform_Report/elderltcreport2columnnewer.pdf [hereinafter NYSBA ELDER LAW SECTION]; *see* Miller, *supra* note 10, at 90.

90. While spousal refusal is allowed under federal law, it requires an assignment of support rights, which falls under state law and may vary in process. *See* Morenz v. Wilson-Coker, 415 F.3d 230, 235–36 (2d Cir. 2005).

91. Thomas D. Begley, Jr. & Jo-Anne Herina Jeffreys, *Medicaid Planning for Married Couples*, 17 NAT'L ACAD. ELDER L. ATT'YS Q. 19, 21 (2004); *see also* Koopersmith, *supra* note 19 (illustrating how the spousal refusal process functions in New York).

92. *See* Douglas J. Chu, *Medicaid Transfer Rules and Penalties*, *in* N.Y. ELDER LAW HANDBOOK 377, 397 (Practicing Law Institute 2004); NAELA, *supra* note 9, at 327–28. These support obligations are statutorily established in most states, although some have also implemented the obligations through the common-law doctrine of necessities or community property rules. NAELA, *supra* note 9, at 328. *But see* E-mail from Chester McLaughlin, Attorney, to Andrew Wone, Student, Univ. of Ill. Coll. of Law (Nov. 2, 2005, 19:07 CST) [hereinafter McLaughlin] (on file with author) (stating that Arizona is one such state that utilizes community property law, and expressing skepticism about the possibility of spousal refusal absent a statute requiring support).

93. *See* NAELA, *supra* note 9, at 328 (commenting that the assignment of support rights is automatic in some states through the operation of law or through the Medicaid application form).

94. Begley & Jeffreys, *supra* note 91.

95. Steven H. Stern, *Case Study: Medicaid Crisis Planning for Spouses*, 2 T.M. COOLEY J. PRAC. & CLINICAL L. 71, 92–93 (1998).

the state, the "state has an implied right to bring a support proceeding against the community spouse."[96]

Following these actions, the state Medicaid agency is required to determine the eligibility of the institutionalized spouse based solely on his or her income and resources, without considering the community spouse.[97] However, after the institutionalized spouse receives benefits, the state agency has the option of seeking recovery of the nursing home costs from the community spouse, a procedure called "spousal recovery."[98]

Although the process of implementing spousal refusal can vary by state, this strategy is supported—some would argue mandated[99]—by both federal statute and by the CMS State Medicaid Manual.[100] The federal code, 42 U.S.C. § 1396r-5(c)(3), states that "[t]he institutionalized spouse shall not be ineligible by reason of resources determined . . . to be available for the cost of care where . . . the institutionalized spouse has assigned to the State any rights to support from the community spouse."[101] Moreover, the CMS State Medicaid Manual parallels the federal statute by stating that an institutionalized spouse shall not be denied eligibility when "all support rights" of an institutionalized spouse are assigned to the state even if the resource level exceeds the maximum.[102] The *Morenz v. Wilson-Coker* decision directly addressed the legal ramifications of this federal statute and the deference to be given to the CMS regulation.

III. Analysis

To understand spousal refusal's national implications on Medicaid, it is important to consider the relevant social, political, and fi-

96. Begley & Jeffreys, *supra* note 91.

97. *See* Howard Davidoff, *Medicaid Planning for the Stay-At-Home Spouse*, 32 EST. PLAN. 40, 42 (2005); Elder Law Answers, Medicaid Planning, http://www.elderlawanswers.com/elder_info/elder_article.asp?id=701 (last visited Sept. 8, 2006).

98. Begley & Jeffreys, *supra* note 91.

99. Filisko, *supra* note 69 (arguing that states should be required to follow the federal statute that allows spousal refusal).

100. 42 U.S.C. § 1396r-5(c)(3)(A) (2005); STATE MEDICAID MANUAL, *supra* note 42, § 3262.2.

101. 42 U.S.C. § 1396r-5(c)(3)(A).

102. STATE MEDICAID MANUAL, *supra* note 42, § 3262.2. CMS interpretations are usually given deference by courts. *See* Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 497 (2002); Cmty. Health Ctr. v. Wilson-Coker, 311 F.3d 132, 138 (2d Cir. 2002).

nancial factors. The *Morenz* court's rationale established a legal foundation for understanding spousal refusal and its ramifications by providing an interpretation of the federal statute and how it interacts with applicable state laws. *Morenz* also showed the potential effects of spousal refusal on governments and the burden on state agencies seeking financial recovery from refusing community spouses. Moreover, this section provides a comparative look at general Medicaid estate recovery programs to further illustrate the competing political, social, and economic tensions. Finally, this section profiles a few states with reported cases on spousal refusal to examine how they have addressed the issue and to explore its ramifications on Medicaid.[103]

A. Spousal Refusal Is Both a National and State Issue

Although spousal refusal is allowed only in certain states, it is a nationally important issue due to its effect on Medicaid expenditures. Medicaid receives funding from both state and federal governments,[104] with the proportion of federal funding varying by state, depending on the state's financial needs.[105] For the 2007 fiscal year, the federal government anticipates contributing anywhere from 50% to 75% to each state's Medicaid budget.[106] In addition to the shared-cost structure, states also have discretion and are encouraged to expand coverage and services within the program's rules.[107] According to one estimate, two-thirds of Medicaid's total spending is an exercise of state discretion rather than being required by federal law.[108] Medicaid's financing structure creates an incentive for states to attempt to maximize their federal payments within the program's rules.[109]

103. There may be other jurisdictions that have allowed spousal refusal, such as Maryland and the District of Columbia. Miller, *supra* note 10, at 95; CLTCF, *supra* note 10. However, spousal refusal is not possible in states such as Arizona due to the lack of a state law mandating spousal support. *See* McLaughlin, *supra* note 92. Spousal refusal has not been attempted in some states, such as Oregon. *See* Reiter, *supra* note 14.

104. Mann & Westmoreland, *supra* note 11.

105. Kaplan, *supra* note 20, at 64.

106. Federal Financial Participation in State Assistance Expenditures, FY 2007, 70 Fed. Reg. 71,856 (Nov. 30, 2005) [hereinafter Federal Assistance].

107. Mann & Westmoreland, *supra* note 11, at 420 (noting that there has been a recent political push to grant states more authority through waivers).

108. *Id.* (stating that these optional expenses come from providing nonrequired services to mandatory beneficiaries or from coverage to optional beneficiaries).

109. *Id.*

A state's liberal policy in allowing Medicaid-planning strategies such as spousal refusal adds to the program's total economic burden for both the state and the nation because spousal refusal provides Medicaid services to people who would not otherwise be eligible.[110] Consequently, Medicaid's total expenditures increase, and much of the funding comes from federal tax dollars, not just state revenues.[111] Medicaid is already facing budget constraints and has been the regular subject of fiscal cuts by Congress and many state governments.[112] State and federal governments would face higher costs if the use of spousal refusal was expanded.[113]

Spousal refusal could also play a greater national role given recent congressional actions regarding Medicaid and assets eligibility rules.[114] Congress took steps to further restrict Medicaid with the Deficit Reduction Act of 2005 (DRA 2005).[115] To limit eligibility, DRA 2005 made Medicaid's asset transfer rules and penalties more stringent.[116] DRA 2005 also mandated a less favorable means of calculating resources, known as the income-first method, which was previously

110. Takacs & McGuffey, *supra* note 4, at 141–44.

111. Mann & Westmoreland, *supra* note 11, at 418, 420.

112. *Medicaid Reform: The National Governors Association's Bipartisan Roadmap: Hearing Before the H. Comm. on Energy & Commerce*, 109th Cong. 25 (2005) (statement of Mark Warner, former Governor of Virginia); 151 CONG. REC. S12065 (2005) (statement of Sen. Gregg); NAT'L GOVERNORS ASS'N, MEDICAID REFORM: A PRELIMINARY REPORT 11 (2005), *available at* http://www.nga.org/Files/pdf/0506medicaid.pdf; *see also* Friedman, *supra* note 13 (discussing efforts to cut Medicaid spending in New York by Governor Pataki); Op-Ed, *Cuts and the Poor*, ROCHESTER DEMOCRAT & CHRON. (N.Y.), Apr. 21, 2003, at 14A [hereinafter Op-Ed, *Cuts and the Poor*] (noting that despite many changes to Medicaid, the New York legislature failed to address spousal refusal).

113. *See generally* Mann & Westmoreland, *supra* note 11, at 418, 420 (stating that Medicaid is a federally supported program and that rises in state costs can increase the aggregate federal contribution).

114. Reiter, *supra* note 14; Shok, *supra* note 14.

115. Deficit Reduction Act of 2005, Pub. L. No. 109-171, §§ 6001–6087, 120 Stat. 5, 54–130 (2006); PR Newswire, *supra* note 13.

116. §§ 6004–6015, 120 Stat. at 61–67; PR Newswire, *supra* note 13. Congress both lengthened the look-back period to five years and delayed the start of any penalty period within the five-year window until the time of Medicaid application. Gene V. Coffey et al., *Analysis of Changes to Federal Medicaid Laws Under the Deficit Reduction Act of 2005*, 2 NAT'L ACAD. OF ELDER L. ATTY'S J. 189, 194–98 (2006). On July 27, 2006, CMS provided states with information regarding the implementation of rules related to DRA 2005, but there may still be some uncertainty about how DRA 2005's changes will be implemented. NAT'L ACAD. ELDER L. ATT'YS, ADDENDUM TO THE NAELA ANALYSIS OF CHANGES TO FEDERAL MEDICAID LAWS UNDER THE DEFICIT REDUCTION ACT OF 2005 BASED ON ANALYSIS OF CMS GUIDELINES TO STATES DATED JULY 27, 2006 1 (2006).

optional.[117] Due to DRA 2005's limitations on Medicaid planning, spousal refusal may become more widely used by the elderly.[118] In addition, the National Academy of Elder Law Attorneys (NAELA) has advocated using the courts to force states to allow spousal refusal,[119] while Medicaid's coverage and nursing home costs remain regularly debated issues in many states across the nation.[120] Spousal refusal could become an increasingly relevant national issue given the increasing costs of nursing homes, the expanding elderly population, and its potential to assist the elderly in handling this financial burden.[121] *Morenz* reflects spousal refusal's growth potential and its implications on Medicaid's financial burden for both federal and state governments.

