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**An Analysis of the Federal Medicaid Statute's
Spousal Anti-Impoverishment Provision in Light of
the Patient Protection and Affordable Care Act's
Medicaid Expansion and Current Federal Budgetary
Constraints**

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I. INTRODUCTION

In 1987, Senators Mikulski, Mitchell and Kennedy introduced the Medicaid Community Spousal Protection Act of 1987, later incorporated as an amendment into the Medicare Catastrophic Illness Coverage Act of 1988.¹ The Senators intended this provision to prevent a spouse from becoming impoverished due to paying for an institutional level of care² for the other spouse.³ As enacted, the provision allows couples to sequester some assets for the community spouse,⁴ while still preserving the other spouse's Medicaid benefit eligibility.⁵

The financial impact of this expansion of Medicaid eligibility is felt in the budgets of both state and the federal governments.⁶ The federal

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1. 133 CONG. REC. 29353 (1987) (statement of Sen. Barbara Mikulski); Medicare Catastrophic Coverage Act of 1988 § 303, 42 U.S.C. § 1396r-5 (2006 & Supp. 2011).

2. A spouse requiring an institutional level of care generally refers to needing care delivered in a nursing home. This spouse is also referred to as the "institutionalized spouse." Wone, *infra* note 40, at 492.

3. 133 CONG. REC 29353, *supra* note 1.

4. Community spouse refers to the spouse who does not need an institutional level of care such as a nursing home and continues to reside in the "community," often in the family home. Wone, *infra* note 40, at 492.

5. 42 U.S.C. § 1396r-5(d), *supra* note 1.

6. ELICIA J. HERZ, CONG. RESEARCH SERV., RL 33202, MEDICAID: A PRIMER 1 (July 18, 2012).

government pays for at least half (and generally much more) of the costs associated with care for Medicaid beneficiaries.⁷ Additionally, it is the state government that is generally responsible for the remainder of the costs as opposed to the beneficiary.⁸ Further, the expansion applies to an otherwise mandatory eligibility category, meaning that states do not have the option of refusing to provide coverage for these individuals.⁹ As both state and the federal governments look to reduce their spending, federal elected officials may view modifications to mandatory categories of Medicaid eligibility as an attractive option to counter the rising costs associated with increases in Medicaid enrollment.¹⁰ State governments are seeking to reduce expenditures at the same time as the federal government shifts more and more of the financial burden onto them.¹¹ Additionally, under health care reform, spousal anti-impovertshment protections will extend to couples where one spouse needs home and community based services, not just institutional care.¹² In the current budgetary climate, the evolution of Medicaid eligibility under spousal anti-impovertshment protections begs the

7. *Id.* at 9.

8. *Id.*; 75 Fed. Reg. 69083 (Nov. 10, 2010). Federal Medical Assistance Percentage [FMAP] rates for FY 2012 reflect a range of 50 – 74.18 as the percentage of Medicaid expenditures covered by the federal government. *Id.*

9. HERZ, *supra* note 6, at 2.

10. See *Percent Change in Monthly Enrollment of Adults in Medicaid*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=615&cat=4&sub=52&yr=1&typ=2> (last visited April 27, 2013); *Average Annual Growth in Medicaid Spending, FY1990 - FY2010*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=181&cat=4> (last visited April 27, 2013)

11. Philip Galewitz & Matthew Fleming, *13 States Cut Medicaid To Balance Budgets*, KAISER HEALTH NEWS, July 24, 2012, <http://www.kaiserhealthnews.org/Stories/2012/July/25/medicaid-cuts.aspx>.

12. Spousal impoverishment protections will also be temporarily extended starting January 1, 2014 to couples where one spouse requires home and community-based services. This expansion is mandatory, as opposed to as an optional expansion for the states. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 2404, 124 Stat. 119, 305 (2010); *Long-Term Services Health Reform Provisions: Expanded Spousal Impoverishment Protection in Medicaid*, FAMILIES USA: THE VOICE FOR HEALTH CARE CONSUMERS, <http://www.familiesusa.org/issues/long-term-services/health-reform/spousal-impovertshment.html> (last visited April 26, 2013).

question: should spousal anti-impovertshment protections remain part of federal law? This paper will consider the possible policy ramifications of eliminating spousal protections from Medicaid eligibility and will also analyze the impact of the Patient Protection and Affordable Care Act (PPACA) on Medicaid eligibility and budgetary constraints.

