

**NATIONAL ACADEMY OF ELDER LAW ATTORNEYS**

**ANALYSIS OF CHANGES TO FEDERAL MEDICAID LAWS UNDER THE  
DEFICIT REDUCTION ACT OF 2005**

JUNE 20, 2006

***EDITORS***

*Gene V. Coffey*

*Bernard A. Krooks, CELA*

*Howard S. Krooks, CELA*

*Brian W. Lindberg*

*Vincent J. Russo, CELA*

***CONTRIBUTING AUTHORS***

*Gene V. Coffey*

*Jason A. Frank*

*Gregory S. French, CELA*

*Michael A. Gilfix*

*Howard S. Krooks, CELA*

*Susan H. Levin*

*Vincent J. Russo, CELA*

*Charles P. Sabatino*

*Scott R. Severns, CELA*

*Timothy L. Takacs, CELA*

*Ira S. Wiesner, CELA*

*Copyright © 2006 by the National Academy of Elder Law Attorneys, Inc.*

---

This issue is a special edition of the *NAELA Journal*. NAELA's Special Editions are published periodically between issues and continue the page numbering from the previous issue, unless printed as the first publication in the volume year.

The *NAELA Journal* (ISSN 1553-1686) is published twice a year by the National Academy of Elder Law Attorneys, Inc., and distributed to members of the Academy and to law libraries throughout the country.

Elder law topics range over many areas and include: Preservation of assets, Medicaid, Medicare, Social Security, disability, health insurance, tax planning, conservatorships, guardianships, living trusts and wills, estate planning, probate and administration of estates, trusts, long-term care placement, housing and nursing home issues, elder abuse, fraud recovery, age discrimination, retirement, health law, and mental health law.

Articles appearing in the *NAELA Journal* may not be regarded as legal advice. The nature of elder law practice makes it imperative that local law and practice be consulted before advising clients. Statements of fact and opinion are the responsibility of the author and do not imply an opinion or endorsement on the part of the officers or directors of NAELA unless otherwise specifically stated as such.

Subscriptions to the *NAELA Journal* are \$60.00 per year. Single issues are available for \$30.00. Combined subscriptions to the *NAELA News*, distributed six times a year, and the *NAELA Journal* are \$125.00. Back issues of the *NAELA Journal* and the *NAELA News* are available on [www.naela.org](http://www.naela.org) for NAELA members. Address changes or other requests regarding subscription information should be directed to Frances Smith, NAELA Subscriptions Coordinator, at [fsmith@naela.com](mailto:fsmith@naela.com), (520) 881-4005.

---

The *NAELA Journal* Editorial Board invites the submission of manuscripts year-round with the following guidelines:

1. Please conform text and citations to *The Association of Legal Writing Directors (ALWD) Citation Manual: A Professional System of Citation* or *The Bluebook: A Uniform System of Citation*. Citations submitted in *Bluebook* will be converted to *ALWD*.
2. Please include a cover letter containing the title of your manuscript, your professional affiliation or school, address, telephone, and e-mail address.
3. Manuscripts can be submitted electronically to the attention of the Editor-in-Chief at [editor@naela.com](mailto:editor@naela.com) or by mail on disk or CD to:

National Academy of Elder Law Attorneys, Inc.  
1604 N. Country Club Rd.,  
Tucson, AZ 85716  
(520) 881-4005 Phone  
(520) 325-7925 Fax

ISSN 1553-1686

## TABLE OF CONTENTS

INTRODUCTION .....	193
A. LOOKBACK PERIOD EXTENDED TO FIVE YEARS, §6011(A) <sup>1</sup> .....	194
1. Pre-DRA Law .....	194
2. Post-DRA Law .....	195
3. Language of the DRA .....	195
4. Analysis and Issues .....	195
5. Practice Issues .....	196
B. COMMENCEMENT DATE OF PENALTY PERIOD, §6011(B) <sup>2</sup> .....	197
1. Pre-DRA Law .....	197
2. Post-DRA Law .....	197
3. Language of the DRA .....	197
4. Analysis and Issues .....	198
5. Practice Issues .....	200
C. UNDUE HARDSHIP, §6011(D) & (E) <sup>3</sup> .....	202
1. Pre-DRA Law .....	202
2. Post-DRA Law .....	204
3. Language of the DRA .....	204
4. Analysis and Issues .....	205
5. Practice Issues .....	206
D. DISCLOSURE AND TREATMENT OF ANNUITIES, §6012 <sup>4</sup> .....	207
1. Pre-DRA Law .....	207
2. Post-DRA Law .....	208
3. Language of the DRA .....	209
4. Analysis and Issues .....	211
5. Practice Issues .....	213
E. INCOME-FIRST, §6013 <sup>5</sup> .....	215
1. Pre-DRA Law .....	215
2. Post-DRA Law .....	217
3. Language of the DRA .....	219
4. Analysis and Issues .....	219
5. Practice Issues .....	220
F. HOME EQUITY CAP UNDER THE DRA, §6014 <sup>6</sup> .....	223
1. Pre-DRA Law .....	223
2. Post-DRA Law .....	223
3. Language of the DRA .....	224