B. *Morenz v. Wilson-Coker*

In *Morenz v. Wilson-Coker*, the U.S. Court of Appeals for the Second Circuit focused its analysis on two questions: (1) whether spousal refusal existed under federal law; and (2) whether Mr. Morenz satisfied the state law requirements for assignment of support rights.[122] Robert Morenz, an eighty-two-year-old man living in a Connecticut nursing home, was institutionalized within the definition of Medi-

117. Elizabeth D. Lauzon, Annotation, *Application of "Spousal Impoverishment Provisions" of Medicare Catastrophic Coverage Act (42 U.S.C.A. § 1396r-5)*, 186 A.L.R. FED. 437, 458–62 (2005); Sarah Lueck, *Stiffer Rules for Nursing-Home Coverage*, WALL ST. J., Dec. 21, 2005, at D1; Shok, *supra* note 14. See *Wisconsin Department of Health & Family Services v. Blumer*, 534 U.S. 473 (2002), for a discussion on the income-first method.

118. Coffey et al., *supra* note 116, at 221.

119. *Id.* at 202.

120. In a given week, there can be many articles in newspapers throughout the nation discussing Medicaid costs or nursing homes. *See generally* Brevetti, *supra* note 59; Catherine Dolinski, *Perk Proposed to Thin Ranks on Medicaid-Insured Could Keep Assets and Qualify Later*, TAMPA TRIB., Mar. 15, 2006, at 1; Neil Downing, *Moneyline—When Spouse Dies, Some Special Tax Rules Apply*, PROVIDENCE J., Mar. 20, 2006, at A-08; Editorial, *Our Opinion: Bills Rob State, Shower Seniors One-Sided Tax Breaks Put Heavier Load on the Poor and Younger Generations*, ATLANTA J. & CONST., Mar. 19, 2006, at B6 [hereinafter Editorial, *Our Opinion*]; Editorial, *Saving Money Down the Road*, BIRMINGHAM NEWS, Mar. 14, 2006, at 6A; Letter to the Editor, *Responses to "Medicaid Will Go After Assets,"* ATLANTA J. & CONST., Mar. 19, 2006, at B5; Mary Reinhart, *Advocates Seek Aid for Aging: AZ Budget Surplus Could Bolster Care*, TRIB. (Mesa, Ariz.), Mar. 20, 2006 at A1.

121. Filisko, *supra* note 69; Gross, *supra* note 2; Scheffey, *supra* note 6.

122. Morenz v. Wilson-Coker, 415 F.3d 230, 234, 235 (2d Cir. 2005). Connecticut made an Eleventh Amendment argument regarding the effective date of Mr. Morenz's Medicaid eligibility. *Id.* at 237. This argument was rejected by the court, but this discussion is not directly relevant to the issue of spousal refusal. *Id*.

caid.[123] Mr. Morenz's wife, Clara was seventy-seven years old and lived in the community.[124] In January 2004, Mr. Morenz filed his application for Medicaid with the Connecticut Department of Social Services (DSS).[125] As part of his application, Mrs. Morenz, who held his power of attorney, filed an assignment of spousal support rights[126] to transfer Mr. Morenz's right of support from Mrs. Morenz to the state.[127] Mrs. Morenz also submitted a signed "spousal refusal statement" declaring that "she 'decline[d] to further contribute to the financial support'" of her husband.[128] Despite these Medicaid-planning measures, DSS denied Mr. Morenz's application because the couple's financial resources exceeded the statutory limit.[129]

On appeal of the DSS determination, the district court found in favor of Mr. Morenz.[130] The appellate court affirmed the lower court's decision, and Mr. Morenz was awarded Medicaid benefits.[131]

1. SPOUSAL REFUSAL IS PERMISSIBLE UNDER FEDERAL LAW

The Second Circuit concluded that Mr. Morenz, an institutionalized person, was eligible for Medicaid regardless of resources if he assigned his support rights to the state.[132] The appellate court affirmed the district court's interpretation of the statutory exception in 42 U.S.C. § 1396r-5(c)(3).[133] This statute provides:

> The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse; (B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; *or* (C) the State determines that denial of eligibility would work an undue hardship.[134]

123. Morenz v. Wilson-Coker, 321 F. Supp. 2d 398, 400 (D. Conn. 2004) (noting that Mr. Morenz's nursing home costs were $9145 per thirty-one-day month).
124. *Id.*
125. *Id.*
126. *Morenz*, 415 F.3d at 232–33.
127. *Id.*
128. *Id.* at 233.
129. *Id.*
130. *Morenz*, 321 F. Supp. at 408.
131. *Morenz*, 415 F.3d at 237; *Morenz*, 321 F. Supp. at 407.
132. *Morenz*, 415 F.3d at 234.
133. *Id.*
134. 42 U.S.C. § 1396r-5(c)(3) (2005) (emphasis added).

Utilizing a textual interpretation, the appellate court read § 1396r-5(c)(3) in conjunction with the CMS State Medicaid Manual, which explicitly states that "[e]ligibility will not be denied [to] institutional spouses who have resources in excess of the eligibility limits when . . . all support rights of institutionalized spouses are assigned to [s]tates."[135] The court found that the language in the CMS Medicaid Manual parallels the language in § 1396r-5(c)(3). CMS's administrative interpretation was informal, but it merited "'some significant measure of deference.'"[136]

In response to this argument, Connecticut contended that Mr. Morenz also had to satisfy 42 U.S.C. § 1396r-5(c)(3)(C), which requires "the [s]tate [to] determine[] that denial of eligibility would work an undue hardship."[137] However, the appellate court rejected this argument because it would have required the court to read the statute's "disjunctive 'or' as a conjunctive 'and.'"[138] The appellate court determined that federal law does not require an applicant using spousal refusal to show undue hardship.[139]

Furthermore, the court found consistency between the two requirements of spousal refusal: (1) that the assignment of support rights is made, and (2) that the assignment is valid under state law.[140] Connecticut argued that this interpretation of § 1396r-5(c)(3), which released an applicant from the resource limitations, was inconsistent with another part of the Medicaid Act, 42 U.S.C. § 1396k(a)(1)(A), which automatically conditions receipt of Medicaid benefits upon assignment of support rights to the state.[141] The state argued that it was illogical to "provide an exemption from the general spousal-

135. STATE MEDICAID MANUAL, *supra* note 42, § 3262.2.

136. *Morenz*, 415 F.3d at 235 (quoting Rabin v. Wilson-Coker, 362 F.3d 190, 197 (2d Cir. 2004)). CMS and the Department of Health and Human Services (DHHS) have broad latitude in establishing guidelines interpreting Medicaid. *Morenz*, 321 F. Supp. 2d at 403 (noting that when "consistent with the federal statute's plain language, . . . DHHS's rulemaking authority is entitled to 'legislative effect' and 'is controlling unless [ ] arbitrary, capricious, or manifestly contrary to the statute.'") (quoting Atkins v. Rivera, 477 U.S. 154, 162 (1986)).

137. 42 U.S.C. § 1396r-5(c)(3)(C); *Morenz*, 415 F.3d at 234. Mr. Morenz conceded that at the time of application, a denial would not have been an undue hardship. *Morenz*, 321 F. Supp. 2d at 400. Connecticut has a reputation for strict Medicaid enforcement, and the undue hardship argument is rarely successful. Scheffey, *supra* note 6.

138. *Morenz*, 415 F.3d at 235.

139. *Id.*

140. *Id.* at 235 n.4.

141. *Id.* at 235.

contribution requirements for precisely the same assignment of support rights" simply because an elderly couple is using spousal refusal.[142] However, the court specifically rejected the assumption that these two provisions could not both be simultaneously valid.[143] The court found these two requirements of support rights assignment to be "comfortably consistent."[144] Section 1396k(a)(1)(A) requires a valid assignment while § 1396r-5(c)(3) provides an exception that assumes the assignment is valid. Moreover, even if the statutes are assumed to be inconsistent, the court found no "clearly expressed legislative intention" to interpret the statutes differently.[145]

The court also addressed the argument that the MCCA was intended to protect only a certain amount of assets and that the couple's resources in excess of the state's allowed amount should be applied to cover Medicaid costs.[146] The Second Circuit concluded that deference should be given to the CMS interpretation when it is consistent with the statute and when the statute is clear.[147]

Thus, the court concluded that analysis of legislative history was unnecessary because the statute was unambiguous and the agency's interpretation was not only consistent with the statute but was almost identical.[148] The statute's language was a fundamental part of statutory construction, and "'[a]bsent a clearly expressed legislative intention to the contrary, that [statute's] language must ordinarily be regarded as conclusive.'"[149] The court found that Mr. Morenz fell within § 1396r-5(c)(3) and could not be found ineligible due to excess resources if his right to support was assigned properly to the State of Connecticut.[150]

142. *Id.*
143. *Id.*
144. *Id.* at 235 n.4.
145. *Id.*
146. Morenz v. Wilson-Coker, 321 F. Supp. 2d 398, 406 (D. Conn. 2004) (noting that Wilson-Coker contended that Medicaid was "designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of necessary care and services."). *But see* Brief of Plaintiffs-Appellees at 26–29, Morenz v. Wilson-Coker, 415 F.3d 230 (2d Cir. 2005) (No. 04-4107-CV) (arguing that there is some legislative history to suggest that spousal refusal as applied in the *Morenz* case was consistent with the legislature's intent to provide flexible standards to prevent the impoverishment of community spouses).
147. *Morenz*, 415 F.3d at 237.
148. *Id.* at 234 (noting the complexity of Medicaid and the expertise of the administrative agency); *Morenz*, 321 F. Supp. 2d at 406.
149. *Morenz*, 415 F.3d at 234 (quoting Rose v. Long Island R.R. Pension Plan, 828 F.2d 910, 919 (2d Cir. 1987)).
150. *Id.*

2. MR. MORENZ'S ASSIGNMENT OF SUPPORT RIGHTS WAS VALID UNDER CONNECTICUT LAW

After finding that spousal refusal is possible under the federal statute, the appellate court determined that Mr. Morenz properly assigned his support rights under Connecticut law as required by § 1396r-5(c)(3).[151] Support rights are within the province of state law,[152] and states have the ability to curtail the availability of enforceable support rights for community spouses.[153] However, a spousal duty of support clearly existed under Connecticut state law.[154]

While Connecticut was able to interpret federal Medicaid laws, a state "cannot create laws or regulations under which institutionalized spouses who have assigned rights to support to the State are ineligible for Medicaid coverage because of excess resources."[155] Connecticut General Statute section 17b-285 governed the assignment of support rights for institutionalized Medicaid applicants:

> An institutionalized person in need of institutional care who applies for Medicaid *shall* assign to the Commissioner of Social Services the right of support derived from the assets of the spouse of such person, provided the spouse of such person is unwilling or unable to provide the information necessary to determine eligibility for Medicaid.[156]

Connecticut argued that state law prohibited assignments except when the community spouse was unwilling or unable to provide resource information.[157] The court rejected this argument and followed the methodology Connecticut had provided for interpreting its own statutes.[158] Thus, the court interpreted the statute using Connecticut's plain meaning rule:[159]

> The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relation-

151. *Id.* at 235.
152. STATE MEDICAID MANUAL, *supra* note 42, § 3260.1; *see also* NAELA, *supra* note 9, at 327.
153. NAELA, *supra* note 9, at 328; *see also* STATE MEDICAID MANUAL, *supra* note 42, § 3260.1. For example, in North Carolina, as late as 1994, spouses did not have a spousal duty of support, and spousal refusal did not apply. NAELA, *supra* note 9, at 328 (noting that North Carolina has since changed its law, and spouses are now liable to reasonably support each other). *See also* Brief of Plaintiffs-Appellees, *supra* note 146, at 13.
154. CONN. GEN. STAT. § 17b-285 (2004); *Morenz*, 415 F.3d at 235–36.
155. Morenz v. Wilson-Coker, 321 F. Supp. 2d 398, 403 (D. Conn. 2004).
156. CONN. GEN. STAT. § 17b-285 (emphasis added).
157. *Morenz*, 415 F.3d at 236.
158. *Id.* at 236–37.
159. *Id.* at 236.

