Asset Preservation and Long-term Care

Assault in the Name of Deficit Reduction

By Michael Gilfix and Bernard A. Krooks

Tax planning opportunities and loopholes purportedly abound. They are sometimes blamed for exacerbating the national debt and the nation's ongoing budgetary deficits. The grandly titled Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4, purports to address the nation's deficit by making it tougher for middle- and lower-income elders who face the devastating cost of long-term care to access government-financed health care.

Subchapter A of the DRA is specifically designed to prohibit or dramatically limit an elder's ability to preserve any portion of his or her estate by restricting access to the Medicaid program. The states and the federal government participate jointly in funding the cost of the Medicaid program.

The adoption of the DRA was highly contentious. A tie-breaking vote by Vice President Cheney was needed for the Senate to pass this legislation, and it passed the House of Representatives by the narrow margin of 216 to 214 votes. President Bush signed the measure into law on February 8, 2006.

Challenges to the constitutionality of the DRA may turn out to be a footnote. In a development that seems more Hollywood fiction than fact, a clerk in the Senate purportedly made a typographical error and sent a version of the DRA to the House of Representatives that was identical, but for one number in a different subchapter of the legislation. As a result, the version passed by the Senate is not identical to the version passed in the House of Representatives. Several constitutional challenges to the legislation have been filed in the courts, some of which have already been dismissed.

If any of these challenges is successful, the DRA will evaporate until new votes are taken in Congress. Although many observers opine that the legisla-

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tion would again be voted into law, others suggest that it could not recapture the number of votes necessary to maintain its razor-thin margin of victory. For purposes of this article, the authors assume that the DRA remains law and will be implemented across the nation.

Notwithstanding anecdotally-based statements by advocates of the DRA, the fiscal legislation's effect on Medicaid financing will be minuscule. "The Office of Management and Budget estimates that federal Medicaid outlays would be reduced by $4.5 billion between 2006 and 2015—a reduction of less than two-tenths of one-percent in projected federal Medicaid expenditures." Ellen O'Brien, *Medicaid's Coverage of Nursing Home Costs: Asset Shelter for Wealthy or Essential Safety Net?*, Georgetown University, Long-Term Care Financing Project, May 2005, at 8, available at http://ltc.georgetown.edu/papers.html.

The objective of shifting greater responsibility for paying the cost of care to elders is transparent. For example, DRA provisions mandate expansion of long-term care insurance as a means of financing the cost of long-term care. As discussed more completely below, the authors have no objection to the expansion of this insurance as a means of paying for home care, assisted living, and nursing home care. It is troubling, however, that countless elders will either be unable to obtain such insurance because of medical conditions or unable to afford the cost of annual premiums.

More directly stated, the DRA provides restrictions, not answers. It rather purposefully creates hardship for America's elders.

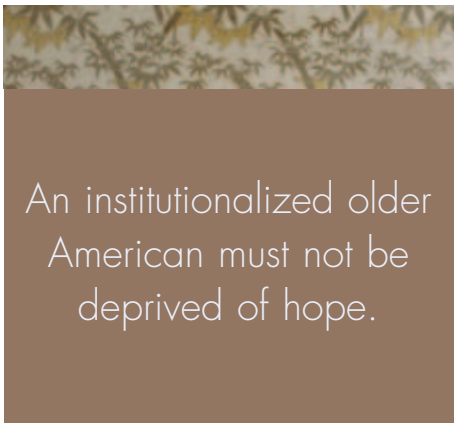
Exposing the Family Residence

Federal Medicaid law, in keeping with well-established public policy, considers the residence a protected resource. It has been on the very short list of assets characterized as exempt. This means that the residence has long been excluded in determining eligibility for the federal Medicaid program.

The policy objective is clear: an institutionalized older American must not be deprived of hope. Returning home after a convalescent period in a nursing home is something everyone hopes for. So long as the institutionalized individual had the intent to return home, the residence continued to be exempt.

The residence was also exempt if one's spouse or disabled child was living in the residence. It was exempt, regardless of value, if a sibling with an equity interest resided in the residence for one year or if a child devoted two years of home care services to the now-institutionalized elder.

The DRA places a punishing cap on the "equity interest" an institutionalized individual can have in a residence if it is to retain its exempt status. That cap is $500,000, a figure so low as to strip elders of home ownership protection in many parts of the nation. DRA § 6014. Each state has the option of increasing this cap to as much as $750,000. In the current political climate, few states are expected to take this step.