---

1. This section was written by Howard S. Krooks, CELA, Boca Raton, Florida.

2. This section was written by Howard S. Krooks, CELA, Boca Raton, Florida.

3. This section was written by Gene V. Coffey, Washington, D.C.

4. This section was written by Gregory S. French, CELA, Cincinnati, Ohio.

5. This section was written by Susan H. Levin, Newton, Massachusetts.

6. This section was written by Michael A. Gilfix, Palo Alto, California.

4. Analysis and Issues .....	225
5. Practice Issues .....	225
G. IMPLICATIONS OF THE CCRC PROVISIONS OF THE DRA, §6015 <sup>7</sup> .....	226
1. Pre-DRA Law .....	226
a. Prohibition on Requiring Waiver of Federal Rights .....	227
b. Treatment of Entrance Fees as Exempt Assets .....	228
2. Post-DRA Law .....	229
3. Language of the DRA .....	229
4. Analysis and Issues .....	230
a. Must Be Available .....	231
b. Refundable .....	231
c. Must Not Convey a Property Interest .....	232
d. Other Issues .....	232
5. Practice Issues .....	233
H. OTHER OPERATIONAL CHANGES IN THE IMPOSITION OF TRANSFER PENALTIES, §6016 <sup>8</sup> .....	233
H-1. Requirement to Impose Partial Months of Ineligibility, §6016(A) .....	233
1. Pre-DRA Law .....	233
2. Post-DRA Law .....	234
3. Language of the DRA .....	234
4. Analysis and Issues .....	235
H-2. Accumulation of Multiple Transfers, §6016(b) .....	236
1. Pre-DRA Law .....	236
2. Post-DRA Law .....	236
3. Language of the DRA .....	237
4. Analysis and Issues .....	237
H-3. Promissory Notes, Loans, and Mortgages .....	237
1. Pre-DRA law .....	237
2. Post-DRA law .....	238
3. Language of the DRA .....	238
4. Analysis and Issues .....	239
5. Practice Issues: .....	239
H-4. Inclusions of Transfers to Purchase Life Estates .....	240
1. Pre-DRA Law .....	240
2. Post-DRA Law .....	240
3. Language of the DRA .....	240
4. Analysis and Issues .....	241
5. Practice Issues .....	242

---

7. This section was written by Jason A. Frank, Lutherville, Maryland.

8. Part H1 and H2 of this section were written by Ira S. Wiesner, CELA, Sarasota, Florida. Part H3 of this section was written by Scott R. Severns, CELA, Indianapolis, Indiana. Part H4 of this section was written by Vincent J. Russo, CELA, Westbury, New York.

I. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM, §6021 <sup>9</sup> .....	242
1. Pre-DRA Law .....	242
2. Post-DRA Law .....	243
3. Language of the DRA .....	243
4. Analysis and Issues .....	249
J. EFFECTIVE DATES FOR PROVISIONS OF THE DRA <sup>10</sup> .....	252
1. Pre-DRA Law .....	252
2. Post-DRA Law .....	252
3. Language of the DRA .....	253
4. Analysis and Issues .....	256
5. Practice Issues .....	258
CONCLUSION .....	258

#### INTRODUCTION

The *Deficit Reduction Act of 2005*, Pub. L. No. 109-171 (DRA), requires that billions of dollars in spending be reduced from a number of domestic programs. The DRA<sup>11</sup> especially targets Medicaid. One of the most controversial cost-cutting provisions contained in the law relates to the changes made to the eligibility rules for long-term care coverage. Medicaid is the single largest purchaser of long-term care services in the nation (paying more than \$86 billion annually to cover more than four million individuals<sup>12</sup>). Congress targeted Medicaid because of its central role in the nation's long-term care system. The DRA imposes new eligibility rules that will deny coverage to at least 120,000 individuals within the next five years who would have been eligible for coverage in the absence of the DRA's changes.<sup>13</sup> Specifically, Congress made drastic changes to the asset transfer rules, so that aged individuals and persons with disabilities in need of long-term care will be denied Medicaid coverage on the basis of gifts they made to their children and grandchildren, or donations they made to charities, in the five years preceding their application for Medicaid.