> ship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning shall not be considered.[160]

Using this framework, the appellate court affirmed the district court's conclusion that section 17b-285 and the DSS regulations did not preclude Mr. Morenz's assignment of his support rights.[161] Thus, Connecticut's statute provided that an institutionalized person who applies for Medicaid and has a spouse who is unwilling or unable to provide resource information "shall" assign support rights, but it does not limit when a person "may" make the same assignment.[162]

Furthermore, the DSS policy manual did not explicitly prevent an assignment of support rights in other instances, but it stated when an institutionalized individual "must" make an assignment.[163] To further support this textual interpretation, the district court explained that the state's legislature and DSS had in the past used the phrase "only if" when it intended to "limit the application of a state law to particular circumstances."[164]

The appellate court noted that this interpretation of Connecticut law might be inconsistent with legislative history.[165] However, in order for a federal court to consider legislative history, the state statute must be ambiguous or yield an unworkable or absurd result.[166] The appellate court did not find any ambiguity or unworkable result and, therefore, adopted the district court's findings.[167] Ultimately, the court concluded that Mr. Morenz had properly assigned his support rights and could not be deemed ineligible for Medicaid.[168]

160. CONN. GEN. STAT. § 1-2z (2004).
161. *Morenz*, 415 F.3d at 237.
162. *Id.* at 236.
163. *Id.*
164. Morenz v. Wilson-Coker, 321 F. Supp. 2d 398, 403–04 (D. Conn. 2004).
165. *Id.* at 407.
166. CONN. GEN. STAT. § 1-2z (2004); *Morenz*, 415 F.3d at 236. States have broad discretion to implement and interpret Medicaid as long as the state laws and regulations do not conflict with federal law. *See, e.g.*, *Morenz*, 321 F. Supp. 2d at 402.
167. *Morenz*, 415 F.3d at 236–37; *see also Morenz*, 321 F. Supp. 2d at 404, 407 (stating that the court is required to interpret the statute's plain meaning even if it wastes resources and encourages litigation).
168. *Morenz*, 415 F.3d at 237. On the district court level, Wilson-Coker also made the following arguments, both rejected by the district court, regarding the validity of the assignment: the power of attorney did not authorize such an assignment, and the assignment violated Mrs. Morenz's fiduciary responsibility. *Morenz*, 321 F. Supp. 2d at 404–05.

C. Potential Ramifications of *Morenz*

Morenz, the first reported federal decision regarding spousal refusal, provides legal support for spousal refusal and could have lasting national repercussions.[169] The case comes just prior to congressional action to increase the penalty period for asset transfers and to mandate an income-first approach as part of the DRA 2005.[170] DRA 2005's effect on curtailing Medicaid planning might encourage elderly couples and elder law attorneys even in states outside the jurisdiction of the Second Circuit to use spousal refusal.[171] To date, most state governments may have been ignoring the spousal refusal provision,[172] but it would not be surprising if other courts follow the Second Circuit's plain meaning interpretation of Medicaid's spousal impoverishment statute in a case of spousal refusal.[173] Some commentators assert that spousal refusal is endorsed by federal statute and should be recognized as legal throughout the nation while being subject to any conditions imposed by a state's support right laws.[174]

After *Morenz*, states may become more aware of spousal refusal and take proactive steps to address its potential effects. States are now on notice regarding spousal refusal's potential legality and face the need to reevaluate the application of 42 U.S.C. § 1396r-5(c) in the context of their own support laws.[175] This is a change from the complacency prior to *Morenz*.[176] Since its enactment more than a decade ago, the Connecticut statute in *Morenz* was disregarded because there was no threat of oversight from the federal government and no substantial risk of legal action from residents.[177] Other states may be in similar situations as Connecticut.[178]

While a change to the federal statute can be made only by Congress, states may take steps to change their laws or regulations to pre-

169. NAELA, *supra* note 9, at 328 (noting that New York, covered by the Second Circuit, already recognized spousal refusal); Scheffey, *supra* note 6 (arguing that *Morenz* will have a ripple effect throughout the country). See *In re Shah*, 733 N.E.2d 1093 (N.Y. 2000), for a discussion on spousal refusal in New York.

170. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 5, 61–64 (2006); PR Newswire, *supra* note 13.

171. Reiter, *supra* note 14; Shok, *supra* note 14.

172. Scheffey, *supra* note 6.

173. NAELA, *supra* note 9, at 328.

174. *See generally* Filisko, *supra* note 69; Scheffey, *supra* note 6.

175. Filisko, *supra* note 69.

176. *Id.*

177. *Id.*

178. *Id.*

vent the implementation of spousal refusal.[179] If jurisdictions outside the Second Circuit were to allow spousal refusal and residents were to consequently start utilizing this Medicaid-planning tactic more frequently, states would have the burden of managing increased numbers of institutionalized patients and the responsibility to collect from community spouses.[180] Whereas states had previously been able to reject Medicaid eligibility of institutionalized patients with assets above the CSRA, states now stand to lose revenue due to the increased number of people gaining Medicaid eligibility.[181]

Connecticut did not appeal the Second Circuit's decision in *Morenz*.[182] As a result, the federal statute, which requires eligibility for an institutionalized spouse regardless of resources when support rights are assigned, and Connecticut's own statute, which allows an assignment of support rights, together create a "pay-and-chase" system.[183] A pay-and-chase system is when the state provides Medicaid services to the institutionalized spouse and then expends resources to recover the cost of these services from the community spouse.[184] The State of Connecticut repeatedly stressed the inefficiency of a pay-and-chase system in its brief and in its oral arguments before the Second Circuit.[185] The "chase" in this context is the state's efforts to recover payment from the community spouse, a process known as "spousal recovery," a potential focal point of future legislative change.[186]

179. *Id.* (speculating that states will change their rules and repeal spousal refusal provisions following *Morenz*); Scheffey, *supra* note 6 (noting the response of the Connecticut Attorney General regarding changes to policy or state law). In 2006, Connecticut explored possible legislative changes. Shok, *supra* note 14.

180. Scheffey, *supra* note 6 (stating that previously the state was not required to pursue recovery from the spouse).

181. *Id.*; *see also* Filisko, *supra* note 69.

182. Shok, *supra* note 14 (noting that the case was not appealed because the Attorney General did not believe there was a high chance for success). Connecticut's DSS is in the process of drafting legislative changes, which were not publicly available as of July 2006. *Id.*

183. Morenz v. Wilson-Coker, 321 F. Supp. 2d 398, 406–07 (D. Conn. 2004).

184. *Id.* at 407.

185. Brief of Plaintiffs-Appellees, *supra* note 146, at 24–25; Scheffey, *supra* note 6.

186. Scheffey, *supra* note 6.

D. Medicaid Spousal Recovery Efforts in New York

1. THE SPOUSAL RECOVERY PROCESS IN NEW YORK

Spousal recovery programs in the state of New York illustrate the interaction between the government "chase" and the community spouses who use spousal refusal. In New York, Medicaid spousal recovery is defined as the state agency's attempts to recover assets from the community spouse of the Medicaid beneficiary while the community spouse is alive.[187] The agency can collect only the incurred costs.[188] Unlike general estate recovery for Medicaid, the community spouse and the institutionalized spouse do not need to be deceased.[189] These recovery actions are buttressed by state marital support law obligations[190] or by an "implied contract" between the state and the community spouse created by the spousal refusal.[191] Because an institutionalized spouse assigns his or her support rights to the state, the state is able to pursue recovery immediately from the community spouse for any Medicaid expenditures.[192]

In New York, where spousal refusal is more commonly used than in any other state, a state appellate court has affirmed the state's right of immediate spousal recovery.[193] In *Commissioner of the Department of Social Services of New York v. Spellman*,[194] the court concluded that the state Medicaid agency is "required to 'take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services.'"[195] Consistent with this duty, New York law "pro-

187. *In re* Shah, 733 N.E.2d 1093, 1101 (N.Y. 2000); DHHS, SPOUSES, *supra* note 63, at 7.

188. ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 7.10 (2006).

189. Comm'r of the Dep't of Soc. Servs. of N.Y. v. Spellman, 661 N.Y.S.2d 895, 897 (N.Y. Sup. Ct. 1997) (indicating that the state had already attempted to collect from the community spouse while the institutionalized spouse would continue to receive care as long as she was eligible); Marvin Rachlin, *Liability for Medicaid: What Is a Spouse's Liability for Medicaid Benefits Paid?*, 30 EST. PLAN. 117, 120 (2003).

190. *In re* Shah, 733 N.E.2d at 1101; DHHS, SPOUSES, *supra* note 63, at 7.

191. Comm'r of Dep't of Soc. Servs. of N.Y. v. Spellman, 672 N.Y.S.2d 298, 300 (Sup. Ct. 1998); CARLSON, *supra* note 188. *But cf. In re* Tomeck, 811 N.Y. S.2d 790, 793 (N.Y. App. Div. 2006) (noting that there is a restriction on allocating Social Security income from the institutionalized spouse to the community spouse and that this could prohibit the formation of an implied contract); Rachlin, *supra* note 189, at 120–22 (suggesting possible arguments against the implied contract theory).

192. Marvin Rachlin, *Do Implied Contract Principles or Fraud Theories Support Medicaid Suits Against Community Spouses?*, N.Y. ST. B. J., Feb. 2001, at 32; CLTCF, *supra* note 10.

193. *Spellman*, 672 N.Y.S.2d at 299.

194. *Id.* at 298.

