Asset Protection Planning

Medicaid and the Deficit Reduction Act of 2005

By Michael Gilfix and Bernard A. Krooks

When President Bush signed the Deficit Reduction Act of 2005 (DRA) on February 8, 2006, a stated goal was to reduce the federal Medicaid budget by $5 billion over the next 10 years. The law's supporters view the changes as a way to reduce expenses and close loopholes. Its opponents see the measure as placing a unfair burden on older Americans, because it will make it harder for them to receive assistance from Medicaid when they face the substantial cost of nursing home care.

The DRA has been implemented in all but a handful of states. Nevertheless, it remains to be seen how specific DRA provisions will be interpreted in practice.

Financial planners must consider this time to be a transition period. The DRA has yet to be consistently implemented, and the harshest critic of the DRA legislation, the Democratic party, is now in control of Congress. The DRA passed into law by the narrowest of margins; the Senate vote witnessed a 50–50 tie, with Vice President Cheney casting the tie-breaking vote. In the House,

the DRA became law by a 216–214 vote. It is therefore possible that selected provisions of the DRA may be amended or repealed in coming years.

The Critical Role of CPAs

Because tax preparers generally meet with individuals annually, they are more likely to become aware of the need for long-term care and asset-preservation planning than other professionals, such as an individual's attorney. If significant health issues arise, a CPA may be in a position to raise issues of tax deductibility of medical expenses, as well as other long-term care planning issues. It becomes an opportunity for affirmative, protective planning. If necessary, CPAs can also play a role in referring individuals to an attorney specializing in eldercare law.

While CPAs need not become fluent in the intricacies of federal Medicaid law, they should be aware of major changes, such as the DRA, in order to develop a sound elder-care plan. The most relevant provisions of the DRA are noted below, along with the steps that can be taken to protect an individual's assets if threatened by long-term care costs.

Legislative Background

Medicaid is a government program designed to ensure the delivery of fundamental healthcare services to elders, individuals with disabilities, and others who would otherwise be deprived of such care. Significantly, Medicaid is the only federal program that can pay all or a portion of the cost of long-term nursing home care.

Many elders and some financial advisors mistakenly believe that Medicare pays the ongoing costs of a nursing home. As a result, many elders fail to save for these costs or obtain long-term care insurance. Without planning or insurance, elders may have to pay $6,000–$15,000 per month out of their own pockets. This has given rise to last-minute attempts to access government-financed healthcare.

Medicaid is a needs-based program. Depending on the approach taken in a particular state, an individual must have extremely limited assets (typically between $2,000 and $4,500) to qualify. In other states, there also is an income test, and if the individual's income exceeds a nominal amount (approximately $1,900 per month), Medicaid is presumptively denied, notwithstanding the individual's inability to pay for the cost of care.

Before the DRA, the Omnibus Budget Reconciliation Act of 1993 (OBRA) set forth the rules with regard to Medicaid eligibility and restrictions with regard to asset transfers. The DRA significantly changed many of those rules. Despite the DRA's restrictions, with proper planning assets can be preserved while qualifying for Medicaid.

Change in Asset Transfer Rules

Before the DRA, asset transfers presumptively resulted in a period of Medicaid ineligibility if they were for less than fair market value. If a gift was made within the prior 36 months (the look-back period), it would generate a period of Medicaid ineligibility. A gift made 12 months prior to admission to a nursing home in the amount of $15,000, for example, would have generated a three-month period of ineligibility if the state's average cost of care was $5,000. Note that such a gift would present no barrier to eligibility if the application had been filed at the time of institutionalization, because the period of ineligibility commences on the date of the gift. So this three-month period of ineligibility would have run out nine months beforehand.

Under the DRA, the period of ineligibility commences not on the date of the gift, but on the date that the individual would already be receiving institutional care (presumably in a skilled nursing facility), has applied for Medicaid, and has demonstrated eligibility but for the gift previously made. This look-back period has also been extended to 60 months. Regardless of whether the $15,000 gift was made one year ago, three years ago, or up to five years ago, it would generate a three-month period of ineligibility commencing on the date of application for a nursing home resident.

If an individual is denied Medicaid for three months and has no money to pay the private cost of care, the nursing home is left "holding the bag." It has no source of reimbursement, and is deprived of the opportunity to transfer the resident from the facility, because no other nursing home would accept her. Such a scenario led the authors to refer to the DRA as the "Nursing Home Bankruptcy Act of 2005" in a prior work (Michael Gilfix and Bernard A. Krooks, "Throw Mama from the Train: The Deficit Reduction Act of 2005 Abandons Our Nation's Elders," *Trusts & Estates*, March 2006).

To better understand the impact of this provision in the DRA, consider the following example: A grandmother gifts $25,000 gift to a grandchild to make the down payment on a new house. If the gift was made on or after February 8, 2006 (the implementation date of the DRA transfer rules), she would be denied Medicaid eligibility for five months using the prior assumption, if she applies within five years of making the gift. The law previously provided that transfers made without any intention to qualify for Medicaid coverage are to be excused; while this continues to be the case, state Medicaid programs have consistently rejected this defense, notwithstanding evidence of innocent intent.