II. HISTORY OF THE SPOUSAL ANTI-IMPOVERTHMENT PROVISION

The federal government requires states to finance nursing home services, allowing Medicaid to be a fall-back option for those who do not purchase long-term care insurance.¹³ However, prior to the Mikulski-Mitchell-Kennedy amendment, the income and assets for both spouses were included in calculating Medicaid eligibility.¹⁴ Before Congress adopted the Mikulski-Mitchell-Kennedy amendment, the community spouse had an allowance that was below the federal poverty level.¹⁵ The Senators' intended to reduce the level of poverty among elderly women, especially those who had not worked over the course of their marriage.¹⁶ Therefore, this amendment targeted those asset allocation rules that would impact eligibility and, if not changed, would continue to contribute to the impoverishment of elderly women with no other source of income than their husbands' pension.¹⁷ Prior to the enactment of the Medicare Catastrophic Illness Coverage Act, many couples faced the difficult decision of either joint impoverishment in order to qualify for Medicaid to

13. HERZ, *supra* note 6, at 6.

14. GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, MEDICAID'S SPOUSAL IMPOVERTHMENT PROTECTIONS 1 (Feb. 2007), available at <http://ltc.georgetown.edu/pdfs/spousal0207.pdf>.

15. 133 CONG. REC. 29353, *supra* note 1.

16. *Id.*

17. Louis D. Torch, *Spousal Impoverishment or Enrichment? An Assessment of Asset and Income Transfers by Medicaid Applicants*, 4 ELDER L.J. 459, 466 (1996).

finance an institutional level of care for one spouse, or divorce.¹⁸

Federal Medicaid law has always required that the potential beneficiary be categorically eligible and medically needy in order to receive benefits.¹⁹ Even with the spousal protection provision, a married Medicaid applicant's inventory of resources includes the assets of the spouse needing an institutional level of care and the community spouse.²⁰ The spousal anti-impoverishment provision, however, allows that while the community spouse's income and assets are considered when determining Medicaid eligibility, there are also certain exclusions.²¹ Significantly, the institutionalized spouse can transfer a monthly maintenance allowance as well as specific resources such as the family home to the community spouse without forfeiting Medicaid eligibility.²² Under the spousal protection provision, there is a federally mandated floor,²³ below which the institutionalized spouse's assets must be used to support the community spouse.²⁴ Additionally, any income that the community spouse receives in his or her own name may be retained by the community spouse.²⁵ This

18. GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, *supra* note 14, at 1.

19. Torch, *supra* note 17, at 466.

20. *Id.*

21. *See id.* at 467-72.

22. *See id.*

23. The spousal anti-impoverishment provision's requirement on the institutionalized spouse to provide financial support to the community spouse means that the community spouse cannot be forced to live below a set threshold above poverty level. The intent of the provision is to "protect the community spouse[] from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance," Wone *infra* note 40, at 492.

24. GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, *supra* note 14, at 1.

25. *Id.* In 2011, the federal government set minimum and maximum amounts that a community spouse could receive as the monthly maintenance allowance at \$1,838.75 and \$2,739.00 respectively, with the individual circumstances of the community spouse determining the final number. In addition, the community spouse may retain resources of up to \$109,560.00 while the institutionalized spouse is eligible for Medicaid. *Spousal Impoverishment*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Spousal-Impoverishment-Page.html> (last visited Feb. 18, 2013).

greatly expands the possible pool of Medicaid beneficiaries.