195. *Id.* at 299 (citing 42 U.S.C. § 1396a(25)(A) (2005)).

vides that if a responsible relative with sufficient income and resources to provide medical assistance refuses to provide necessary assistance, the furnishing of such assistance by DSS 'shall create an implied contract with such relative.'"[196] In *Spellman*, the community spouse refused to provide for his institutionalized wife's care despite possessing assets above the allowable level.[197] The court determined that the state could bring action against the husband to recover the cost of Medicaid benefits received by the institutionalized spouse.[198]

The state agency may also pursue a claim to recover up to 25% of the community spouse's income in excess of the allowed amount.[199] The agency would be able to recover these costs from the community spouse's resources above the CSRA[200] and may immediately notify the community spouse of its right to collect.[201] To protect assets from Medicaid recovery, a community spouse and his or her attorney may explore a posteligibility financial plan prior to the initiation of suit by the Medicaid agency.[202] Additionally, the state Medicaid agency may choose to settle its cases, taking into account factors such as the age and health of the community spouse.[203] However, if Medicaid continues to provide benefits to the institutionalized spouse and the community spouse still has resources above the CSRA, the community spouse should attempt to gain a waiver of future claims from the state agency before settling.[204]

Although Medicaid payments made on behalf of the institutionalized spouse can be collected immediately, one significant benefit for the community spouse is that the state agency's recovery efforts are limited to the actual expenditures made by Medicaid and the amount

196. *Id.* at 300.
197. *Id.* at 299.
198. *Id.* at 300; *see also* Koopersmith, *supra* note 19 (noting that Mr. Spellman signed a refusal form which stated that a relative who was legally responsible could be sued for failing to support a spouse).
199. Rachlin, *supra* note 189.
200. *Id.*
201. CLTCF, *supra* note 10.
202. Daniel G. Fish, *Elder Law: "Spousal Refusal" Lawsuits Increase*, N.Y. L.J., May 21, 2001, at 9.
203. Lynn Brenner, *Family Finance Column: Joint Assets Jeopardize Aid*, NEWSDAY (N.Y.), Mar. 26, 2006; Rachlin, *supra* note 189; Joan Stableford, *Misconceptions Abound in Long-Term Health Care, Medicaid*, 44 WESTCHESTER COUNTY BUS. J. 19 (2005) (stating that one approach to avoiding a lawsuit would be to "negotiate the matter out of court").
204. Fish, *supra* note 202 (noting that if the institutionalized spouse is still alive, the amount owed will continue to increase over the figure in the Medicaid agency's claim letter); Rachlin, *supra* note 189.

up to the CSRA cannot be taken away.[205] Additionally, spousal recovery is allowed only if the community spouse was able to pay for the institutionalized spouse's long-term care at the time of application for Medicaid.[206] Although Medicaid pays a lower rate than the private sector charges,[207] the Medicaid applicant is required to receive the same services as private patients.[208] Typically, Medicaid pays 30% to 40% less than private, out-of-pocket payers for identical services.[209] Therefore, even if the state agency were to successfully sue for recovery, the community spouse may still save money.[210]

2. THE STATUS OF SPOUSAL RECOVERY IN NEW YORK

Spousal recovery efforts vary widely throughout New York State because the collection policy is left to each county's discretion.[211] The benefits of spousal refusal improve as the risk of state legal action decreases.[212] New York counties often have little incentive to pursue spousal recovery because of limited information about spouses, decentralized responsibilities among different agencies, and an absence of a consistent methodology to settle cases.[213] After a "labor-intensive and time-consuming" process that involves identifying spouses and legal actions, Nassau County, for example, retains only 10% of the amount it recovers, while the State of New York receives 40%.[214]

Despite this limited incentive, Nassau County has been relatively aggressive in its recovery efforts, pursuing even marginal cases that offer little return.[215] Nassau County's active recovery effort was

205. Anthony J. Enea, *What Every Attorney Should Know About Elder Law*, 28 WESTCHESTER B. J. 17, 23 (2001).
206. CARLSON, *supra* note 188.
207. Enea, *supra* note 205; Takacs & McGuffey, *supra* note 4, at 144; Tapper, *supra* note 14.
208. Davidoff, *supra* note 97.
209. Scheffey, *supra* note 6.
210. Enea, *supra* note 205.
211. Chu, *supra* note 92, at 399.
212. Enea, *supra* note 205.
213. OFFICE OF THE COMPTROLLER FIELD AUDIT BUREAU, NASSAU COUNTY DEPARTMENT OF SOCIAL SERVICES MEDICAL ASSISTANCE (MEDICAID) UNIT 28 (2003), *available at* http://www.nassaucountyny.gov/agencies/comptroller/Docs/PDF/MedicaidAudit0403.pdf [hereinafter AUDIT].
214. *Id.* at 29. The federal government contributes 50% of New York's Medicaid costs and would receive the remaining 50% that is recovered. Federal Assistance, *supra* note 106.
215. Friedman, *supra* note 13; NYSBA ELDER LAW SECTION, *supra* note 89, at 60 (noting that Nassau County has adopted a policy of not settling for less than 100% of the amount owed by the community spouse).

motivated by a 1999 audit that estimated a potential loss of $3 million for the county.[216] From January 2004 through October 2004, Nassau County recovered approximately $170,980.[217] More recently, Nassau County has recouped about $2.5 million from forty-nine spousal refusal cases.[218] Neighboring Suffolk County has recovered approximately $200,000 from fifteen cases over a five-year period.[219] New York City, consisting of five counties and with a dedicated staff of ten lawyers pursuing spousal recovery, collects an estimated $1,335,000 annually.[220] New York City's five counties appear to rarely pursue collection unless the community spouse has retained many thousands of dollars above the CSRA.[221] Overall, New York City averages approximately 40,000 Medicaid cases a year, and about 3000 involve spousal refusal.[222] Of these 3000 cases, an average of 300 face potential legal action.[223] Westchester County, adjacent to New York City, brought approximately thirty-two spousal recovery actions in 1999 and another thirty-five in 2000.[224] Westchester County often adopts a case-by-case approach and focuses on negotiating settlements.[225] Finally, Monroe County in upstate New York had 103 incidents of spousal refusal in 2005, and consequently opened cases against seventy-one spouses.[226] As illustrated by these counties in New York, the recovery level can vary greatly by county depending on local resources, political interests, and approaches used.

Perhaps in response to the differences in recovery efforts and results among counties, Governor George Pataki proposed in his 2005

216. AUDIT, *supra* note 213.

217. NASSAU COUNTY OFFICE OF MGMT. & BUDGET, REVENUE MANUAL: FISCAL YEAR 2005, at 173 (2005), *available at* http://www.nassaucountyny.gov/agencies/OMB/Docs/PDF/REVENUE_MANUAL_2005.pdf.

218. Carl Campanile, *Suozzi $ocking it to Medicaid Millionaires*, N.Y. POST, Apr. 24, 2006, at 11A.

219. AUDIT, *supra* note 213, at 29.

220. *Id.*

221. Friedman, *supra* note 13.

222. Fish, *supra* note 202, at 10.

223. *Id.*

224. COUNTY EXECUTIVE, WESTCHESTER COUNTY, THE PEOPLE'S BUDGET 2000: ADOPTED OPERATING BUDGET, *available at* http://www.westchestergov.com/Budget2000/books/pdfbook/AdoptedOperating/SectC2.pdf.

225. *See, e.g.*, Comm. on Budget and Appropriation, Minutes (2003), http://www.watpa.org/wcbol/comm/ba/2003/ba030210.htm; Comm. on Budget and Appropriation, Minutes 3 (2001), http://www.watpa.org/wcbol/comm/ba/2001/ba011126.htm.

226. John Summers, *Rich Shouldn't Bill Medicaid for Nursing Home Services*, ROCHESTER DEMOCRAT & CHRON. (N.Y.), Apr. 24, 2006, at 11A.

budget to assign all Medicaid litigation to the state attorney general.[227] Such a move could result in improved recovery efforts by consolidating enforcement within a single state entity.[228] Recovery efforts may also be improved by developing better coordination among agencies, more accurate record-keeping processes, and workable settlement and litigation strategies.[229]

E. Medicaid General Estate Recovery: A Comparison

General Medicaid estate recovery provides a useful analogy for exploring the social, economic, and political issues surrounding spousal recovery. While spousal recovery differs from estate recovery,[230] a clear understanding of the estate recovery process and its results can be applied to analyzing a spousal recovery program targeting couples using spousal refusal.

1. MECHANICS OF MEDICAID ESTATE RECOVERY

Estate recovery is a state's effort to recover Medicaid expenditures from a recipient's estate after the recipient's death.[231] Estate recovery has long been possible under Medicaid, subject to the state's discretion, but it was not until the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA) that states have been required to operate an estate recovery program for Medicaid.[232] Under the theory that estate recovery is a viable means of offsetting costs to the government and promoting equity,[233] OBRA requires states to seek recovery of Medicaid payments for nursing home expenses upon the death of any recipient who was age fifty-five or older when he or she re-

227. Daniel G. Fish, *Elder Law; Legislative Update: "Silver," Proposed Changes to Medicaid Eligibility*, N.Y. L.J., Mar. 10, 2005, at 3.
228. AUDIT, *supra* note 213, at 29.
229. *Id.*
230. Rachlin, *supra* note 189.
231. Kaplan, *supra* note 20, at 70; *see also id.* at 71 (noting that there is no de minimis level of assets needed for estate recovery to occur).
232. OFFICE OF ASSISTANT SEC'Y FOR POL'Y EVALUATION, DEP'T OF HEALTH & HUMAN SERVS., MEDICAID ESTATE RECOVERY 2 (2005), *available at* http://aspe.hhs.gov/daltcp/reports/estaterec.pdf [hereinafter DHHS, RECOVERY] (noting that since 1965, states were authorized to use property liens to recover and that twelve states had recovery programs prior to 1990).
233. *Id.*

ceived Medicaid benefits or was permanently disabled notwithstanding age.[234]

For couples, both countable and noncountable assets are eligible for estate recovery.[235] The scope of what is included and the execution process varies by state.[236] OBRA requires states to recover any real or personal property or other assets included in the state's probate law definition of "estate."[237] However, the state has discretion to classify as recoverable other assets in which the recipient has a legal interest or title at the time of death, even if it bypasses probate.[238] Assets from the sale of a home, from an inheritance, or from a gift by the Medicaid recipient are recoverable.[239] The state's ability to recover also depends on order-of-debt payment laws and other local probate laws, which may protect certain assets such as a family home.[240] Unlike spousal recovery, the community spouse is protected from estate recovery until after his or her death.[241]

234. *Id.* at 3; *see also id.* at 6 (noting that there are further provisions that prevent estate recovery of a Medicaid recipient's former home when a qualifying sibling or adult child is also living in the home); Takacs & McGuffey, *supra* note 4, at 130.