In keeping with previous and well-established Medicaid legislation and policy, exceptions exist. If an individual's spouse or minor, blind, or disabled child is living in the residence, the value of the exempt residence is not capped. As a practical matter, this issue applies to single individuals, overwhelmingly widows and other older women.

This problematic cap is already in effect. It applies to individuals who are using a nursing facility's services or other long-term care services and who apply on or after January 1, 2006. As with all provisions of the DRA, however, implementation at the state level remains to be seen. Some state Medicaid agencies have drafted regulations to implement this and/or other provisions of the DRA. If history is the guide, some states will delay implementation for months or even years.

In states slow to implement the DRA, there is no clarity about the treatment of individuals who apply for Medicaid after January 1, 2006, while owning a residence with equity valued in excess of $500,000. Such applications will be routinely approved. Once the DRA is implemented, one can only speculate.

In the interest of administrative efficiency, such applications may be grandfathered, and eligibility will remain undisturbed even if the value of the residence exceeds the DRA cap. Other states may review such applications at the time of annual re-determinations of ongoing Medicaid eligibility. State agencies may deny ongoing eligibility, creating a difficult, challenging circumstance for elderly nursing home residents and for the nursing home itself. Facilities will then be deprived of a source of payment because such elders will be without funds, yet suddenly deprived of Medicaid eligibility because of illiquid home ownership interests.

What if a single individual owns a residence with an equity interest in excess of the cap? The DRA suggests two solutions, neither of which is practical or workable. The DRA specifically refers to a "reverse mortgage or home equity loan" to reduce equity interest to the point of eligibility. Either approach is likely to result in the loss of the residence.

Reverse mortgage contracts provide ongoing distributions to the individual only if she continues to reside in her residence. If, for example, a 75-year-old widow permanently leaves her $800,000 residence, and permanent departure is typically presumed if she has not been in the residence for one year, the loan obligation must be paid off in full. This can only be achieved by selling the house. This results in the conversion of a non-exempt

resource (the residence) into cash, a Medicaid-disqualifying resource. This widow must then pay the monthly cost of nursing home care out of her cash resources. Her home is lost.

A home equity loan is no better. If the same widow with an $800,000 residence instead obtains a home equity loan in the amount of $300,000, she must make payments on that loan if the house is to be preserved. She would be compelled to use the loan proceeds to pay for the cost of nursing home care while simultaneously making home equity loan payments. When her assets are exhausted and Medicaid eligibility is achieved, she has no money to satisfy the ongoing loan obligations. She will either obtain still another loan, typically at a very high interest rate, or be forced to sell the home. Ultimately, loss of the widow's family home, her legacy to her family, is assured.

Federal Medicaid legislation has long taken the position that one ought not to be able to simply give away all of his or her assets and immediately qualify for Medicaid.

This DRA provision is unduly burdensome and unnecessary. Existing law provides that each state Medicaid agency must establish a program to obtain reimbursement from the estates of Medicaid recipients at the time of their deaths. If an individual owns an exempt residence, a lien or an estate claim would be asserted and the state would be repaid for Medicaid dollars expended on her behalf. This approach, which avoids any fiscal damage to the Medicaid program, dramatically enhanced the ability of family members to raise money and save the family home.

Residents of states with modest property values will be little troubled by this change in the law. Countless others will suffer the loss of their residences, and family legacies, because of the DRA.

Consider the treatment of the residence in the nation's tax code. The residence enjoys protection on many levels, reflecting the nation's policy of supporting and reinforcing the concept of home ownership. Interest paid on mortgage obligations is tax deductible. Enormous capital gains tax protection is afforded homeowners of any age. An individual may sell her residence and protect the first $250,000 of gain from capital gains tax exposure. A married couple can protect the first $500,000 worth of capital gain. Yet the DRA punishes the most vulnerable among us, stripping them of support for home ownership, stripping them of the hope of returning home from a skilled nursing facility.

Asset Transfers and the "Look-back Period"

Federal Medicaid legislation has long taken the position that one ought not to be able to simply give away all of his or her assets and immediately qualify for Medicaid. It has allowed and continues to allow for certain exceptions, such as transfers to a spouse or to a disabled or minor child, among others. If an individual was in a nursing home and applied for Medicaid, he or she was required to disclose any asset transfers made within the prior 36 months. Certain transfers involving trusts were subject to a longer 60-month "look-back period." Generally speaking, this individual would be ineligible for Medicaid for the number of months the gifted money would have paid for nursing home care had she kept it.

The DRA extends the look-back period to 60 months in all circumstances. DRA § 6011. It casts a broad, over-inclusive net over those who routinely make gifts for charitable and family purposes and who will now be punished for their generosity. It applies to gifts made on or after February 8, 2006.