III. THE IMPACT OF MORENZ V. WILSON-COKER ON MEDICAID ELIGIBILITY

In *Morenz v. Wilson-Coker*, the Second Circuit considered the case of a Connecticut couple where the community spouse, the wife, refused to provide spousal support to her husband who needed an institutional level of care.²⁶ Mr. Morenz assigned his spousal support rights to the state of Connecticut such that any obligation that Mrs. Morenz still held to support her husband would reimburse the state of Connecticut for any funds expended for his care.²⁷ The Second Circuit held that the community spouse could refuse to provide additional support for the institutionalized spouse by assigning his or her right of support to the state, in order for the institutionalized spouse to become eligible for Medicaid benefits.²⁸ The court considered whether 42 U.S.C. § 1396r-5 prohibited a state from deeming the community spouses' assets to be available for purposes of supporting the institutionalized spouse when making a determination of Medicaid eligibility.²⁹ In finding that the statutory language in question was unambiguous, the court held that "[a] community spouse's resources cannot be included in making an institutionalized spouse's initial eligibility determination if the institutionalized spouse has assigned support rights to the state or undue hardship is present."³⁰ Federal law did not prohibit a community spouse from refusing to provide support to the institutionalized spouse.³¹

The court also examined whether under Connecticut law, as distinct from

26. *Morenz v. Wilson-Coker*, 415 F.3d 230, 233 (2d. Cir. 2005).

27. *Id.* at 232-3.

28. *Id.* at 234.

29. *Id.*

30. *Id.*

31. *Id.*

federal eligibility requirements, an institutionalized Medicaid applicant could assign spousal support rights to the state only when the Medicaid applicant's spouse is unwilling or unable to provide the financial information needed to determine Medicaid eligibility.³² If the court had upheld the state limitation, then the holding that federal law allows for an institutionalized spouse to assign their support rights to the state would effectively be irrelevant.³³ Medicaid eligibility could still be restricted because state law could prohibit spousal refusal and assignment of rights of support.³⁴ However, the court held that the limitation on assignment of spousal support rights only pertained to mandatory assignment of spousal support rights.³⁵ If a community spouse voluntarily gave up his or her spousal support rights and the institutionalized spouse assigns them to the state, then the institutionalized spouse did not depend upon the community spouse's assets for determining Medicaid eligibility.³⁶

The policy impact of the court's holding in *Morenz* is complicated by the fact that the court's decision turns on both federal and state law. The rule protects the community spouse from having to divorce the institutionalized spouse and allows him or her to continue living in the couple's home, as Congress intended with the enactment of 42 U.S.C. § 1396r-5.³⁷ However, it also creates the possibility that many individuals who would not otherwise receive Medicaid benefits based upon being "categorically

32. *Morenz*, 415 F.3d at 254

33. *Id.* 235.

34. *Id.* n.4.

35. *Id.* at 236.

36. *Id.* at 234.

37. *Women and Aging: Bearing the Burden of Long-Term Care: Joint Hearing Before the Spec. Comm. on Aging and the Subcomm. on Aging of the Comm. on Health, Educ., Labor and Pensions*, 107th Cong. 3 (2002) (opening statement of Sen. Barbara Mikulski, Chairman, S. Subcomm. on Aging of the Comm. on Health, Educ., Labor and Pensions); 133 CONG. REC 29354 (1987) (statement of Sen. Edward Kennedy).

needy”³⁸ can receive government-funded care. This possible, unintended, expansion of Medicaid eligibility makes the spousal anti-impoverishment provision an attractive target for those in Congress who seek to reduce the size and scope of the federal budget.

The vast majority of couples that take advantage of the option of spousal refusal³⁹ are those in need of nursing home and other long-term care services.⁴⁰ Without the option for spousal refusal, many couples would not be able to cover the cost of long-term care for the institutionalized spouse for even one year without depleting the couple’s resources and leaving the community spouse dependent upon Medicaid when he or she also needed care.⁴¹ However, granting the option of spousal refusal also makes reductions in Medicaid long-term care spending difficult to attain.⁴² Currently, spousal refusal is not available in every state.⁴³ When available, it allows couples to plan for Medicaid eligibility, rather than applying for benefits only after all income and assets have been consumed by paying for care.⁴⁴ As such, individuals who may become eligible for Medicaid benefits after spending down assets are able to receive benefits sooner through careful estate planning.⁴⁵ It therefore becomes a question of policy

38. “Categorically needy” generally refers to those individuals who are automatically eligible for Medicaid coverage, assuming certain income qualifications are met, with the income qualifications varying somewhat by state. See HERZ, *supra* note 6, at 1. Those categories include pregnant women, children, women with breast or cervical cancer, individuals with disabilities, the elderly, and uninsured individuals with tuberculosis. *Id.*

39. For a more in depth discussion of the process of spousal refusal, see Wone, *infra* note 40, at 498-99.

40. Andrew D. Wone, *Don’t Want to Pay for Your Institutionalized Spouse? The Role of Spousal Refusal and Medicaid in Funding Long Term Care*, 14 ELDER L.J. 485, 490 (2006).