235. *Medicaid Waste*, *supra* note 63, at 11. Countable and noncountable assets refer to Medicaid's distinction between assets that are counted in the CSRA and those that are not. *See* DHHS, SPOUSES, *supra* note 63, at 6.

236. *Medicaid Waste*, *supra* note 63, at 11.

237. *Id.*

238. *Id.*

239. Kaplan, *supra* note 20, at 70–71.

240. DHHS, RECOVERY, *supra* note 232, at 4. For information regarding the success ratio of state estate recovery claims and the manner in which claims are resolved, see NAOMI KARP ET AL., ABA COMM'N ON LAW & AGING, MEDICAID ESTATE RECOVERY: A 2004 SURVEY OF STATE PROGRAMS AND PRACTICES 53 (2005), *available at* http://assets.aarp.org/rgcenter/il/2005_06_recovery.pdf.

241. *Medicaid Waste*, *supra* note 63, at 11–12 (noting that there are also conditions to prevent recovery if there is a surviving child who is younger than twenty-one, is blind, or has another disability). Long-term care Medicaid recipients may be exempted from estate recovery if they fall within any of the following three exceptions: (1) the recovery would impose an undue hardship, based on a state's determination; (2) the recovery would not be cost effective; and (3) the person had participated in a state approved long-term care insurance partnership plan. *Id.* at 12. States have broad latitude to provide more generous waiver policies and expand the definition of hardship beyond the federal guidelines. DHHS, RECOVERY, *supra* note 232, at 8. A House of Representatives Report indicated that in developing hardship waiver standards, the agency must consider "(1) the adequacy of notice to, and representation of, affected parties; (2) the timeliness of the process; and (3) the availability of appeals." KARP ET AL., *supra* note 240, at 10. For a more detailed overview of various states' waiver policies and statistics, see *id.* at 31–35.

2. STATUS OF MEDICAID ESTATE RECOVERY

Despite recovery being required by Congress, states have not aggressively enforced estate recovery from Medicaid recipients.[242] As of February 2005, almost all states have implemented recovery programs;[243] however, in 2004, states recovered less than 1% of the approximately $361.7 million in total Medicaid nursing home expenditures.[244] Forty-seven states recovered less than 3% of their respective nursing home expenditures.[245] Only Idaho, Oregon, and Arizona collected more.[246] Estate recovery programs tend to have low recovery rates, but there is potential for growth and increased efficiency.[247]

Estate recovery of total long-term care expenditures does not fare better than recovery of nursing home expenditures alone, with Oregon having the highest recovery rate of 2.2%.[248] Only eight states have recovered more than 1% of expenditures, with a median rate of 0.05%.[249] In real dollars, the levels ranged from $86,000 to $54 million.[250] To estimate the economic effect of high-end recovery programs in every state, Oregon could serve as a model.[251] If every state achieved similar results as Oregon, the national total would be an estimated $1.8 billion.[252] To increase their recovery levels, states can ex-

242. *Medicaid Waste*, *supra* note 63, at 12.

243. *Id.* at 11 n.28; *see also* KARP ET AL., *supra* note 240, at 12 (indicating that Michigan, Texas, and Georgia were unable to participate in the survey, collected from April 2004 through August 2004, due to not having existing estate recovery programs). There is indication that Texas, Michigan, and Georgia were able to avoid having estate recovery programs without any negative ramifications from CMS. Takacs & McGuffey, *supra* note 4, at 130. Moreover, West Virginia attempted to discontinue the estate recovery program in 2002. *Id.* However, facing the possibility of the federal government withholding funds, West Virginia sued in federal court and lost. *Id.* The state unsuccessfully argued that Congress' attempt to make funding contingent on an estate recovery program was unconstitutional. *Id.* Consequently, West Virginia's estate recovery program is still active, according to 2003 data from the Congressional Research Service. *Medicaid Waste*, *supra* note 63, at 13.

244. *Medicaid Waste*, *supra* note 63, at 12.

245. *Id.* at 12, 13 tbl.1.

246. *Id.* at 3 (noting that Arizona's estate recovery collections as a percentage of nursing home spending is not comparable to other states due to the state's extensive use of managed-care contracts and the differences in data collection); see KARP ET AL., *supra* note 240, at 31–35, for details on the percentage of recovery as compared to total long-term care expenditure.

247. DHHS, RECOVERY, *supra* note 232, at 8–9; *see* KARP ET AL., *supra* note 240, at 6.

248. *See* KARP ET AL., *supra* note 240, at 43.

249. *Id.*

250. *Id.*

251. *Id.*

252. *Id.*

ercise their discretion by expanding the types of assets subject to estate recovery to include assets such as annuities, life estates, or trusts.[253] In a 2003 survey by the American Bar Association (ABA) of state agency officials, ten states forecasted an increase in estate recovery efforts within the next two years.[254] Only Vermont expected the program to decline due to increases in approval of hardship waivers.[255]

3. POLITICAL AND SOCIAL CONSIDERATIONS

While estate recovery seems poised for growth, there are legitimate concerns about its role and effectiveness.[256] Political and social factors play a large role in dictating a state's recovery program,[257] which remain extremely unpopular in some states, even as state governments attempt to increase recovery rates.[258] Senator Russ Feingold (D-Wis.) has criticized estate recovery for "effectively impos[ing] a 100% estate tax on the country's most vulnerable citizens."[259] In the ABA survey, some state agency officials expressed a belief that estate recovery encourages Medicaid planning to shelter assets and unfairly hurts recipients who cannot afford a "cat and mouse game."[260] Moreover, the threat of recovery may discourage people in need of Medicaid from applying for benefits, thus leading to adverse health effects and higher future medical costs.[261]

These potential political and social concerns are important considerations in evaluating estate recovery expansion, and they contribute to the difficulty of predicting the future efficacy of such programs.[262] For example, in the ABA survey, a Massachusetts state agency official responded that he expected Medicaid recovery to expand,[263] while a practitioner expressed concern about the recent fail-

253. *Id.* at 44.
254. *Id.* at 18.
255. *Id.*
256. *Medicaid Waste*, *supra* note 63, at 12.
257. *Id.*
258. Andy Miller, *Medicaid Will Go After Assets: Homes May Be Sold to Reimburse the State*, ATLANTA J. & CONST., Mar. 12, 2006, at A1; Elder Law Answers, Last Estate Recovery Holdouts Coming Out with Hands Up, http://www.elderlawanswers.com/resources/article.asp?ID=3156 (last visited Sept. 8, 2006).
259. Takacs & McGuffey, *supra* note 4, at 130.
260. KARP ET AL., *supra* note 240, at 19.
261. DHHS, RECOVERY, *supra* note 232, at 10–11.
262. KARP ET AL., *supra* note 240, at 39–40.
263. *Id.* at 18.

ure of such efforts due to complaints from elderly and disabled residents.[264] The Massachusetts legislature had voted to increase recovery beyond the probate estate, then delayed collection efforts under the new law due to community backlash, and ultimately repealed the new law.[265] The expansion of estate recovery is a sensitive issue that presents challenges due to political forces. These difficulties are not unique to Massachusetts and have become evident in other states such as Pennsylvania, Minnesota, Indiana, and Georgia.[266]

4. FINANCIAL COSTS AND BENEFITS

In addition to political and social factors, economics play a major role in estate recovery. States with a low per-capita income could argue that it is not cost effective to pursue recovery of assets.[267] Additionally, there is uncertainty as to the effect of estate recovery after taking into account the administrative costs of running such a program.[268] In the ABA study, only nine states could provide statistics on administrative costs, and these states averaged a 6.84% rate of collection, which suggests strong performance.[269] However, further data is necessary to examine this factor more closely.[270] Administrative costs can vary by state due to discrepancies in determining who to target for recovery and degrees of success.[271] When measured on a per-estate basis, the average amount recovered can range from $93 to more than $25,000.[272] Overall, the median recovery amount was approximately $5,000, while the average was around $8,000.[273] The administrative costs could be lower if states were to concentrate resources on larger estates or claims.[274] In furtherance of this approach, some states have implemented minimum estate value or claim levels, although such standards are not required by federal law.[275]

264. *Id.* at 40.
265. *Id.*
266. *Id.*; Editorial, *Our Opinion*, *supra* note 120.
267. *Medicaid Waste*, *supra* note 63, at 12.
268. KARP ET AL., *supra* note 240, at 44.
269. *Id.*
270. *Id.*
271. *Id.*
272. *Id.*
273. *Id.*
274. *Id.*
275. *Id.* It is also possible for states to focus their recovery efforts on smaller estates that do not involve probate and through tort recovery, when applicable. *Id.* at 40; *see also* Elder Law Answers, *supra* note 258.

A cost-effective estate recovery program can function to support a financially strapped Medicaid program, while lessening the effects of economic downturns and lowering tax burdens.[276] The additional income from settlements with the community spouse would benefit both the state and Medicaid recipients.[277] An Ohio study argued that estate recovery had a positive effect on the state budget by obtaining more than $17 million in a three-and-a-half year period.[278] Finally, estate recovery can be characterized as promoting equity because it prevents a recipient's heirs from unfairly benefiting from the program and stops abuses of the system.[279]

Similar to estate recovery, spousal recovery is also affected by these complex social, political, and financial factors. If efficiently designed and coordinated among government agencies, spousal recovery programs would likely provide economic benefits by recovering expenditures from community spouses and by discouraging the use of spousal refusal.[280] However, unlike estate recovery, which generally starts after death, spousal recovery involves suing a living community spouse.[281] This may be more politically risky because it could result in pauperizing the middle class, and each case would lead to two people dependent on taxpayer money rather than one.[282] These experiences from estate recovery programs illustrate the many obstacles that face a pay-and-chase system.

F. A Look at Spousal Refusal in Practice by State

It is also useful to examine the ways different courts have interpreted 42 U.S.C. § 1396r-5(c)(3) in the context of different states and their applicable laws. Furthermore, looking at these states can show the current trends in spousal refusal's use and the relevant factors that have influenced its development.

