

## Throw Mama From the Train

The Deficit Reduction Act of 2005 abandons our nation's elders

It just got harder to be old and anything short of wealthy. Chapter 2 of the new Deficit Reduction Act of 2005 (DRA) focuses exclusively on “long-term care under Medicaid” and seeks to make it much harder for elders to protect any assets if they are to receive assistance from the federal Medicaid program while in skilled nursing facilities.

Adopted in the U.S. Senate by a margin of 51-50 (because Vice President Dick Cheney cast a deciding vote), and adopted in the House by the minuscule margin of 216 to 214, the legislation is fiercely partisan: Not a single member of the Democratic Party voted for it in the House. President Bush signed the DRA into law on Feb. 8.

One transparent purpose of the DRA’s “long-term care under Medicaid” chapter is to trim Medicaid rolls. The legislation is designed to make it more difficult for elders who need long-term care to qualify for the program. Given the harsh and perhaps draconian nature of some provisions, this objective will no doubt be achieved.

Another purpose of the legislation is to increase the sales of long-term care insurance products. We expect this goal will be achieved as well. Government will pay less, private industry will sell more—but what will happen to the elderly? Many will be abandoned. And we’re not just

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talking about the poorest of the poor. Many more middle-class elderly who exhaust their assets will be denied Medicaid because, for example, they inadvertently gifted in previous years, for purposes that had nothing whatsoever to do with asset preservation or Medicaid eligibility. Also, many skilled nursing facilities will be put in an untenable position. They either will have to provide care to individuals who cannot pay and are not Medicaid-eligible, or they'll be forced to discharge such residents. And when these elderly are put out of nursing homes, then what?

This is not just an issue for the middle class and the poor. It's an issue for all Americans with a conscience.

### DRAMATIC CHANGES

Perhaps one of the most dramatic changes is what's been done to the penalty period. Since passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), the "look-back period" has been 36 months or, in the case of transfers to or from certain trusts, 60 months.<sup>1</sup> The look-back period is important because it may identify asset transfers that, if made for less than fair market value, create a period of Medicaid ineligibility.

If an individual is in a nursing home and applies for Medicaid under pre-DRA law, and assuming that he made a gift within the preceding 36-month period, he'll be ineligible for Medicaid for the number of months the gifted money would have paid for care had he retained the funds. A \$10,000 gift made one year ago, for example, would create about a two-month period of ineligibility in most states. Very importantly, that period of ineligibility started on the date that the gift was made. In other words, this person would be ineligible for Medicaid for the two-month period following the date of the gift, which was 12 months ago. His period of ineligibility would have expired 10 months ago; thus the gift would not affect his current application for Medicaid.

The DRA changes this. The extension of the look-back period from 36 months to 60 months would not be so bad if, as under

pre-DRA law, the ineligibility period began on the date of the transfer. Instead, the DRA takes a punitive approach that will severely impact the ability of seniors to access government-financed health care.

Under the DRA, the period of ineligibility starts on the date when the individual is in the skilled nursing facility, applies for Medicaid, and proves that he would have been eligible but for the application of the penalty period.<sup>2</sup>

Fortunately, the DRA is crystal clear in stating that pre-DRA law applies to all transfers made before the date of enactment of the DRA.<sup>3</sup>

Applications made in June 2007, for example, will be unaffected by transfers made in April 2004 because such transfers, (1) were made before DRA's enactment, and (2) were effected more than 36 months before the date of application.

These new provisions will be a formidable trap for the innocent and the unwary. Consider the grandmother who, four years before her stroke and placement in a nursing home, made a \$40,000 gift to her granddaughter to help her granddaughter purchase a first home. Under pre-DRA law, that gift might have generated an eight-month period of ineligibility. That period would have started on the first day of the month in which the transfer was made.<sup>4</sup> Her period of ineligibility would have expired about eight months after making the gift. Medicaid eligibility for this now-destitute octogenarian for Medicaid would be granted.

But if this gift is made after the DRA's implementation date, it would result in a denial of eligibility. She'd apply for Medicaid and it would be determined that, but for the gift made four years ago, she would be eligible. Now, though, the eight-month period of ineligibility starts the month when she would otherwise have been eligible and is receiving skilled nursing care. She is already in a nursing home, destitute, and facing an eight-month period of ineligibility. She has no funds and Medicaid is denied. The nursing home will be stuck caring for a resident with no source of payment. Perhaps the DRA of 2005 should be renamed the "Nursing Home Bankruptcy Act of 2005."

