

Medicaid Changes Pursuant to the DEFICIT REDUCTION ACT OF 2005

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On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. Among numerous changes to existing law were changes to the Federal Medicaid Laws in an effort to restrict transfer of assets. One of the goals of the Act is the reduction of expenditures made via the Medicaid nursing home program for senior citizens and disabled individuals. The intent is to restrict the ability of individuals to protect assets from spend down and increase the amount paid by the individual to the long-term care facility. The following is a statement and/or analysis of the changes. The law as it relates to transfer of assets, to include implementation of penalty start dates and the look back period, became effective when signed by the President.

1. Transfer of Assets

Old Law

- 36 month look back (60 month look-back for transfers to trusts);
- Penalty start date for transfers begins in the month gift or transfer is made. Transfer is considered a gift when made for less than fair market value.
- Gifts made **prior to** February 8, 2006 are subject to old law, i.e., look back and penalty start rules.
- Rounding down of penalty periods **permitted**.
- Fractional periods of ineligibility not calculated.
- Transfers not cumulated unless the penalty periods ran together.
- Application made at expiration of penalty periods when individual is eligible for Medicaid.

New Law

- 60 month look back for all transfers;
- Penalty start date for transfer begins in month when applicant would be qualified for Medicaid except for the existence of the transfer/gift.
- Gifts made **on or after** enactment (February 8, 2006) are subject to the new law, i.e. look back and penalty start date.
- Rounding down of penalty periods **not permitted**.
- Fractional periods of ineligibility calculated.
- Transfers taking place during look back are cumulated and treated as if one transfer was made.
- Application made when individual is impoverished at which point penalty for transfers imposed and begins running.

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Problems Presented by New Law in Relationship to Transfers

Due to the fact that the penalty start date begins only after the applicant is impoverished (i.e. insufficient income to meet cost of care requirements and assets less than \$2,000.00 for Medicaid Only program or \$4,000.00 for Medically Needy program) individuals in nursing homes or assisted living facilities will be incapable of paying for care during penalty imposition period.

Question: Who will pay for care and what will happen to the individual?

How are “innocent” gifts, i.e. those made for purposes other than to qualify for Medicaid to be treated? The law states that transfers made which are not for the purpose of qualifying for Medicaid are not penalized.

Question: Who bears the burden of proving that gifts were not made for the purpose of qualifying for Medicaid?

The applicant will have to bear the burden of making a “satisfactory showing” that “the assets were transferred exclusively for a purpose other than to qualify for medical assistance.” Will the caseworker be able to pass judgment on the merits of the explanation or will the application require an appeal? Procedures will need to be developed that vests case workers with authority to decide obvious situations.

(A) Treatment of Purchase of Annuities as Transfers of Assets

The purchase of an annuity is treated as a transfer of assets unless the annuity complies with the following requirements:

- The State of New Jersey must be the first remainder beneficiary (a spouse, child under 21 or disabled child may be remainder beneficiary ahead of State if such exists).
- The annuity is actuarially sound based upon the annuitant’s life.
- The annuity provides for payments in equal amounts during term.
- No deferrals or balloon payments permitted.

-OR-

- The annuity is actuarially sound based upon the annuitant’s life and,
- The annuity is irrevocable and non-assignable, and
- The annuity provides for payments in equal amounts during the term.

The interest in an annuity owned by the resident or spouse must be disclosed to Medicaid. The interest in the annuity will then be considered to be an asset of the applicant unless the annuity meets the above requirements. Even if the annuity meets the above requirements, the State is to be notified if there is a change in the

amount of principal or income to be withdrawn and the State will notify the issuing company of the State's interest in the annuity.

Comment: The State of New Jersey has taken the position in the past that an applicant for Medicaid, or his/her spouse (subject to the community spouse resource allowance), must attempt to sell (liquidate) any annuity for fair market value on the "open market" in order to raise funds to pay for care. Whether the state will continue to take this position is, at this time, subject to conjecture in view of the fact that Federal Law (as it did in the past) authorizes the use of annuities.

(B) Treatment of Promissory Notes, Loans or Mortgages

Assets of an individual include funds used to purchase a promissory note, loan or mortgage unless the note, loan or mortgage meets the following requirements:

- Repayment terms are actuarially sound.
- No deferral or balloon payments permitted.
- Obligation provides for payments in equal amounts.
- Debt obligation may not be cancelled upon death of lender.

Comment: If the promissory note, loan or mortgage does not satisfy the requirements set forth above, the value of the asset, for Medicaid spend down/application purposes, shall be the outstanding balance due on the obligation as of the date of the application.