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The DRA acknowledges such problems by allowing an "undue hardship" showing that can result in eligibility, notwithstanding asset transfers that would deny eligibility. Undue hardship is established when the application of the transfer of asset provisions would deprive the individual of medical care such that the individual's health or life would be endangered, or such that the individual would be deprived of food, clothing, shelter, or other necessities of life.

The undue hardship concept is by no means new, yet advocates across the country report that state Medicaid programs consistently and perfunctorily deny undue hardship defenses and assertions. Moreover, state Medicaid programs are notoriously slow in ruling on such claims, wth some cases taking over a year.

The DRA does allow a nursing home to file an undue hardship claim if it has the consent of the resident or the resident's representative. The mere filing of the claim may result in Medicaid approval for a period of up to 30 days. Given the typical delays in processing undue hardship claims, this is a modest reprieve. The DRA calls for enhanced procedures to ensure a timely response and the right to appeal, but only time will tell what comes of it.

Practice point. Unless individuals have long-term care insurance or are able to self-insure, the DRA must be kept in mind when answering questions about the implications of gifting. The $12,000 annual gift tax exclusion does not apply to Medicaid planning. Middle-class clients, in particular, must be advised of the Medicaid implications of such gifts. An amount of $48,000 in gifts made to four individuals will typically be aggregated, resulting in an initial Medicaid period of ineligibility. This will remain a serious problem for the five-year look-back period.

Note that there is no exception for charitable gifts. Under the DRA, a gift to a charitable organization would affect Medicaid eligibility, unless it can be proven that the gift was not made for such purposes. Many states have already implemented waivers for "de minimus gifts" (e.g., $500 or less).

Protected Transfers Remain Intact

The DRA makes no changes in certain provisions of OBRA that allow gifts to identified categories of individuals. For example, any amount of money can be gifted from one spouse to another, or to a child who is blind or disabled. A residence may still be transferred to a spouse, a minor, a blind or disabled child, a sibling who has any equity interest in the residence and has lived there for a year beforehand, or a caretaker child. To qualify for the caretaker child exception, the child must have lived in the residence with the parent for at least two years immediately prior to when the parent entered the skilled nursing facility.

Assault on Home Ownership

Medicaid has long allowed an individual to retain home ownership without imposing any barriers to eligibility. A residence of any value has been "exempt" and excluded when determining eligibility. The DRA very dramatically changes this rule.

The DRA allows a residence to be exempt for the noninstitiutional spouse (i.e., the community spouse) only if the nursing home resident's equity interest in the home is under $500,000. The states have the option of increasing this limit up to $750,000, and a few states have opted for a higher limit.

In some regions, it can be difficult or impossible to find a residence that is valued as low as $500,000. (In the San Francisco Bay Area, for example, the median home value is $800,000.) Virtually all elderly homeowners in such expensive real estate markets are therefore threatened with the loss of their residence if they cannot otherwise pay the cost of nursing home care. The DRA acknowledges that this provision presents a problem, but merely offers alternative solutions, such as a reverse mortgage or a home equity loan.

Annuities

Annuities have long been utilized as a means of protecting some portion of an elder's estate when nursing home care becomes unavoidable. The DRA solidifies the role of annuities so long as several requirements are satisfied.

The purchase of an immediate annuity (i.e., with no cash surrender value) is not a transfer because fair market value is received in return. An appropriately crafted annuity must be "actuarially sound," providing for equal monthly payments scheduled within the life expectancy of the annuitant, as prescribed by the Centers for Medicare and Medicaid Services (CMS; www.cms.hhs.gov).

The state Medicaid program must be named as the primary remainder beneficiary, to the extent that Medicaid benefits have been paid for the benefit of the annuitant.

MEDICAID STRATEGIES POST-DRA

Once the DRA is fully implemented, Medicaid and asset-preservation strategies will fall into two categories. The first contains the many strategies that were effective before the DRA and remain so. The second contains the strategies that will flow from and respond to the changes wrought by the DRA.