Nursing facilities will get caught in the middle: forced to care for elderly who can't pay, or try to move them out—but where to?

Realistically, of course, nursing homes cannot be compelled to provide care without compensation. It's also an inescapable conclusion that safe, alternative placement options will simply not exist in most cases. States may therefore have no choice but to pay for long-term care out of other budgetary sources. So perhaps the DRA should be renamed the "State Budget Busting Act of 2005."

Also consider the individual who makes a \$15,000 donation to his local charity in April 2006. In February 2011, that same individual is suffering from Parkinson's disease and requires long-term care in a nursing home. All of his assets have been spent on his care at home and thus he would otherwise be eligible for Medicaid coverage in a nursing home. But the \$15,000 gift to charity almost five years earlier triggers a three-month penalty period starting when he goes into the nursing home. Unfortunately, he has no assets to pay for the cost of his care during this three-month period and he will either be denied admission to the nursing home or the nursing home will not be reimbursed for his care during that period. It is anticipated that the DRA will have a chilling effect on charitable giving by seniors for fear that they may need long-term care at some future date. So perhaps the DRA should be renamed "The Charity-Chilling Act of 2005."

There may be some solace in that Section 6011(d) of the DRA requires states to include a "hardship waiver process" in accordance with pre-existing federal law.<sup>5</sup> An "undue hardship" would be established when the application of the new transfer of assets provisions would deprive the individual "of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life."

States are required to give notice to recipients of the undue hardship exception, provide a timely process

for determining when hardship waivers will be allowed, and establish a process for appeal.<sup>6</sup>

But don't be fooled by this escape hatch. Experienced advocates know that "undue hardship" waivers, which have been encoded in federal legislation for years, traditionally have been elusive, at best. It's not uncommon for such waiver requests to be routinely denied without even the pretense of a hearing. Still, such hardship waivers inevitably are going to have to play a major role in coming years. Given the extensive five-year look-back period, there will be many elders who transfer funds to children, grandchildren, and charities for reasons that have nothing to do with Medicaid eligibility. Indeed, there is even a new provision that permits nursing homes to file for undue hardship waivers on behalf of a resident with the consent of the individual or the personal representative of the individual. When a waiver request has been appropriately filed, states may provide payment for up to 30 days to hold the bed for the elder.

### EFFECTIVE DATE?

When will this new look-back period and these penalty period computations go into effect? The answer to this critically important question is unclear. The new look-back period applies to transfers made on or after the date of enactment.<sup>7</sup> Presumably, that's when the president signed the DRA into law on Feb. 8.

But Section 6016(e) of the DRA has a somewhat different effective date provision. Section 6016 deals with additional reforms of Medicaid asset transfer rules, such as partial months of ineligibility, the aggregation of multiple gifts, limitations on certain notes and loans, and the treatment of life estate purchases. It leaves open the possibility that state legislative action may be required before its provisions go into effect. These aspects of asset transfers may continue to be analyzed under pre-DRA law until the earlier of

state legislative action or the first day of the first calendar quarter that begins after the close of the first regular session of the appropriate state legislature that begins after the date of enactment. Section 6016(e) effectively imposes a one-year limit, stating that states with a two-year legislative session shall nevertheless be deemed as having one year to act for purposes of these provisions.

Perhaps unfortunately, this determination will not be up to state Medicaid programs. Rather, this potential and necessary delay in implementation will occur only in states where the U.S. Secretary of Health and Human Services determines that a particular state plan, as the DRA puts it, "requires State legislation in order for the plan to meet the additional requirements" imposed by Section 6016.

### ANNUITIES

The DRA also changes the rules for annuities. Under the DRA, the purchase of an annuity is presumptively deemed a "disposal of assets" that is subject to the imposition of a period of ineligibility, unless the state is named as a remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or the state is named as a remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such individual disposes of such remainder interest for less than fair market value.<sup>8</sup>

In addition, the annuity must be irrevocable and non-assignable, actuarially sound, and provide for equal payments during the term of the annuity with, the DRA states, "no deferral and no balloon payments made." Thus, a balloon annuity or an annuity providing for deferred payments will be treated as an uncompensated transfer of assets and be subject to the penalty period provisions of the DRA even if the

state is named as a remainder beneficiary in the first position.