Consider a couple in their mid-60s who give a grandchild $24,000 to help him with a down payment on his first home. One year later, they make an $18,000 charitable gift to their church. Their assets consist of a residence and savings in the amount of $100,000. Assume further that, four years later, after the gifts had been made, the husband enters a nursing home after a debilitating stroke. How will these transfers affect his application for Medicaid?

Pre-DRA Law

Before the DRA, the look-back period was 36 months. Because the first gift was completed before the 36-month look-back period, it would be irrelevant. The second gift of $18,000 would be within the 36-month look-back period. The period of ineligibility flowing from this gift commenced on the date of the gift. In most states, an $18,000 gift would generate a three-month period of ineligibility. That period of ineligibility commenced on the date of the gift and expired three months after it was made. Appropriately, it would have no negative effect on today's eligibility for Medicaid.

New DRA Laws

Under the DRA, the result is markedly different. First, both gifts are within the five-year look-back period. Under the most restrictive interpretation of the DRA, they would be aggregated (added together), so the gifts would total $42,000. Rather than a period of ineligibility commencing on the date of the gift, the DRA period of ineligibility does not begin to run until the individual is in a skilled nursing facility or otherwise in need of skilled care, applies for Medicaid, and demonstrates that he would be eligible for Medicaid *but for* the gifts previously made.

A resulting seven- or eight-month period of Medicaid ineligibility would then commence, eliminating eligibility for that very lengthy period of time. In

eight months, the couple's savings would be virtually eliminated, leaving the wife at home without any liquid resources at all.

In addition, a second Medicaid application would have to be filed when the period of ineligibility runs its course. Additional costs to the elder and additional administrative burdens for the Medicaid program are endured.

Another analysis suggests that an application at the first stage may be unnecessary and that a subsequent showing of eligibility but for the gifts would suffice. State programs that adopt this approach would save a small fortune in administrative costs, but it remains unclear how this will be interpreted and implemented.

In other circumstances, there may be no assets to pay for the ongoing cost of nursing home care. Assume that a single elder made the same gifts to a grandchild and to her favorite charity. She gets to the point of Medicaid eligibility by having only $2,000 to her name *after spending all of her assets on the cost of her care.* Gifts made three and four years ago result in a multi-month period of Medicaid ineligibility at a time when she is destitute. If she has no assets and Medicaid is denied, one wonders how the cost of nursing home care will be paid. Nursing home administrators will have particular questions in this regard. Indeed, this provision of the DRA has been referred to as the Nursing Home Bankruptcy Act of 2005.

This problem is nominally acknowledged by the DRA, which allows the nursing home, with permission of the individual or the individual's personal representative, to file a hardship waiver on her behalf and receive payment for another 30 days. DRA § 6011(e)(1). Administrative action on hardship waivers within 30 days is highly unlikely, so even this safety valve will prove to be unsatisfactory.

An undue hardship exists when the asset transfer rules result in the denial of Medicaid eligibility and when the individual would therefore be deprived "of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life." Id. § 6011(d).

State Medicaid programs are to give notice of this undue hardship exception to applicants, and the state is to provide a timely process for determining the existence of an undue hardship. States must also establish a process for appeal of denials. Id. § 6011(d)(2).

Advocates have had long and painful experiences with undue hardship requests at the state level. It is notoriously difficult to win such appeals. They are often denied out of hand. Inevitably, however, undue hardship requests and appeals will emerge as an important area of practice. The long-term care industry will join with elder advocates in achieving this necessary outcome.

What is a nursing home administrator to do? A hardship waiver may or may not be successful. Payment may or may not be forthcoming. The nursing home may not evict a resident unless a safe alternative placement is available. Other nursing homes will not accept her because a payment source is not forthcoming and no other level of care is appropriate. Nursing home administrators are compelled to become advocates of careful planning on behalf of their residents. They must be as certain as possible that Medicaid eligibility will be achieved when a resident's assets are exhausted.

Will other programs at the state level be tapped on an emergency basis to pay the cost of nursing home care for destitute elders denied Medicaid coverage? Will the DRA 2005 end up actually increasing state Medicaid budgets?

When do the asset transfer rules go into effect? The presumptive date of implementation is February 8, 2006, the date the DRA was signed into law by President George W. Bush. As a matter of administrative reality, however, some states may rely on a later implementation date. Few states are expected to take the necessary legislative or administrative steps to implement the DRA within six to eight months of its passage. As a practical matter, the implementation of the new look-back period should have no effect until February 2009 and should not be fully phased in until February 2011. Nevertheless, some states have already indicated that they will apply the 60-month look-back period immediately despite the fact that the DRA does not apply to transfers before the date of enactment.

