# Medicaid

Medicaid is a jointly-funded, federal-state welfare program which provides medical care to individuals and families with very low resources and income. Each state administers its own program and, within guidelines set by the federal government, establishes its own rules regarding program eligibility and the type, duration, and scope of services provided.

## Qualifying For Medicaid

Just being poor is no guarantee that an individual will qualify to receive Medicaid. An individual must belong to one of several specified groups as well as meet certain income and asset limitation tests.

To qualify for federal funds, states must provide care for certain, targeted populations. Included in the mandatory category are persons receiving federally assisted income maintenance payments, such as Supplemental Security Income (SSI), or Aid to Families With Dependent Children (AFDC).

The One Big Beautiful Bill Act of 2025 introduces a federal work mandate of 80 hours per month with applications filed on or after December 31, 2026. This requirement applies to "able-bodied" adults between 19 and 64. The work mandate can be satisfied with paid work, job training, attending school or volunteer work. Any combination of these activities will qualify.

A state may choose to provide healthcare services to certain "categorically needy" populations, individuals and families whose financial situation is similar to those in the mandatory group, but with different qualifying criteria. Medicaid benefits may also be offered to "medically needy" persons, those with incomes too high to qualify under any other category. Such individuals can "spend down" their excess income by incurring medical and/or remedial care expenses, reducing the excess income to a level below the maximum allowed under the state's plan.

## What Medical Services Are Provided?

A wide range of services is provided to Medicaid beneficiaries. Some services are mandatory under federal rules, while others are optional. Provided services can include:

- Inpatient hospital services.
- Outpatient hospital services.

- Nursing facility services for beneficiaries age 21 and older.
- Prenatal and delivery services as well as postpartum care.
- Physicians' services and medical and surgical services of a dentist.
- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21, including vaccines.
- Payment of Medicare premiums (Part A and/or Part B) for certain needy elderly or disabled individuals.
- Long-term care (LTC).

## Resource and Income Limitations

Generally, a single individual cannot have more than $2,000 in assets and still qualify for Medicaid. In this calculation, certain assets are "exempt" and are not counted:

| Asset | Observation |
|---|---|
| Personal residence | Generally, with no more than $730,000 of equity. A state may raise this limit to $1,097,000. |
| Cash value life insurance | With a face value of up to $1,500. |
| Household goods, personal effects | Furniture, appliances, artwork, clothing, jewelry. |
| Automobile | One car, generally limited to a value of $4,500. |
| Burial funds | Generally limited to $1,500. |
| Burial space | Burial plot, grave marker, urn, crypt, mausoleum. |
| Business assets | Property employed in a trade or business, if essential to self-support. |
| Jointly owned residence | Exempt if other resident owners would be forced to move if property were sold. |

Those applying for Medicaid must also meet certain monthly income limitations, which vary by state. These income limitations generally change from year to year.

## Transferring Assets To Qualify For Medicaid

Some individuals, often those needing expensive nursing home care, will attempt to meet Medicaid's asset limitations by gifting or otherwise transferring assets to others for less than fair market value. However, such transfers can result in a delay in benefit eligibility if made within a "look-back" period of 60 months before the application date.[1]

To avoid a period of ineligibility, an individual who anticipates needing care can either (1) transfer assets more than 60 months before applying for Medicaid benefits; or, (2) keep enough assets to pay for needed care for 60 months, transfer the remainder, and not apply for Medicaid benefits until 60 months have elapsed after the last transfer.

The period of ineligibility is generally determined by dividing the value of the assets transferred by the average monthly cost of nursing home care to a private patient in the local community. Ineligibility begins on the later of: (1) the date of the gift or transfer; or, (2) the date the individual would otherwise have qualified to receive Medicaid benefits.[2]

> Example: George lives in a state where the average monthly cost of nursing home care is $6,000 per month. If he transfers property worth $120,000, he will be ineligible for Medicaid benefits for 20 months ($120,000 ÷ $6,000 = 20).

## Annuities

The purchase of a commercial annuity is considered in the same light as a gift or transfer of assets for less than fair market value, unless certain requirements are met. In general, an annuity is not counted as an asset if it is: (1) irrevocable; (2) non-transferrable; (3) actuarially sound, compared to the beneficiary's life expectancy; and; (4) provides for equal payments during the annuity's term.

---

[1] Under federal rules, some transfers, such as those made for the benefit of a spouse, a blind or disabled child, or a disabled individual under age 65, will not trigger a period of benefit ineligibility.

[2] Under the Deficit Reduction Act of 2005, the 60 month look-back period applies to transfers made on or after February 8, 2006. For transfers before that date, a 36 month look-back period generally applied (60 months in the case of certain trusts).

Additionally, there can be no payment deferral or balloon payments and the state must be named as the primary remainder beneficiary (in some cases the secondary remainder beneficiary) for the amounts paid by Medicaid for the beneficiary's care.[1]

## Trusts

If an individual, or his or her spouse, or anyone acting on the individual's behalf, establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for determining Medicaid eligibility.