276. KARP ET AL., *supra* note 240, at 18; DHHS, RECOVERY, *supra* note 232, at 10.
277. KARP ET AL., *supra* note 240, at 18.
278. *Id.*
279. *Id.*; Takacs & McGuffey, *supra* note 4, at 130.
280. AUDIT, *supra* note 213, at 29.
281. *See* Gallagher, *supra* note 70.
282. *Id.*

1. NEW YORK

Spousal refusal has gained most of its notoriety in the state of New York.[283] In the 2000 case *In Re Shah*, the Court of Appeals of New York affirmed the right of spousal refusal for New Yorkers.[284] Mrs. Shah had executed a spousal refusal document, filed a Medicaid application for her husband, and transferred all of her husband's assets to a guardian spouse under her control, only to be denied Medicaid benefits by the state agency.[285] The court concluded that "both Federal and New York State law provide for the right of 'spousal refusal' . . . which essentially permits avoidance of these resource allowance rules and limitations."[286]

In Re Shah specifically referenced New York State's Social Services Law section 366(3)(a), which requires that medical assistance be given to Medicaid applicants in cases where the community spouse has sufficient resources and income that are not available to the applicant because of spousal refusal.[287] However, the court also noted that spousal refusal still allowed the state agency to seek recovery from the financially able community spouse.[288] The *In Re Shah* court observed that "'any person in Mr. Shah's condition would prefer the costs of his care to be paid by the State, as opposed to his family.'"[289]

New York has an expansive spousal refusal policy that goes beyond the federal statute. Nonapplicant spouses in New York can exercise the refusal even if their spouses are receiving noninstitutionalized services.[290] The broad coverage and extensive usage of spousal

283. Takacs & McGuffey, *supra* note 4, at 143–44.

284. *In re* Shah, 733 N.E.2d 1093, 1100 (N.Y. 2000). It is unclear when spousal refusal was first utilized in New York. For earlier reported cases directly dealing with the issue, see *In re DaRonco*, 638 N.Y.S.2d 275 (N.Y. Sup. Ct. 1995), and *Maimonides Medical Center v. Ostreicher*, 604 N.Y.S.2d 480 (N.Y. Civ. Ct. 1993).

285. *In re* Shah, 733 N.E.2d at 1095.

286. *Id.* at 1100 (noting that there is no look-back period for transfers of assets between spouses for the purpose of determining eligibility).

287. N.Y. SOC. SERV. LAW § 366(3)(a) (2005); *In re Shah*, 733 N.E.2d at 1100. The stakes were particularly high in Mrs. Shah's case because there was some question as to whether her husband was a resident of New York or New Jersey. *Id.* at 1095. As the *In re Shah* court noted, spousal refusal was a benefit not available in New Jersey. *Id.*

288. *In re* Shah, 733 N.E.2d at 1101.

289. *Id.* at 1099 (quoting Matter of Shah, 257 A.D.2d 275, 282 (N.Y. App. Div. 1999)).

290. Chu, *supra* note 92, at 398; NYSBA ELDER LAW SECTION, *supra* note 89, at 64 (indicating that a community spouse can file a spousal refusal even if her spouse requires only home care and not institutionalization). The option for using spousal refusal for noninstitutionalized services in New York is beyond the scope of this note.

refusal in New York has thrust the provision into the state's political spotlight.[291] Based on one study of Nassau County, community spouses refused to support their institutionalized spouses approximately 95% of the time.[292] In another study, more than 3,000 New York City community spouses signed spousal refusal letters in 2000.[293]

a. High Costs Long-term care costs are directly correlated to spousal refusal and play a substantial role in the state's large expenditures toward Medicaid.[294] These high costs exemplify how spousal refusal is a national issue. In New York, Medicaid is the single largest component of the state budget, at a cost of $42 billion in the 2003–2004 fiscal year.[295] With the federal government paying for $22.9 billion of its total expenses, New York is the highest Medicaid-spending state in the country.[296] In 2000, New York spent almost twice as much as the national average on Medicaid, on both a per-capita and cost-per-beneficiary basis.[297] As of 2002, these payment ratios remained relatively unchanged, and given the continued disparity in aggregate spending totals, they are unlikely to change in the near future.[298]

More specifically, long-term care alone accounted for $10.4 billion in spending for the 2003–2004 fiscal year, equal to almost 25% of Medicaid's expenditures, and had increased 9% since the previous year.[299] Nationally, an average of 64% of nursing home residents are

291. Chu, *supra* note 92, at 398; Friedman, *supra* note 13; Op-Ed, *Cuts and the Poor*, *supra* note 112.

292. CITIZENS BUDGET COMM'N, CONFRONTING THE TRADEOFFS IN MEDICAID COST CONTAINMENT 8 (2004), *available at* http://www.cbcny.org/medicaid04.pdf.

293. *Id.*

294. Joe Mahoney, *First Aid for Medicaid Tab*, N.Y. DAILY NEWS, Jan. 15, 2004, *available at* http://www.nydailynews.com/01-15-2004/news/story/155078p-136332c.html.

295. *Id.*

296. N.Y. STATE SENATE MEDICAID REFORM TASK FORCE, REPORT OF THE SENATE MEDICAID REFORM TASK FORCE 10 (2003), *available at* http://www.senate.state.ny.us/sws/medtfreport.pdf [hereinafter MEDICAID REFORM].

297. CITIZENS BUDGET COMM'N, *supra* note 292; MEDICAID REFORM, *supra* note 296, at 8.

298. *See generally* MSIS TABLE, *supra* note 14 (detailing that New York's average payment per recipient was $8031 compared to a national average of $4291). See ROCHESTER BUS. ALLIANCE & RUMP GROUP, MEDICAID INC. 6, http://www.rochesterbusinessalliance.com/scriptcontent/va_custom/Medicaid/RBA_RumpReportFINAL.pdf (last visited Sept. 11, 2006), for statistics showing that New York's total Medicaid expenditures are substantially greater than those of any other state by at least $10 billion.

299. HEALTH CARE REFORM WORKING GROUP, INTERIM REPORT 7 (2004), *available at* http://www.health.state.ny.us/health_care/medicaid/related/health_care

on Medicaid, compared with 80% in New York.[300] To shoulder this financial burden, 50% of New York's program cost comes from federal funding, while 40% comes from the state, and 10% comes from local coffers.[301] Furthermore, these costs will continue to rise as the number of people over the age of sixty-five in New York is projected to increase from 2.3 million in 1995 to 3.3 million in 2025.[302]

New York's Medicaid costs are particularly burdensome on the local level due to the state's decision to allocate a portion of the costs to counties.[303] In comparison, more than half of the states fund the state Medicaid portion entirely with state resources.[304] Of the states that require local contribution, most mandate a significantly lower one than does New York.[305] The rationale for this policy dates back to Medicaid's beginning, at a time when the rural, upstate counties did not want to subsidize the urban areas, especially New York City, which accounted for two-thirds of the program's participants.[306] In response, the legislature shifted some of the financial burden from the state level to local government.[307] This funding model is now leaving many counties in financial hardship due to declining economies and a Medicaid bill that can consume as much as 30% of a county's budget.[308]

_reform/pdf/interim_report.pdf (stating that long-term care includes: skilled nursing facilities, home nursing services, home health aides, and personal care services). This $10.4 billion spent on long-term care includes paying for approximately 82% of all nursing home expenditures within the state. Robert Hinckley, Panelist at the Ctr. for N.Y. City Affairs Medicaid Forum, Medicaid: Can New York Control Spending? 24 (Feb. 25, 2004), http://www.newschool.edu/milano/nycaffairs/trans/medicaid.pdf (commenting that New York has the most generous spousal refusal law in the country).

300. MEDICAID REFORM, *supra* note 296 at 8 (stating that 10% of New York's over-sixty-five population is receiving benefits from Medicaid, compared to a median of 4.6% nationally).

301. AUDIT, *supra* note 213, at i; Hinckley, *supra* note 299, at 4.

302. HEALTH CARE REFORM WORKING GROUP, *supra* note 299, at 7. Concurrent with this overall increase in the elderly population, the age seventy-five-plus segment will grow from 1.07 million to 1.4 million during this same thirty-year period. *Id.*

303. Richard Pérez-Peña & Michael Luo, *As Medicaid Rolls Grow, Costs Take a Local Toll*, N.Y. TIMES, Dec. 23, 2005, at A1.

304. *Id.*

305. *Id.*

306. *Id.*

307. *Id.*

308. *Id.*

b. Efforts to Reform Spousal Refusal While spousal refusal is popular with elderly New Yorkers,[309] many politicians, especially Governor Pataki, have unsuccessfully recommended that the spousal refusal loophole be closed or restricted.[310] These efforts came at a time when state reform committees were recommending large-scale overhauls, including changes to spousal refusal. In 2003, a Senate Medicaid Reform Task Force advocated restricting spousal refusal as one possible long-term care reform.[311] In 2004, Governor Pataki's Health Care Reform Working Group continued this trend by supporting the elimination of spousal refusal so that Medicaid would not need to pay for applicants who have their own resources to pay for long-term care.[312]

In response to such proposals, activist organizations and policy groups have argued that such restrictions will have detrimental financial, social, and health effects on the elderly population.[313] Moreover, some organizations have cautioned that closing the spousal refusal loophole will not be enough to significantly lower Medicaid costs.[314]

309. KATHERINE BRIDGES, LONG-TERM CARE: A SURVEY OF NEW YORK AARP MEMBERS 8–9 (2004), *available at* http://assets.aarp.org/rgcenter/health/ny_ltc.pdf.

310. CTR. FOR DISABILITY RIGHTS, INC., ANALYSIS OF GOVERNOR PATAKI'S 2005–2006 EXECUTIVE BUDGET 2–3 (2005), *available at* http://www.rochestercdr.org/BudgetAnalysis2005.pdf; N.Y. StateWide Senior Action Council, Inc., Special Report on the State Budget (Mar. 15, 2005), http://www.nysenior.org/News/2005/05-0315.htm (noting that the legislative branch rejected attempts to eliminate spousal refusal). Proposed bills in the New York Assembly and Senate have included a provision to eliminate spousal refusal. A 4932, 2005–06 Assemb., Reg. Sess. (N.Y. 2005); S 4932-A, 2005–06 S., Reg. Sess. (N.Y. 2005).

311. MEDICAID REFORM, *supra* note 296, at 12.

312. HEALTH CARE REFORM WORKING GROUP, *supra* note 299, at 14; Mahoney, *supra* note 294 (stating Working Group member Herman Badillo's view that the middle class is taking advantage of spousal refusal, keeping assets, and forcing Medicaid to pay).