41. *Id* at 496.

42. See *id.* at 490. Medicaid pays for approximately half of all long-term care expenses as is. *Id.*

43. For a general discussion for spousal refusal rules in New York, Massachusetts and Florida, see *id.* at 519-27.

44. See *id.*

45. Torch, *supra* note 17, at 460.

if these beneficiaries should receive Medicaid benefits as opposed to depleting their assets and allowing the program to serve a smaller set of individuals who are deemed especially needy.

IV. MEDICAID ELIGIBILITY EXPANSIONS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The state-option Medicaid expansion under the PPACA expanded the ceiling of Medicaid eligibility, and changed the face of Medicaid beneficiaries.⁴⁶ Additionally, the PPACA includes an expansion of the spousal protections to include those couples with a spouse in need of home and community based services, not just institutional care.⁴⁷ This change may make it more politically and socially acceptable for individuals who consider themselves middle class to receive Medicaid benefits, but it also makes Medicaid much more expensive for the federal government.⁴⁸ Both Republican and Democratic governors are announcing their intention to expand Medicaid eligibility in accordance with the PPACA.⁴⁹

The PPACA creates a new category for Medicaid eligibility, in addition to the existing groups that had comprised the traditional “categorically needy.”⁵⁰ While the expansion directly affects low-income, childless

46. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT MEDICAID’S ROLE, 2 (April 2010), available at <http://www.kff.org/healthreform/upload/7920-02.pdf>.

47. PPACA § 2404.

48. KAISER FAMILY FOUND., *supra* note 46. Even though the Medicaid expansion is done at state option, for those states that participate, it is fully funded by the federal government until 2016 with a phase down to 90% FMAP by 2020 for that and subsequent years. *Id.*

49. Sara Kliff, *Republican Governors Embrace Part of Health-Care Law*, WONKBLOG, WASH. POST (Feb. 7, 2013, 10:16 PM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/07/republican-governors-embrace-part-of-health-care-law/>. Were the governors to do otherwise, they would be leaving federal funds available for other states to accept, without reducing the tax burden faced by their own citizens. *Id.*

50. John Blum & Gayland O. Hethcoat II, *Medicaid Governance In the Wake of National Federation of Independent Business v. Sebelius: Finding Federalism’s Middle Pathway, from Administrative Law to State Compacts*, 45 J. MARSHALL L. REV. 601, 612 (2012).

adults, it will also impact eligibility based upon the spousal anti-impovertshment provision.⁵¹ Medicaid beneficiaries who are newly eligible because of the category created by the PPACA will receive “essential health benefits” coverage as opposed to standard Medicaid.⁵² These “essential health benefits” contain some long-term care benefits but they are not identical to those under traditional Medicaid.⁵³ As a result, low-income seniors may receive multiple kinds of Medicaid, and may not realize that assets should be shifted in order for the spouse needing an institutional level of care to receive traditional Medicaid benefits.⁵⁴ This overlap will likely create additional administrative costs for states, and confusion for seniors who are already vulnerable due to financial constraints and the need for long-term care. While the PPACA does include “rehabilitative and habilitative services and devices” within the essential health benefits that all newly eligible Medicaid beneficiaries must receive, nursing home care may fall outside that definition and the federal government has yet to clarify otherwise.⁵⁵ Further modifications, or even elimination, of the spousal

51. *Id.*

52. Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4594, 4629 (proposed Jan. 22, 2013).

53. Blum & Hethcoat, *supra* note 50, at 612; 42 U.S.C. § 18022(b)(1). The PPACA defines “essential health benefits” to include the following items: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. 42 U.S.C. § 18022(b)(1).

54. See Blum & Hethcoat, *supra* note 50 at 612. Traditional Medicaid benefits include long term care services but the types of coverage vary by state. See *Long-Term Services & Support*, MEDICAID.GOV, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html> (last visited April 26, 2013).