(C) Treatment of Life Estates

The purchase of a life estate in the property of another is not considered a disqualifying transfer so long as the individual applying for Medicaid lived in the home for at least one year. Failure to reside in the home for at least one year results in the life estate being considered an assets of the individual for Medicaid purposes.

(D) Hardship Application

Facilities are now permitted to file "undue hardship waiver applications" for residents. Consent of the individual or personal representative is required. During the pendency of the application and assuming the application meets established criteria the State of New Jersey may provide payment for bed hold for a maximum period of 30 days.

Question: What happens if neither the resident nor the personal representative consent to the application?

What procedures the State will implement to provide an expedited hearing regarding hardship waivers remain to be developed.

2. Treatment of Continuing Care Retirement Communities

Contracts for admission to a State licensed Continuing Care Retirement Community (CCRC), including services in a nursing facility associated with the CCRC, may require residents to spend assets declared in the admission application on care before qualifying for Medicaid.

An entrance fee shall be considered a resource available to the individual to the extent that:

- The individual has the ability to use the fee to pay for care
- The fee does not confer and ownership interest to the individual
- The individual is eligible for a refund of any remaining entrance fee when the individual dies, terminates the contract and leaves the community

Note: It is anticipated that CCRC's will find it necessary to institute suit against residents and/or families to capture assets transferred following admission to the facility. The question remains, however, how Medicaid will view the situation should the CCRC decide not to pursue the funds.

Query: If the CCRC does not sue residents and their families to obtain funds disclosed in the application which are thereafter transferred, will a hardship exist pursuant to the hardship waiver provisions?

3. Income First Rule

In situations where there is a "community spouse" Medicaid will look to the income of the institutionalized spouse to support the community spouse before diverting assets to the community spouse for support purposes. This has been the rule in the State of New Jersey and poses no change to the implementation of the Medicaid program.

4. Treatment of Home Equity

In instances where the institutionalized individual possesses a home with equity in excess of \$500,000.00 he/she will be required to access the excess equity to pay for care. The act encourages the use of a home equity loan or reverse mortgage as a means of tapping the equity. The amount of equity that the individual can retain may be increased by the various states to \$750,000.00. The requirement to access equity does not apply to a residence in which the individual's spouse, a child under the age of 21 or a disabled child resides.

As a general rule, if the individual will be a long term care resident, the State of New Jersey requires an individual to liquidate any real property, so long as no spouse, child under 21 years or disabled child lives in the property. It is presumed by the State of New Jersey that an individual who is institutionalized, and who will be so institutionalized for at least six months, will not be returning home. As a consequence, the State requires the sale (or at the very least the listing for sale) of those homes as a condition of granting Medicaid eligibility. Therefore, the new requirement regarding equity would seem not applicable in New Jersey.

NOTE: There can be significant costs associated with obtaining a reverse mortgage. Use of a reverse mortgage does not require monthly mortgage payments and therefore it may be a more appropriate device to use notwithstanding the high costs associated with it. Use of a home equity loan will undoubtedly require minimum monthly payments.

Query: Where does the individual obtain the funds to make those payments?

5. Long-Term Care Partnership Program

The DRA encourages the creation of a state long-term care insurance partnership. The partnership would be created by a state plan amendment to the Medicaid laws of the state. The pertinent provision of the partnership is that the state Medicaid office would “disregard” assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual subject to compliance with the following requirements:

- The policy is a qualified long term care insurance policy.
- The policy covers an insured who is a resident of the state when coverage first became effective.
- The policy if sold to a person under the age of 61 provides for compound annual inflation protection.
- The policy if sold to a person over the age of 76 may, but need not, provide for some level of inflation protection.
- The policy if sold to a person between the ages of 61 and 76 (but not 76) provides for some level of inflation protection.

Note: This provision, as indicated, requires state action to implement. It would appear that once implemented the purchase of long-term care insurance will be a device which will allow individuals to protect assets in an amount equal to the benefit to be paid. This provision is the result of intense lobbying efforts from the long-term care insurance industry.

The purchase of long-term care insurance, in any event, is something which should be advocated for those whose health and resources permit acquisition of such policy. Purchase of at least a five-year policy would seem to allow Medicaid planning with resulting asset preservation via use of the five-year look back.

6. Applications for Medicaid

As a result of the change in the look back and penalty start dates it may very well come to pass that multiple applications, or multi-stage single applications, will be necessary. Individuals who made transfers will undoubtedly be denied benefits when application is made due to the imposition of the penalty which begins at the time. It is unclear whether the individual will be granted eligibility for a time in the future or if the individual will have to make a follow-up application in order to substantiate that no changes in financial and health areas have occurred. It is possible, however, that like with the “snap shot” under the old Medicaid regulations, the “otherwise eligible” standard under the DRA will be assessed by Medicaid at the time of the later application.

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