Exceptions apply for annuities described in sub-section (b) or (q) of Internal Revenue Code Section 408, or for those annuities purchased with proceeds from an account or trust described in sub-sections (a), (c), or (p) of IRC Section 408, a simplified employee pension (under IRC Section 408 (k) or a Roth IRA described in IRC Section 408(A)).

The DRA requires the applicant for Medicaid 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.”<sup>9</sup> In addition, 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 if there is 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.

### FORCING HOME SALES

Before the DRA, a residence of any value was an “exempt resource.” This means that its value was simply ignored in determining eligibility. So long as an individual, spouse, or siblings or children in limited circumstances were still residing in the residence, or an institutionalized homeowner maintained the “intent to return home,” the house retained its exempt status and was not a barrier to Medicaid eligibility. The lack of a cap on the value of a residence was realistic, given the enormous variety in average home prices in different parts of the country.

As a matter of public policy, the average \$200,000 residence in Michigan was given the same level of protection as an \$800,000 house in

Connecticut or California. Public policy was clear: Elders should not be disrupted and compelled to sell their residence as a condition of eligibility. This treatment was consistent with our nation’s tax policy, which encourages home ownership and protects substantial gain from capital gains tax exposure.

The DRA imposes a \$500,000 cap on the value of an exempt residence when the owner is institutionalized in a nursing home.<sup>10</sup> States are given the option of increasing the level of protection to no more than \$750,000. These values will increase annually with the Consumer Price Index commencing in 2011.

Fortunately, there are exceptions. When an individual’s spouse or his minor, blind or disabled child is living in the residence, this cap will not apply. It will, however, apply to single elders, most of whom will be women with no living spouse. The home equity cap provisions apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after Jan. 1.<sup>11</sup>

This provision of the DRA specifically references a “reverse mortgage or home equity loan” to reduce the equity interest in the home. The use of a reverse mortgage could be catastrophic and may result in the forced sale of the residence. Virtually every reverse mortgage contract calls for acceleration and complete payment of total indebtedness when an individual has ceased to reside permanently in her home. This is typically a maximum of one year after an individual moves out of the home for any reason.

Satisfaction of the loan will compel a sale that, in turn, results in cash proceeds then being in the name of the institutionalized individual. Deprived of any exempt asset (the residence), the individual will have countable or includible assets well in excess of the

allowable limit (typically \$2,000) and be denied Medicaid coverage. Her entire estate may then be dissipated.

A home equity loan will have the same result, given the immediate repayment responsibility and the inevitable inability of net rental income (assuming viability of renting) to service any home equity loan. Again, forced sale will be inevitable and the entire value of the residence will be lost.

This provision is aimed at the individual who resided in a “million dollar house” and who somehow, therefore, ought not to receive any protection or support from the Medicaid program. But state Medicaid programs have long been protected in such circumstances by their right to assert estate claims on the estates of deceased Medicaid recipients or to impose liens on Medicaid-exempt residences. In other words, state Medicaid programs have been able to recover benefits paid and have collected hundreds of millions of dollars in this way. But at least they waited until the individual was deceased and clearly had no further use for their home.

The plight of a 68-year-old widow, a resident of San Jose, Calif., painfully makes the point. Afflicted with both diabetes and polio, she is extremely limited in mobility. She receives assistance from a state program that provides limited in-home care and receives help from family members. Her eventual placement in a skilled nursing facility is a virtual certainty.

Her only asset is her residence, worth perhaps \$700,000. Even in her lower-middle-class community, this is the average home value. As she’ll be entering a skilled nursing facility after Jan. 1, the value of her residence will preclude Medicaid eligibility. Either a reverse mortgage or a home equity loan will, inevitably, cause the loss of her only asset, an asset she acquired after a

lifetime's labor. This loss should be considered in the context of the Bush administration's overall tax, entitlement and fiscal policies. The administration relentlessly advocates the elimination of the estate tax because it doesn't want to force the sale of a parent's business to pay taxes. But the President doesn't hesitate to force middle- and lower-middle-class families to sell their primary asset, the parent's home, before allowing any degree of assistance from the Medicaid program.