In general, payments actually made to or for the benefit of the individual are treated as income to the individual. Amounts that could be paid to or for the benefit of the individual, but are not, are treated as available resources. Amounts that could be paid to or for the benefit of the individual, but are paid to someone else, are treated as transfers for less than fair market value. Amounts that cannot, in any way, be paid to or for the benefit of the individual are also treated as transfers for less than fair market value.[2]

Certain trusts, for disabled or institutionalized individuals, are not counted as being available to the individual. These trusts must provide that the state receives any funds, up to the amount of Medicaid benefits paid on behalf of the individual, remaining in the trust when the individual dies.

## Spousal Impoverishment

The high cost of nursing home care can rapidly exhaust the savings of almost anyone. Because of this, Congress has enacted laws to prevent what has been called "spousal impoverishment," which can leave the spouse who is still living at home (the "community spouse") with little or no income or resources. These provisions help ensure that the community spouse will be able to live out his or her life with independence and dignity. These spousal impoverishment rules apply when one member of a couple enters a nursing home or other medical institution and is expected to remain there for at least 30 days.

When the couple applies for Medicaid, an assessment of their combined (regardless of

---

[1] Annuities purchased before February 8, 2006, the effective date of the Deficit Reduction Act of 2005, were subject to individual state rules.

[2] Transfers from trusts for less than fair market value are subject to the same 60-month "look-back" period applicable to other transfers.

ownership) resources is made. The couple's home, household goods, an auto, and burial funds are not included in the accounting. The result is the couple's combined countable resources. This total is then used to determine a "Protected Resource Amount" (PRA) for the community spouse.[1] After the PRA is subtracted from the couple's combined resources, the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the state's resource standard, the individual is eligible for Medicaid.

The community spouse's income is not considered available to the spouse who is in the medical facility and the two individuals are not considered a couple for income eligibility purposes. The state uses the income eligibility standard for one person rather than two. If most of the couple's income is in the name of the institutionalized spouse, and the community spouse has insufficient income in his or her own right to live on, a separate calculation is made which allocates a portion of the institutionalized spouse's income to support the community spouse and any other family members living in the household.

## Estate Recovery

When a Medicaid beneficiary dies, federal law requires the states to seek recovery of amounts paid by the state for many of the services provided to Medicaid beneficiaries, unless undue hardship would result. Generally, recovery is made from property held in the beneficiary's name only. Some states may seek also recovery from a life estate, assets held in a revocable "living" trust, or jointly held assets. Assets that pass to a surviving spouse are exempt from recovery as long as that spouse is alive.

## Long-Term Care Partnership

In a Long-Term Care Partnership, a state government and private health insurers work together to make available to residents of that state LTC insurance policies that are "linked" to Medicaid. If a buyer of a partnership LTC policy later faces long-term care needs that exceed the policy's limits, he or she may apply for assistance from the state's Medicaid program under more relaxed eligibility rules. In what is termed an "asset disregard," the policy owner may keep a larger amount of assets than would normally be allowed under standard Medicaid rules. These relaxed eligibility rules apply only to the amount of assets than an individual can retain; all other normal Medicaid eligibility requirements apply.

[1] The PRA may also be determined by either a court order or by a state hearing officer.

## Patient Protection and Affordable Care Act (PPACA)

Beginning in 2014, PPACA expanded eligibility for Medicaid to individuals not currently eligible for Medicare (generally, individuals under age 65). This expansion embraced children, pregnant women, and adults without dependent children, with incomes up to 133% of the federal poverty level (FPL). Coverage is provided through an essential health benefits package purchased through a state's American Health Benefits Exchange.

## Seek Professional Guidance

Qualifying for Medicaid services requires meeting complex legal and regulatory requirements. The guidance of trained financial professionals is highly recommended.

See the general information made available by the federal government's Centers for Medicare and Medicaid Services at: https://www.medicaid.gov/.

# Disclosure Notice

The information that follows is intended to serve as a basis for further discussion with your financial, legal, tax and/or accounting advisors. It is not a substitute for competent advice from these advisors. The actual application of some of these concepts may be the practice of law and is the proper responsibility of your attorney. The application of other concepts may require the guidance of a tax or accounting advisor. The company or companies listed below are not authorized to practice law or to provide legal, tax, or accounting advice.

Although great effort has been taken to provide accurate data and explanations, and while the sources are deemed reliable, the information that follows should not be relied upon for preparing tax returns or making investment decisions. This information has neither been audited by nor verified by the company, or companies, listed below and is therefore not guaranteed by them as to its accuracy.

**If a numerical analysis is shown, the results are neither guarantees nor projections, and actual results may differ significantly. Any assumptions as to interest rates, rates of return, inflation, or other values are hypothetical and for illustrative purposes only. Rates of return shown are not indicative of any particular investment, and will vary over time. Any reference to past performance is not indicative of future results and should not be taken as a guaranteed projection of actual returns from any recommended investment.**