Treatment of Annuities

The DRA also changes the rules for annuities. It appears that the intent of the DRA was to treat the purchase of an annuity as an uncompensated

transfer of assets unless the state is named as the remainder beneficiary in the first position. If there is a community spouse or minor or disabled child, the state must be a remainder beneficiary in the second position. A close reading of the statute, however, suggests that the state need not be the remainder beneficiary so long as the annuity (1) is irrevocable, (2) is nonassignable, (3) is actuarially sound, and (4) provides for equal payments during the term of the annuity. Additional exceptions apply for annuities described in subsection (b) or (q) of Code § 408, or for those annuities purchased with proceeds from an account or trust described in subsections (a), (c), or (p) of Code § 408, a simplified employee pension (under Code § 408(k), or a Roth IRA, described in Code § 408A). Despite

this statutory language, the Center for Medicare and Medicaid Services (CMS) has informally indicated that it will require the state to be named as the beneficiary for all annuities; otherwise the purchase of an annuity will be penalized.

In addition, the DRA imposes certain disclosure requirements for annuities regardless of whether they are treated as penalized transfers. Under the DRA, applicants for Medicaid are required to disclose "any interest (or that of a spouse) in an annuity (or similar financial instrument that may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset." Moreover, the state then is required to notify the issuer of the annuity of the state's preferred status. The state also may require issuers of annuities to notify the state of any change in the amount of income or principal being withdrawn after the date of the most recent disclosure. These provisions apply to transactions (including the purchase of an annuity) occurring on or after the date of enactment of the DRA.

Partial Months of Ineligibility

Before the DRA went into effect, and until appropriate state action is taken, monthly periods of ineligibility were "rounded down" in many states. If a particular gift generated a 3.9-month period of ineligibility, for example, the resulting period of ineligibility would be three months. Under provisions of the DRA, states will impose partial months of ineligibility. A 3.9-month period of ineligibility would therefore result approximately in a three-month and 27-day period of ineligibility. The DRA specifically states that "a State shall not round down, or otherwise disregard any fractional period of ineligibility . . . with respect to the disposal of assets." DRA § 6016(a).

Treatment of Multiple Transfers

States are given the power to aggregate multiple, separate asset transfers made within the applicable look-back period. Importantly, this is neither automatic nor mandated. States may or may not choose to take this approach. Id. § 6016(b). This has already been the law in most states. Arguably, it allows for separate treatment of individual gifts by specifically making the adoption of this approach optional.

The theory and practice of multiple gifts envisions gifts made in a number of different months, for example, within the look-back period. A gift of $12,000 in month one would generate a two-month period of ineligibility in many states. A gift of $12,000 in month two would, in the absence of aggregation, generate its own, separate two-month period of ineligibility.

Medicaid eligibility rules were not designed to impoverish and limit the economic viability of the spouse living at home when the other spouse was institutionalized.

Because the first penalty period overlaps with a portion of the second period of ineligibility, the resulting penalty period would be only three months, rather than four. This has obvious asset preservation implications. If states choose to mandate the aggregation of gifts, these two gifts would be combined and the period of ineligibility would be four months. Until it is implemented, and in the event that a particular state does not already mandate aggregation, multiple gifting would seem to be available.

Reducing Asset Protection for the Spouse at Home

Previous Medicaid legislation was rather explicit in providing that Medicaid eligibility rules were not designed to impoverish and limit the economic viability of the spouse living at home when the other spouse was institutionalized.

When one spouse is in a nursing home, he can have very modest assets (approximately $2,000) in his name if he is to qualify for Medicaid coverage. The spouse at home has enjoyed a modest level of asset protection from the Community Spouse Resource Allowance (CSRA), which allows that spouse to retain a certain level of assets at the time her institutionalized spouse qualifies for Medicaid. The CSRA was initially capped at $60,000, but annual adjustments now place the CSRA at $99,540 in most states. 42 U.S.C. § 1396-5(f)(2)(A).

Federal legislation has also provided that the CSRA can be increased for the benefit of the spouse at home when appropriate for her support. 42 U.S.C. § 1396r-5(f). Such increases are by no means automatic. One approach that has been available under federal law is to justify an increase in the CSRA when the community spouse (the spouse living at home) has very limited income. Indeed, Medicaid legislation also provides for a minimum level of income that is to be guaranteed to the spouse living at home when her institutionalized spouse qualifies for Medicaid. Known as the Minimum Monthly Maintenance Needs Allowance (MMMNA), the spouse at home is currently guaranteed a maximum of $2,489 per month, hardly lavish living by today's standards.