Pre-DRA Strategies That Remain Viable

- Gifting any assets to a spouse, a blind or disabled child, or a minor child
- Gifting the residence to a spouse, a blind or disabled child, a minor child, a caregiver child, or a sibling with an equity interest
- Court petition or fair hearing to increase the community spouse resource allowance (CSRA) and minimum monthly maintenance needs allowance (MMMNA)
- Spousal refusal
- Converting nonexempt, unprotected assets into exempt resources
- Irrevocable burial trusts

Strategies Responding to Post-DRA Changes

- The use of DRA-compliant annuities and promissory notes
- Advance gifting and trust utilization
- Expanded use of personal services agreements
- Increased reliance on long-term care insurance
- Use of evolving home loan products along with deferred repayment options
- Purchase of a life estate in the residence of a child
- Medicaid grantor-retained annuity trusts (GRAT), an evolving approach using discounts to remove assets from an estate

Example. A single individual is entering a nursing home and has $100,000. Upon entry, she gifts $50,000 to her children. She also purchases a $50,000 annuity that satisfies all the DRA's requirements. She structures her annuity to last for 10 months, which is the period of ineligibility resulting from the $50,000 gift. She then applies for Medicaid. Because she is now penniless, she will be determined eligible for Medicaid but for the $50,000 gift. Because she satisfies all of the prerequisites—she is in the nursing home, applies for Medicaid, and is otherwise eligible—the period of ineligibility commences immediately and will last for 10 months. Upon the expiration of the 10-month period of ineligibility, her annuity will be exhausted and Medicaid eligibility will commence. Proper planning allowed this individual to save $50,000 for the benefit of her children.

Long-Term Care Insurance

The DRA provides for the dramatic expansion of long-term care insurance partnership programs. Originally developed by the Robert Woods Johnson Foundation, such programs, before the DRA, were firmly established in only four states: California, Connecticut, Indiana, and New York. Since the passage of the DRA, many other states have filed plans for the implementation of long-term care insurance partnership programs.

These plans are designed to induce elders to purchase long-term care insurance by protecting their assets (resources) and income, up to 25% above the community spouse allowance.

The California plan allows an individual to protect assets while qualifying for Medicaid if a partnership policy was purchased and its benefits exhausted. For example, an individual might purchase a policy that provides for $150,000 in long-term care insurance benefits. If she enters a skilled nursing facility and exhausts her $150,000 policy, she will be allowed to retain $150,000 in nonexempt assets while qualifying for Medicaid. If she did not have a partnership plan, she would be denied Medicaid eligibility until her assets were reduced to approximately $2,000. Moreover, this $150,000 would be protected from any lien or estate claim that might be asserted by the state at the time of her death. (All states are federally mandated to have "estate recovery" programs to recover costs from the estates of deceased Medicaid recipients.)

The authors believe that the DRA is a positive step for the growth of long-term care insurance. It calls upon the National Association of Insurance Commissioners (NAIC) to assist state Medicaid programs in developing uniform standards. This should enhance the likelihood that partnership plans will be portable across state lines, which removes a major deterrent to the success of partnership plans.

Continuing Care Retirement Communities

Life care communities, generically known as continuing care retirement communities (CCRC), are upscale facilities that typically offer three levels of care: independent living, assisted living, and nursing care. The DRA affects CCRCs in two ways.

The first change reflects successful lobbying by the CCRC industry to effectively overturn a Maryland court case. In *Oakcrest Village Inc. v. Murphy* [379 Md. 229 (2004)], provisions in a CCRC contract that prohibited a resident from transferring assets before applying for Medicaid coverage were ruled a violation of federal Medicaid law, which provides that a Medicaid-certified provider of long-term care may not condition entry upon a promise to pay the cost of care privately for a certain period of time. The CCRC provision in question had precisely this effect. The DRA provides that such anti-alienation contractual provisions are enforceable and do not violate Medicaid law. Such CCRCs may, therefore, require the exhaustion of all assets declared upon entry before a Medicaid application may be successfully filed. The impact of this provision is limited in practice, because most CCRCs do not accept Medicaid. Those that do are typically religious-based or nonprofit in nature.

The second provision in the DRA related to CCRCs allows a Medicaid program to count the funds conveyed to the CCRC upon entry as available assets, if the individual can use the funds to pay for the cost of care in the CCRC if she is otherwise unable to do so, if a refund will be provided upon death or termination of care, and if no ownership interest in the community is conveyed by virtue of the entrance fee.

Practice point. CPAs can and should review the financial statements of CCRCs when elders consider a lifetime's investment in such a community. Some life care communities have gone bankrupt in prior years, leaving elders without assets and with little recourse. The authors routinely advise such individuals to have their accountants review the CCRC balance sheets. This presents an opportunity to advise or warn elders about some typical problems in CCRC contracts that relate to the quality of life. For more information, see Michael Gilfix and Bernard A. Krooks, "Continuing Care Retirement Communities: Issues for Elder Law Attorneys," *The Elder Law Report* (April 2006).

A Starting Point

While it mandates a number of restrictive changes, the DRA does not represent a paradigm shift in the world of Medicaid and asset-protection planning. Beyond the scope of this article is a delineation of the planning steps that remain available to protect assets if an elder enters a skilled nursing facility, as well as a detailed analysis of those options under the laws and programs of each state.

Advisors must nevertheless be aware of how the DRA narrows the asset transfer rules, the requirements with regard to annuities, the allowances for home ownership, and the ability to retain other assets. Elder-law attorneys and competent insurance professionals, specializing in elder-care issues, are helpful partners in a financial advisor's efforts to protect elderly individuals. ❑

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