313. NYSBA ELDER LAW SECTION, *supra* note 89, at 62 (stating that without spousal refusal, the middle class, especially surviving spouses, would be in difficult financial situations); Susan M. Dooha, Executive Dir., Ctr. for Independence of the Disabled in N.Y., Testimony Presented to the N.Y. State Legislature Before the S. Finance Comm. & Assemb. Ways & Means Comm. (Jan. 31, 2005), *available at* http://www.cidny.org/content/Testimony/CIDNY_NYS_06_Budget_Testimony.pdf (stating that the elimination of spousal refusal would be "anti-family," increase social isolation among the disabled elderly, and prevent access to necessary health services); N.Y. State Alliance for Retired Americans, Online News: Medicaid Budget Hearing Shows Balancing the Budget on the Backs of Providers of Services and New York Residents, Feb. 6, 2004, http://www.nysara.org/Feb604.pdf (arguing that prohibiting spousal refusal for the spouses of institutionalized patients would force people to choose between divorce or putting the Medicaid spouse in an institution).

314. Karen Schimke, President and CEO, Schuyler Center for Analysis and Advocacy, Testimony Before the J. Fiscal Comm. on Health, Medicaid & Aging

As recently as 2005, the lobbying efforts of various advocacy organizations, including the Elder Law Section of the New York State Bar Association and the New York Chapter of the National Academy of Elder Law Attorneys, have been successful in preventing the elimination of spousal refusal as a planning tactic for Medicaid eligibility.[315]

In 2006, Governor Pataki again attempted to eliminate spousal refusal from the legislature's budget through an exercise of his veto power, but the state legislature overrode the governor's veto despite his claim that such an action was unconstitutional.[316] Due to New York's current political climate and high Medicaid expenditures, spousal refusal is likely to remain a controversial and relevant issue.[317]

2. MASSACHUSETTS

In Massachusetts, spousal refusal has been less frequently used than in New York, and its success has been less certain.[318] Spousal refusal in Massachusetts is governed by a MassHealth agency regulation that parallels 42 U.S.C. § 1396r-5(c)(3).[319] Under Title 130 of the Code of Massachusetts Regulations section 517.010,[320] the institutionalized spouse will not be ineligible if he or she is unable to report the community spouse's resource information and has assigned his support rights to the state.[321] The Massachusetts Office of Medicaid had

(Feb. 3, 2004), *available at* http://www.scaany.org/initiatives/documents/feb2004_health_testimony.pdf.

315. Littman Krooks, Pataki Budget Rejected: Access to Health Care Preserved (Apr. 12, 2005), http://lkllp.com/in_the_press.php?id=102.

316. Erik Kriss, *Lawmakers Override Vetos; Pork Flows; Governor and Legislators Now Gearing Up for Expected Court Challenges*, POST STANDARD (Syracuse, N.Y.), Apr. 27, 2006, at A6; Press Release, N.Y. State Assembly, Statement on Final Assembly Action to Override Vetoes (Apr. 26, 2006), http://www.assembly.state.ny.us/Press/20060426/ (noting that the Senate and Assembly overrode the governor's veto); *see also* Saul Friedman, *Gray Matters; Tougher to Protect Both Health and Assets*, NEWSDAY (N.Y.), Sept. 23, 2006, at B07 (stating that spousal refusal is still available in New York).

317. Eliot Spitzer and Thomas Suozzi, candidates in the 2006 New York State gubernatorial election, took sides on the spousal refusal issue. Michael Rothfeld, *Suozzi: Well-off Families Can Pay Nursing Tabs*, NEWSDAY (N.Y.), Apr. 11, 2006. Governor Pataki has organized a commission to explore the possibility of a Medicaid waiver from the federal government; the waiver would allow the state to more freely restructure the Medicaid program to better meet the state's needs. Ellen Yan, *New Directions in Long-Term Care*, NEWSDAY (N.Y.), June 3, 2006, at B04.

318. Susan H. Levin, *Masshealth & Resource Planning*, *in* 3 ESTATE PLANNING FOR THE AGING OR INCAPACITATED CLIENT IN MASSACHUSETTS: PROTECTING LEGAL RIGHTS, PRESERVING RESOURCES, AND PROVIDING HEALTH CARE § 36.2.6 (2005).

319. 42 U.S.C.A. § 1396r-5(3) (2003).

320. 130 MASS. CODE REGS. 517.010 (2006).

321. Levin, *supra* note 318.

stated as early as 1996 that spousal refusal was possible.[322] However, this right appears to have been applied inconsistently, depending largely on the individual enrollment office and intake worker.[323] Massachusetts uses a similar process to New York, with the community spouse signing an affidavit to effectuate the refusal in an attempt to increase the chance of a successful application.[324] This refusal statement clearly indicates that the Medicaid applicant is unable to comply with procedures through no fault of his or her own.[325]

Spousal refusal was allowed by a Massachusetts court as recently as 2005.[326] In *Rossetti v. Waldman*, the court found that benefits could not be denied because, "although the federal Medicaid statute nowhere refers expressly to a 'spousal refusal' . . . it does anticipate this possibility . . . so long as the government has the right, by assignment or otherwise under state law, to proceed against the community spouse."[327] Thus, the result of a spousal refusal is not denial of benefits to the institutionalized spouse, "but subrogation to the institutionalized spouse's support rights against the community spouse."[328]

The *Rossetti* court concluded that the case before it technically involved "spousal noncooperation" rather than spousal refusal. Although the federal statute covered only spousal refusal, the Massachusetts statute addressed the issue of noncooperation and found that its construction closely paralleled the federal law.[329] Together, the federal and state laws laid out a framework that reinforced the basic notion that the institutionalized spouse "should not be denied needed care because of his spouse's intransigence"[330] and that the agency's ability to recover against the community spouse is sufficient.[331] The court analyzed spousal noncooperation similarly to spousal refusal because denying the institutionalized spouse eligibility under one but

322. *Id.*
323. *Id.*
324. *Id.*
325. *Id.*
326. Rossetti v. Waldman, No. 04-1418, slip op. at 12 (Mass. Super. Ct. Aug. 17, 2005) (on file with The Elder Law Journal).
327. *Id.* at 10.
328. *Id.*
329. 130 MASS. CODE REGS. 517.010 (2005); *Rossetti*, No. 04-1418, slip op. at 10–11 (noting that the case here is spousal noncooperation because Ms. Rossetti refused "not financial contribution (though that would seem a likely next step), but the information needed to complete the application").
330. *Rossetti*, No. 04-1418, slip op. at 10, 12.
331. *Id.*

not the other would go against the purpose of the statutes and the regulatory scheme.[332] *Rossetti* clearly establishes that spousal refusal can work in Massachusetts.[333] As in Connecticut, Massachusetts might take legislative steps to restrict the use of spousal refusal, and as in New York, the success of any such changes would depend on the state's political, social, and economic environment.[334]

3. FLORIDA

Spousal refusal has historically been allowed in Florida,[335] but this may no longer be the case after the state completes the process of making drastic changes to its Medicaid program.[336] In 2005, Florida received waiver approval from CMS to test and implement modifications to the structure, funding, and services of the program.[337] Florida's Medicaid reform will incorporate changes to long-term care, and these changes may influence the use of spousal refusal or the ability of the state to recover from a refusing spouse.[338]

Florida Administrative Code Rule 65A-1.712 currently states that "the department follows 42 U.S.C. § 1396r-2."[339] Thus, an institutionalized spouse shall not be determined ineligible due to a community spouse's resources if all of the following conditions are met: (1) the community spouse exercises refusal; (2) the institutionalized spouse

332. *Id.* at 13.

333. Elder Law Answers, "Spousal Noncooperation" Not Grounds for Denial of Benefits, http://www.elderlawanswers.com/wsb-sliced/Article.asp?ID=5010&section=35312&FirmID=5312&Template=3 (last visited Sept. 11, 2006).

334. Spousal refusal has created much controversy in New York for several years. *See supra* Part III.F.1.b. While Massachusetts' costs and its spending per beneficiary ratio are substantially lower than New York's, they are higher than the national average; economic factors such as this may draw more attention to spousal refusal in Massachusetts should it become more commonly used in the future following *Rossetti*. MSIS TABLE, *supra* note 14 (stating that Massachusetts expended $6.4 billion in 2003, with a cost of $6134 per beneficiary compared to $4487 on average nationally).

335. JEROME IRA SOLKOFF, WEST'S LEGAL FORMS: ELDER LAW § 10.219 (2005 ed.); Begley & Jeffreys, *supra* note 91.

336. JOAN ALKER, CTR. FOR CHILDREN & FAMILIES, FLORIDA'S HEALTH AT RISK: UNDERSTANDING FLORIDA'S MEDICAID WAIVER APPLICATION 1 (2005), *available at* http://www.wphf.org/pubs/briefpdfs/Medicaid5.pdf; JEROME IRA SOLKOFF, ELDER LAW SECTION OF THE FLA. BAR, ELDER LAW SECTION NEWS, PUB. POLICY LIAISON REPORT—ACAD. OF FLA. ELDER LAW ATTY'S (AFELA) (2005) (on file with The Elder Law Journal).

337. ALKER, *supra* note 336; Agency for Health Care Admin., Florida Medicaid Reform, http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/ (last visited Sept. 11, 2006).

338. SOLKOFF, *supra* note 336; Agency for Health Care Admin., *supra* note 337.

339. FLA. ADMIN. CODE ANN. r. 65A-1.712 (2005).

assigns support rights to the state; (3) the institutionalized spouse is eligible only if the couple's accessible resources are counted; and (4) the institutionalized spouse does not have any other way to pay for the nursing home costs.[340]

In *Gorlick v. Florida Department of Children & Families*,[341] Florida's District Court of Appeal of the Fourth District interpreted this statute to support spousal refusal.[342] Florida's Medicaid agency argued that the community spouse could not act as the institutionalized applicant's representative to sign the assignment of support rights.[343] In rejecting this argument as "unsupported by any statute, rule or precedent," the court interpreted the Florida statute to clearly allow a spouse to participate in spousal refusal and, if acting with a power of attorney, to assign the institutionalized spouse's support rights to the state.[344] Even if it promotes self-interest for the community spouse to assume possession of all of the resources, taking these actions allowed the applicant to become Medicaid eligible and would be a "'no brainer'" to anyone else.[345] Historically, spousal refusal appears to have been effective in Florida because the state did not bring recovery suits against community spouses.[346] Although Florida courts, like New York, Massachusetts, and Connecticut courts, have interpreted 42 U.S.C. § 1396r-5(c)(3) and the corresponding state statute to allow spousal refusal, it is possible that the state's Medicaid reform will have the effect of abolishing spousal refusal.[347]

340. *Id.*

341. Gorlick v. Fla. Dep't of Children & Families, 789 So. 2d 1247 (Fla. Dist. Ct. App. 2001).

342. *Id.* at 1248; *see also* JEROME IRA SOLKOFF, ELDER LAW § 24:324 (2004–2005 ed.); SCOTT M. SOLKOFF & DANIEL A. TENER, FLORIDA GUARDIANSHIP PRACTICE § 2.33 (4th ed. 2003).

