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TRUSTS & ESTATES

The Journal of Wealth Management
for Estate Planning Professionals

March, 2006 Issue

Throw Mama From the Train

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

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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.[1] 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.[2]

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.[3]

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.[4] 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?

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."[9] 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.[10] 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."

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

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.[13]

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.[14]

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.[15] 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).