55. 42 U.S.C. § 18022(b)(1). It is up to the states to define what constitutes “habilitative” benefits as part of what qualifies as a qualified health plan within each state’s Health Benefits Exchange. Until the Exchanges are fully established, seniors will continue to

protection provision could lead to still more confusion for seniors and still higher administrative costs for Medicaid programs. These costs would be borne not by the federal government but by the states.⁵⁶ This fact may make changes to the spousal anti-impoveryment provision appealing to federal budget cutters, but their constituents may respond negatively at the ballot box.

V. SHIFTING THE FINANCIAL BURDEN: ELIMINATION OF THE SPOUSAL ANTI-IMPOVERISHMENT PROVISION

Medicaid funding has always been split between the federal government and the states.⁵⁷ However, the majority of administrative responsibility rests on the state level within federal guidelines.⁵⁸ For beneficiaries, the division means that while there is a federally mandated floor for Medicaid eligibility with spousal asset exclusions, there is still considerable state variety in how the provision will be applied.⁵⁹ One proposal to make access to Medicaid benefits more equitable across state lines is to raise the federal floor to the maximum allowed monthly maintenance allowance, with the federal government increasing FMAP amounts.⁶⁰ This would likely improve the overall quality of care that seniors receive. However, it would simply shift the cost burden to the federal government.

Another possible change to Medicaid that federal budget cutters may

face uncertainty. *See* Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, *supra* note 52, at 4630.

56. CHRIS L. PETERSON, CONG. RESEARCH SERV., RL 32950, MEDICAID: THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE 1 (April 7, 2010).

57. *Id.*

58. HERZ, *supra* note 6, at 1.

59. GEORGETOWN UNIVERSITY LONG-TERM CARE FINANCING PROJECT, *supra* note 14, at 2.

60. *Id.*

consider is the total elimination of the spousal protection provision.⁶¹ If Congress were to adopt this change and reduce Medicaid eligibility, this could reduce federal and state Medicaid outlays, simply by taking potential beneficiaries out of the program.⁶² However, for many individuals without long-term care insurance, another option will be waiting until the need for care is so acute that there is no choice but to go to the hospital – care which is covered by Medicare.⁶³ While Medicare does have limits on the number of days a patient can stay in an acute care hospital, it does not have caps on the financial outlays per patient and costs can quickly add up.⁶⁴

End-of-life care costs are rising equally dramatically as long-term care costs in an inverse relationship such that avoiding Medicaid funded long-term care does not solve the problem of containing costs.⁶⁵ When Medicare is the only payor, the financial burden is borne entirely by the federal government.⁶⁶ The high cost of end-of-life care has been examined by Dr. Peter Pronovost, a physician at the Johns Hopkins University Hospital and a

61. The possibility of completely eliminating the spousal protection provision may seem remote in view that the benefit is expanded in a five year demonstration program under the Patient Protection and Affordable Care Act. PPACA § 2404.

62. The number of Medicaid enrollees has been steadily increasing nationally, coinciding with a growth in the overall amount of Medicaid spending. While the growth has not been linear, it is logical to conclude that reducing the number of potential beneficiaries would lead to some reduction in Medicaid spending. *See Percent Change in Monthly Enrollment of Adults in Medicaid*, *supra* note 10, *Average Annual Growth in Medicaid Spending, FY1990-FY2010*, *supra* note 10. .

63. Jane Gross, Op-Ed., *How Medicare Fails the Elderly*, N.Y. TIMES, Oct. 16, 2011, at SR8

64. Janet Adamy & Tom McGinty, *The Crushing Cost of Care*, WALL ST. J., July 6, 2012, <http://online.wsj.com/article/SB10001424052702304441404577483050976766184.html>. Dr. Peter Pronovost's discussion of the escalating costs of care for Medicare beneficiaries illustrates how the costs of end of life care can rise due to both physicians and patient's families focus exclusively on sustaining life as opposed to quality of life of the patient and cost concerns. *Id.*

65. Korbin Liu, Joshua M. Wiener & Marlene R. Niefeld, *End of Life Medicare and Medicaid Expenditures for Dually Eligible Beneficiaries*, 27 HEALTH CARE FIN. REV. 95, 97 (2006), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/06Summerpg95.pdf>.