343. *Gorlick*, 789 So. 2d at 1248.

344. *Id.* (noting that the state agency did not even file a brief in support of its case).

345. *Id.*

346. SOLKOFF, *supra* note 336 (asserting that the state agency has not sought legal recovery because there is no right of support between spouses in Florida).

347. A Delaware court has interpreted the federal spousal impoverishment statute differently from New York, Florida, or Massachusetts courts. In *Bowden v. Delaware Department of Health & Social Services Division*, 1993 WL 390480, at 3 (Del. Super. Ct. Aug. 25, 1993), the court determined that 42 U.S.C. § 1396r-5(c)(3) required the "institutionalized spouse [to have] assigned to the State all rights of support from the community spouse" and that "denial would work an undue hardship for the institutionalized spouse." *Id.* Supporters of the decision argue that there was not a valid assignment of support rights here. CARLSON, *supra* note 188. However, critics maintain that the court mistakenly interpreted the statute to require both assignment of support rights and undue hardship, whereas the fed-

IV. Resolution: Modified Spousal Refusal

This note proposes "Modified Spousal Refusal" as a viable, balanced alternative within the current Medicaid framework. In an ideal situation, either the government would be able to completely cover nursing home costs for institutionalized individuals, or couples would be able to effectively purchase private insurance to prevent impoverishment of the community spouse. However, given the current political, fiscal, and social realities, these ideal changes are unlikely to occur soon.[348]

Implementing Modified Spousal Refusal would require statutory changes that would by default prohibit the practice of spousal refusal unless a state proactively chooses to allow it through the actions of the state Medicaid agency or legislature. For the states that affirmatively decide to opt in and allow spousal refusal, CMS should develop federal eligibility and process guidelines. These CMS guidelines would create Modified Spousal Refusal, which focuses on the segment of the population most likely to employ spousal refusal: the middle class.[349] Modified Spousal Refusal would provide substantial and targeted relief to elderly couples, would better allocate the risks between the elderly and the government, and would provide stability and consistency through the federal guidelines. In addition, it would control the potential financial risks by requiring states to affirmatively opt in and by using CMS guidelines to target the delivery of benefits to elderly couples that are able to show a requisite level of need.

A. Change the Federal Statute to Disallow Spousal Refusal Unless a State Opts In

This note advocates changing the federal statute so that it no longer automatically allows Medicaid eligibility if the institutionalized spouse's support rights are assigned to the state. Rather, a state should have the option of affirmatively choosing to allow Modified Spousal Refusal. An opt-in provision would effectively balance the

eral statute clearly intended to require one or the other with a disjunctive "or" provision. Brief of Plaintiffs-Appellees, *supra* note 146, at 11. Although the court arguably misinterpreted the federal statute, *Bowden* remains good law, and the decision serves to highlight the complexity and differences among states.

348. Kaplan, *supra* note 20, at 79–80, 87 (discussing some of the problems with the private long-term care insurance market); *see supra* notes 17–39, 120, and accompanying text.

349. Gross, *supra* note 2.

need to prudently control government costs with the need to assist elderly couples with nursing home expenses.

There are several reasons to implement an opt-in system of Modified Spousal Refusal. First, state discretion is consistent with Medicaid's design and the rationale behind the states' monetary contributions to the program.[350] Local governments already have latitude to determine the scope of coverage and to establish processes and regulations that best meet local policy goals.[351] An opt-in provision would allow a state to analyze the need for Modified Spousal Refusal in light of local budgetary considerations as well as the political and social climate.

Second, taking into account MCCA's focus on avoiding spousal impoverishment,[352] Modified Spousal Refusal is a relevant, viable strategy given today's realities. Impoverishment and the use of nursing homes can arguably be considered even more of a concern now than when Medicaid was created. The continued rise in nursing home costs, the longer life expectancies that raise the chances of the elderly needing such services, and the lack of viable alternatives have increased the burden on elderly couples.

Third, Medicaid-planning strategies like spousal refusal have undoubtedly put additional stress on the Medicaid program.[353] With some courts, like *Morenz*, interpreting the current federal law to unambiguously allow spousal refusal,[354] it is possible that spousal refusal will also become feasible in other jurisdictions.[355] The proposed changes would prevent an unexpected allowance of spousal refusal through judicial means, as is the case in *Morenz*.[356]

350. Mann & Westmoreland, *supra* note 11, at 418 (explaining that states have the broad flexibility within Medicaid to determine coverage and design programs).

351. *Id.*

352. CMS Spousal Impoverishment, *supra* note 41; *see also* Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 480 (2002) (discussing MCCA's goal of protecting community spouses from pauperization).

353. As an example, Governor Pataki's office estimated that limiting Medicaid-planning strategies like spousal refusal and asset transferring would save the state $25 million in State Fiscal Year 2004–2005 and $82 million in State Fiscal Year 2005–2006. N.Y. STATE EXECUTIVE, SECTION ONE: HIGHLIGHTS OF EXECUTIVE BUDGET 21 (2005), *available at* http://www.senate.state.ny.us/docs/sfc04a.pdf. Governor Pataki again proposed a similar change in his State Fiscal Year Budget 2006–2007. Press Release, N.Y. State Governor, Governor Pataki Introduces 2006–07 Executive Budget (Jan. 17, 2006), http://www.ny.gov/governor/press/06/0117061.html.

354. Morenz v. Wilson-Coker, 415 F.3d 230, 234 (2d Cir. 2005).

355. Scheffey, *supra* note 6.

356. *Morenz*, 415 F.3d at 234.

Fourth, because spousal refusal is not yet widely used, a legislative change today would have a limited negative effect on the majority of the elderly population. However, such an action would be detrimental to people who have used spousal refusal or intend to use it in the near future.

Modified Spousal Refusal would be a flexible state option beyond the current spousal impoverishment provisions. It addresses the competing concerns between providing assistance to needy elderly couples and controlling Medicaid spending.

B. Federal Guidelines for Modified Spousal Refusal Can Benefit Both Elderly Couples and States That Opt In

To complement the proposed changes to federal law, a revised CMS State Medicaid Manual should provide specific guidelines for a Modified Spousal Refusal exception for states that decide to opt in. Under these proposed guidelines, the institutionalized spouse must contribute part of his or her income or resources to cover nursing home costs.[357] The inquiry would focus on the couple's combined wealth, and the guidelines would establish parameters for mandatory contributions as well as an eligibility cap on total resources and income. This cap would limit the use of Modified Spousal Refusal to situations where there is a substantial, documented need based on a case-by-case analysis. States would be free to determine the specific contribution percentage, which would be on a sliding scale based on countable resources and income. The community spouse would retain the remainder of the assets and not be subject to estate recovery until after death, when a state's standard Medicaid estate recovery procedures would apply. These changes would provide guidance to states and establish baseline standards across the nation for allowing Modified Spousal Refusal with consistency and predictability.

There would also be substantial benefits both for states that opt in and for elderly couples. The state would receive funding in ad-

357. The idea of contributing a portion of assets in order to qualify for Medicaid has been proposed before in substantially different form and with varying conditions by the New York State Bar Association Elder Law Section. NYSBA ELDER LAW SECTION, *supra* note 89, at 62. The New York State Bar Association Elder Law Section's proposal was limited to New York, offered individuals two separate choices, and covered different long-term care services. *Id.* This note's proposed resolution focuses solely on the problems and issues associated with spousal impoverishment and the need for institutionalized care.

vance, while the institutionalized spouse would receive the necessary nursing home care from Medicaid, and the community spouse would be better able to avoid spousal impoverishment. Moreover, elderly couples using Modified Spousal Refusal would receive the benefit of Medicaid's negotiated rates and not be immediately concerned with potential litigation costs stemming from the state's attempts to recover.

Even residents of states that do not allow spousal refusal have an interest in whether this Medicaid-planning strategy is used in other states because at least half of each state's Medicaid costs are federally funded.[358] Hence, taxpayers share this collective burden regardless of their state of residence. These reforms would also control the financial costs of spousal refusal by limiting its use to states that deliberately opt in. The proposed reforms would also ensure that there is a fair, effective process to evaluate applicants using Modified Spousal Refusal.

Although opponents might argue that Modified Spousal Refusal would severely limit the use of spousal refusal and put the onus on the state to voluntarily allow it, this is a necessary change in light of the competing, partially asymmetrical interests between the couple and the community at large. While the health of an institutionalized spouse and an impoverished community spouse is a nationwide social concern, it is impossible to ignore the prospective costs of spousal refusal as it exists now, the limited resources of Medicaid, and the need to cautiously evaluate any measures to expand Medicaid.

Other critics might contend that the effect of the proposed changes would not be much different from the current state of affairs, for even if a court were to allow spousal refusal, the state legislature could act at any time to disallow it. Nevertheless, spousal refusal is not on the political agendas of most state legislatures.[359] This note's resolution takes a proactive step toward clarifying the law and requiring a deliberate political process in a given state if Modified Spousal Refusal is to be allowed.

This proposal also promotes consistency and effectiveness by establishing clear parameters for Modified Spousal Refusal to ensure that its use is tailored to situations in which spousal impoverishment

358. Federal Assistance, *supra* note 106; Mann & Westmoreland, *supra* note 11, at 419.

359. Scheffey, *supra* note 6.

is a substantial risk. By looking forward and recognizing the growing strain of nursing home costs on the elderly middle class, a population with few alternatives beyond Medicaid planning, Modified Spousal Refusal provides a solution that prevents leaving the community spouse in a frail position and potentially in need of additional welfare support. This compromise strives to be politically, economically, and socially beneficial by better allocating the risks among the federal government, the state government, and the individual. Modified Spousal Refusal would offer Medicaid nursing home care to an institutionalized spouse and prevent spousal impoverishment as long as the couple meets the newly established federal eligibility guidelines.

V. Conclusion

Spousal refusal and the *Morenz* decision illustrate the complexity of legal, political, social, and economic issues surrounding spousal impoverishment and Medicaid. The national debate and the importance of an affordable nursing home option that does not cause spousal impoverishment will continue to grow as the elderly population grows. Long-term care costs are burning the proverbial candle at both ends on a national scale. On one side there are high costs and a growing demand for long-term care services, while on the other, governments face fiscal budget constraints. This leaves elderly couples, especially those in the middle class, looking to spousal refusal and Medicaid for support. Medicaid's MCCA amendment sought to end the pauperization of the community spouse who faced catastrophic health care expenses.[360] This note proposes changes that substantially further the MCCA's goal. Modified Spousal Refusal is a constructive step toward providing financial support to needy elderly couples while controlling costs to taxpayers.

360. Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 480 (2002); Takacs & McGuffey, *supra* note 4, at 141–43.