It also should be noted that reverse mortgages are unavailable to individuals who are no longer living in their homes. Individuals who enter nursing homes and have equity in excess of \$500,000, therefore, will have absolutely no opportunity to obtain reverse mortgages, notwithstanding the explicit suggestion in the DRA that they do so.

We also wonder what types of home equity loans will be available to isolated elders who are denied Medicaid because of the value of their homes. They have no income that can be used to repay such loans. Far too many will have no loved ones to protect their interests. Historically, the secondary market of lenders has taken advantage of vulnerable elders, loaning money with excessive closing costs and at high rates, knowing that the elderly homeowner will be unable to make payments. This ultimately results in the loss of the elder's home. Foreclosure will be inevitable.

## INSURANCE

The Republicans are privatizing elder care not only by forcing home sales but also by forcing a move to long-term care insurance. But "private" does not necessarily mean "better."

Subchapter B of the "Long-Term Care Under Medicaid" chapter of the DRA is extensive. It reflects the DRA's rather explicit elevation of long-term care insurance as it seeks

to diminish the role of Medicaid in paying the cost of long-term care for older Americans.

The State Long-Term Care Partnership Program was initiated many years ago with assistance from a grant from the Robert Wood Johnson Foundation. It was designed to encourage individuals to purchase long-term care (LTC) insurance by providing such purchasers with an elevated level of asset protection. The program was curtailed with the enactment of OBRA-93. But four states—California, New York, Connecticut and Indiana—have partnership programs that were grandfathered at that time.

Generally, these policies provide that purchasers of partnership long-term care insurance policies can shelter, dollar for dollar, funds received or utilized through the LTC policy.<sup>12</sup> For example, if a policy provides an individual with \$100,000 worth of coverage and the individual exhausts the policy limits, he will be allowed to qualify for Medicaid while retaining \$100,000, rather than the presumptive level of \$2,000. Such protected assets also are shielded from Medicaid estate claims at the time of the Medicaid recipient's death.

The policies have not enjoyed consistent levels of success, in large part because other long-term insurance policies seemed more attractive and competitive to consumers. In a clear victory for the long-term care insurance industry, the DRA seeks to shift greater responsibility to the private sector and concomitantly, dollar for dollar, diminish the role played by Medicaid.

The protection of assets we've just described is allowed only if seven requirements are satisfied:

(1) The partnership policy must cover an insured who is a resident of the state when coverage first became effective.

(2) The policy must be a "qualified long-term care insurance policy" as defined in IRC Section 7702B(b). The

policy must not be issued earlier than the effective date of the state plan amendment allowing for partnership LTC policies.

(3) The policy must satisfy or comport with sections of the Long-Term Care Insurance Model Act that are identified in the DRA and the 19 identified provisions in the Model Regulation of the National Association of Insurance Commissioners (NAIC). Certification of satisfaction is to be the responsibility of each state's Insurance Commissioner.

(4) A policy must provide for "compound annual inflation protection" if an individual is under age 61 when the policy is purchased, "some level of inflation protection" for individuals age 61 through 75, and the optional provision of inflation protection for individuals age 76 and over at the time the policy is purchased.

(5) Each state Medicaid agency is to provide information and technical assistance to state insurance departments regarding its role in assuring that individual sellers (licensed agents) who sell long-term care insurance under the partnership receive appropriate training about the policies and how they relate to other sources of coverage for long-term care, presumably including other long-term care insurance policies and Medicaid.

(6) The insurance company must provide reports to the U.S. Secretary of the Department of Health and Human Services (DHHS), including the dates, amounts, and termination of any benefits.

(7) The state must not impose requirements on partnership policies that are not imposed on non-partnership policies.

Beyond this, there are extensive reporting requirements for the individual and DHHS ultimately must report on partnership programs and their impact on the cost of care (and specifically Medicare and Medicaid expenditures). DHHS also must

establish a “National Clearinghouse for Long-Term Care Information” to provide consumer information.