66. PATRICIA A. DAVIS, CONG. RESEARCH. SERV., R40425, MEDICARE PRIMER 1 (2010).

professor at the Johns Hopkins University School of Public Health.⁶⁷ Dr. Pronovost's discussion of end-of-life care costs shows how the overall cost can be higher when the care is delivered in an acute care setting.⁶⁸ While expenditures for dual eligible beneficiaries tend to be higher than for Medicare only beneficiaries, if enrollment in Medicaid is delayed until the patient has consumed the resources of both spouses, the beneficiary is likely going to be sicker and in need of more expensive care.⁶⁹

The potential loss of Medicaid eligibility for an institutionalized spouse makes the discussion of dual eligibles⁷⁰ particularly important. Dual eligible beneficiaries of both Medicare and Medicaid represent the highest expenditures for the federal government, using Medicare for acute care services and Medicaid for long-term care needs.⁷¹ The high cost of care for these patients may be in part due to the reasons Dr. Pronovost highlighted as a partial explanation for the high cost of end of life care in general.⁷² However, this cost seems to be shared between Medicare and Medicaid. Long-term care in a nursing facility is often a substitute for acute care in a hospital for older, dual eligible beneficiaries.⁷³ While this has increased the costs of care overall, splitting of costs between two payors may end up reducing the burden borne by the federal government. Combined spending for dual eligible beneficiaries decreased as beneficiaries age.⁷⁴ While the federal government pays for 100% of the costs of dual eligibles, the state

67. Adamy & McGinty, *supra* note 64.

68. *Id.*

69. Liu, Wiener & Niefeld, *supra* note 65, at 95.

70. State Medicaid programs must pay *Medicare cost-sharing expenses* (e.g., Medicare premiums and, in some cases, deductibles and co-insurance) for certain low-income individuals eligible for both programs, often called "dual eligibles." HERZ, *supra* note 6 at 7 (emphasis in original).

71. Liu, Wiener & Niefeld, *supra* note 65, at 96

72. *Id.* at 97.

73. *Id.*

74. *Id.* at 99.

only receives the standard FMAP amount for traditional Medicaid beneficiaries.⁷⁵ However, because the states are administrators of the Medicaid program, states have been using their authority to declare certain transfers of assets ineligible for protection under the federal spousal anti-impovertshment provision.⁷⁶ Allowing states to do this shifts the financial burden back to the federal government, and eventually onto the community spouse, essentially eliminating the intended spousal impoverishment protection.⁷⁷ Shifting the burden may save state governments money in the short term, but the care that the spouse needing an institutional level of care receives will likely be more expensive due to delay and the high cost of care associated with dual eligible beneficiaries. By attempting to save money, state governments could end up increasing overall health care spending costs for both the states and the federal government.

VI. CONCLUSION

While elimination of the spousal asset and income protections first enacted into Medicaid in 1988 may seem attractive to policy makers looking to reduce federal expenditures, it is unlikely to be successful. *Morenz v. Wilson-Coker* has yet to be challenged. While it is only binding in the Second Circuit, it should be viewed as highly persuasive in other jurisdictions. This means that Medicaid continues to be a viable option for middle class families without long-term care insurance. While some family assets must be consumed in order for the institutionalized spouse's assets to meet eligibility guidelines, couples will not have to file for divorce in order to declare that they were not financially prepared for one spouse's medical needs. The PPACA-created Medicaid expansion is optional for states, and

75. PETERSON, *supra* note 56, at 1.

76. Torch, *supra* note 17, at 488.

77. *Id.*

while this reduces the dependence on the spousal anti-impovertshment provision for a spouse needing an institutional level of care, it does not eliminate it completely. Additionally, the Medicaid expansion increases federal outlays because the expansion is fully funded by the federal government until 2016 with a phase down to 90% FMAP by 2020 for that and subsequent years.⁷⁸ Finally, the expansion creates a different pathway for eligibility that also has different benefits. Because there is no guarantee of coverage for nursing home services in this new pathway, low-income seniors may choose to forgo Medicaid until the traditional eligibility point, and depend upon the spousal anti-impovertshment protections to keep the community spouse in the family home. Therefore, elimination of the spousal protection provision of the Medicaid statute, while attractive on paper, is unlikely to lead to significant savings for the federal government without other changes to federal health care programs.

78. PETERSON, *supra* note 56, at 14.