When the community spouse's personal income is extremely limited, such as to a $500 per month Social Security check, it has been possible in some circumstances to justify an increase in the CSRA on grounds that her income—exclusive of her spouse's income—is so limited that she would be at particular risk on her spouse's death when she could also be deprived of his pension.

For example, a couple's combined monthly income is $2,500, in excess of the $2,489 MMMNA. If all income is attributed to the community spouse, her CSRA could not be

increased. If her institutionalized spouse's income is ignored, however, her income is so modest as to justify an increased CSRA so that additional assets would generate additional income that would be secured for her future. In some cases, this could justify a modest increase in the CSRA.

The DRA eliminates this approach by imposing an "income first" requirement. DRA § 6013; 42 U.S.C. § 1396r-5(d). It requires the inclusion of the institutionalized spouse's income in determining whether or not the community spouse's income achieves the federally mandated minimum income. By depriving elders of this approach, modest levels of income protection for truly needy elders are eliminated. Although other approaches to increasing the CSRA still exist, an appropriate and little-used approach is eliminated with minuscule benefit to the Medicaid system.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) are the retirement housing choice for increasing numbers of America's elders. Also known as "life care communities," CCRCs typically provide three levels of care. Initially, an independent living apartment is enjoyed. When needed, assisted living is available. The highest level of care is the nursing home level, typically known by some euphemism as "The Health Center," or "the Magnolia Wing." Some CCRC communities allow Medicaid reimbursement for nursing home services if an individual qualifies. Qualifying will now be difficult.

The DRA provides that assets paid to the CCRC as an entrance fee may be deemed available to the individual and therefore disqualifying for Medicaid because a single individual can typically have no more than $2,000 in countable assets. Id. § 6015(b). If assets deposited with the CCRC or paid as an entrance fee can be used by the resident to pay for the cost of care if other assets are unavailable, all such assets will count for Medicaid eligibility purposes and result in rejection. For this provision to apply, the individual must also be able to obtain a refund if she leaves the CCRC or on her death and if the payment does not confer an ownership interest in the community.

Most new CCRCs do not accept Medicaid reimbursement, so these provisions will have decreasing relevance. Many older communities, typically run by religious and/or nonprofit organizations do accept Medicaid.

In a reversal of law and policy, the DRA also provides that CCRC contracts may require individuals to exhaust all resources they had at the time of application and admission before they can apply for Medicaid coverage. Id. § 6015(a). Anti-alienation (anti-transfer) provisions are common in such contracts. Previously deemed unenforceable by at least one state appellate court, the DRA now, and explicitly, allows enforcement. *Oak Crest Village, Inc. v. Murphy*, 841 A.2d 816 (Md. 2004).

The DRA calls for the expansion of programs that offer long-term care insurance in conjunction with state-approved Medicaid programs.

Long-term Care Insurance "Partnership" Programs Emerge

As the DRA focuses on restricting access to Medicaid, it simultaneously elevates the role of long-term care insurance. More specifically, it calls for the expansion of programs that offer long-term care insurance in conjunction with state-approved Medicaid programs. DRA § 6021.

Currently, only four states offer such partnership programs, which were created as an initiative of the Robert Wood Johnson Foundation. These states are California, New York, Indiana, and Connecticut. They seek to incentivize the purchase of long-term care insurance by allowing a dollar-for-dollar benefit. For example, a Californian may purchase a partnership plan that offers $75,000 in long-term care insurance benefits. If that individual enters a skilled nursing facility and exhausts the benefits, he will be allowed Medicaid eligibility while retaining $75,000 in liquid assets. This is to be compared with the typical asset eligibility criterion of only $2,000.

As other states develop partnership plans, many requirements must be satisfied as a pre-condition. For example, the policy must be a "qualified long-term care insurance policy" as defined in Code § 7702B(b), and it must include significant inflation protection. Significant reporting responsibilities are integrated into this initiative.

Conclusion

To a very large extent, passage of the DRA was an achievement by deeply partisan politicians and the long-term care insurance industry. Supporters of the DRA and others who attack attorneys who advocate for the rights of America's elders have successfully distracted Congress from the real issue and the real culprit: the horrific and economically unmanageable cost of long-term health care.

Advocates of elders must go beyond the DRA, work with its terms, and proactively craft solutions that meet the clients' needs. Planning must itself become long-term. It must focus on the many areas of asset protection planning that were unchanged by the DRA as it responds to a new, post-DRA reality. ■