Historically, long-term care insurance policies have not enjoyed a consumer-friendly reputation. The November 2003 issue of *Consumer Reports* published an extensive analysis of long-term care insurance policies then available. That article was extremely critical on balance. Policy options are proliferating and products are improving in response to such market pressures as the *Consumer Reports* piece, as well as in response to expected restrictions on access to Medicaid (as evidenced by the DRA). Consumers increasingly will be attracted to policies that, for example, combine LTC insurance benefit options with annuity features.

To the extent that invested dollars are not used to pay for the cost of long-term care, such dollars ultimately are recovered by identified residual beneficiaries in the form of annuity distributions. Life insurance policies are increasingly expected to allow the insured to utilize cash value or borrow against death benefits to pay the cost of long-term care.

But long-term care insurance cannot be expected to address the needs of individuals who cannot afford the cost of their premiums or who apply for insurance only after experiencing a health problem that enhances the likelihood of their long-term care needs. For such individuals, Medicaid will remain the payer of last resort. And the punishing provisions of the DRA are expected to impose difficult burdens on these individuals.

### CCRC

Increasing numbers of America’s elders are entering life care or continuing care retirement communities (CCRCs) across the nation.<sup>13</sup>

Some CCRC contracts allow a resident to access funds that are

deposited with the CCRC to pay for the cost of living and the cost of care if their other assets are somehow depleted. Still other CCRC contracts provide that, upon the death of the resident, all or some portion of deposited funds are returned to the decedent’s estate.

In determining Medicaid eligibility under the DRA, assets deposited or paid as an entrance fee shall be deemed available if the individual can use those funds to pay for care if other resources are exhausted, if the individual can obtain a refund upon death or termination of care, and if the payment of the entrance fee does not confer an ownership interest in the community.<sup>14</sup>

This provision is not expected to impact many individuals, as few CCRCs, and virtually no new life care communities accept Medicaid coverage for the skilled nursing component of their care continuum. Older communities, and particularly those that are religiously based and managed, often do accept Medicaid for qualifying individuals.

The DRA further provides that a CCRC admissions agreement may require residents to exhaust any resources they had at the time of admission before applying for medical assistance. Although most CCRCs are not Medicaid-certified, admissions agreements typically contain an anti-alienation provision designed to prevent a resident from transferring assets. Some provide for exceptions if prior approval of the facility is obtained. Maryland’s highest court had previously held such provisions to be unenforceable.<sup>15</sup> The DRA, in effect, overrules that decision.

### STOP THE MADNESS

These are just a few of the significant changes the DRA makes to the Medicaid rules. Through the imposition of increasingly restrictive rules and interpretations, the DRA seeks to

restrict access to the Medicaid program as a means of paying all or a portion of the cost of nursing home care for our nation’s elders. It remains to be seen how many states will implement some of the more draconian provisions. Importantly, many other planning approaches that have been legal are not addressed in the DRA. They continue to be legal and will be available to elders in need.

Increased utilization of long-term care insurance is a potential outcome, confirming that the DRA is perhaps more a victory for the long-term care insurance industry than for the actual cause of deficit reduction. Indeed, the impact on the federal budget will be minuscule—while the impact on our most vulnerable elders will be as formidable as it is unfortunate.

As advisors to our clients, we have an affirmative responsibility to monitor implementation of the DRA at the state level and to document its inevitable abuses. Repeal of its onerous, irresponsible provisions must follow. ■

#### Endnotes

1. Some states, such as California, have not yet fully implemented OBRA-93 and are still utilizing the pre-OBRA-93 30-month look-back.
2. DRA Section 6011(b)(2).
3. DRA Section 6011(b)(1).
4. At the state option, the penalty period may commence in the month following the asset transfer.
5. 42 United States Code Section 1396(p)(c)(2)(D) of the Social Security Act.
6. DRA Section 6011(d)(2).
7. DRA Section 6011(c).
8. DRA Section 6012(b).
9. DRA Section 6012(a).
10. DRA Section 6014(a).
11. DRA Section 6014(b).
12. New York has a variation of the dollar-for-dollar partnership policy which provides for unlimited asset protection under applicable circumstances.
13. See Michael Gilfix, “Elder Housing,” *Trusts & Estates*, April 2003, pp. 50-53.
14. DRA Section 6015.
15. *Oak Crest Village Inc. v. Murphy*, 379 Md. 229 (2004).