---

9. This section was written by Charles P. Sabatino, Washington, D.C.

10. This section was written by Timothy L. Takacs, CELA, Hendersonville, Tennessee.

11. The Deficit Reduction Act of 2005 is referenced throughout this work as the "DRA." Sections 6011-6021 of the DRA contain changes in eligibility standards for long-term care to be incorporated in the Medicaid statute.

12. Ellen O'Brien, Georgetown University Health Policy Institute for the Kaiser Commission on Medicaid and the Uninsured, *Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled*, pgs. 6-7, November, 2005.

13. See Congressional Budget Office, *Additional Information on CBO's Estimate for the Medicaid Provisions in H.R. 4241, the Deficit Reduction Act*, November 9, 2005. This figure relates solely to the individuals who will be denied coverage as a result in the change in the penalty period start date. It does not include individuals who will be denied as a result of other changes.

NAELA has followed these changes closely. This analysis of the DRA's<sup>14</sup> momentous changes in Medicaid eligibility has two antecedents. On January 3, 2006, NAELA circulated an E-blast entitled "Medicaid Transfer of Asset Proposals in the Budget Reconciliation Conference Report," alerting members to changes that Congress was at the time considering and which ultimately became part of the new law. After the DRA was enacted, ten NAELA members volunteered to write about different sections of this far-reaching law. Five editors compiled the studies into a working draft placed on the NAELA website in preparation for NAELA's April 2006 Symposium in Washington, D.C. This updated and re-edited version of the original analysis includes a new section on promissory notes and loans.

Each chapter begins with specific reference to the section of the DRA in which the subject matter of the chapter appears. The subject matter of each chapter is separated into five parts:

- the law pertaining to the subject matter before enactment of the DRA (Pre-DRA Law);
- the new law (Post-DRA Law);
- the specific language of the new law (Language of the DRA reproduced in bold type face);
- discussion of the character of the changes (Analysis and Issues); and
- how the changes will affect counseling on Medicaid (Practice Issues).

The Centers for Medicare & Medicaid Services, the federal agency which oversees the Medicaid program, is referenced throughout as CMS. The CMS State Medicaid Manual, which contains the agency's policy proclamations (including what most Elder Law practitioners know as Transmittal 64), is referenced throughout as the State Medicaid Manual.

The authors and editors acknowledge that this analysis may not reflect the thinking of all NAELA members or CMS, which has not put forward its interpretation of the "DRA" as this document goes to print.

#### A. LOOKBACK PERIOD EXTENDED TO FIVE YEARS, §6011(A)

##### 1. *Pre-DRA Law*

Under pre-DRA law, most asset transfers were subject to a 36-month lookback period, although the lookback period for transfers to or from certain trusts was and continues to be 60 months.

---

14. The constitutionality of the DRA is currently being challenged in four different federal lawsuits, including one filed by ten Democratic members of the U.S. House of Representatives, *Conyers, et al v. Bush, et al*, No. 2:06-CV-11972 (E.D.Mich. filed April 28, 2006). Each suit alleges that the bill signed by President Bush was not identical to the bills that passed both chambers of Congress.

## 2. *Post-DRA Law*

Under the DRA, all transfers, whether to individuals or trusts, will be subject to a 5-year (60 month) lookback period.

## 3. *Language of the DRA*

### 42 USC 1396(c)(1)(B)

**(i) The lookback date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section, or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months) before the date specified in clause (ii).**

**(ii) The date specified in this clause, with respect to –**

**(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or**

**(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.**

## 4. *Analysis and Issues*

Because the longer lookback period under the DRA applies to transfers of assets made on or after February 8, 2006, it will take three years from February 8, 2006, before the increased lookback period will require the provision of statements and explanations of financial transactions beyond the 36 months required under pre-DRA law (other than trust-related transfers, which already requires 5 years of statements). Transfers made prior to February 8, 2006, only require a 36-month lookback period and will be subject to pre-DRA transfer rules regarding the start date of the penalty period. It would be administratively inconvenient and would create an unnecessary burden on Medicaid caseworkers if states imposed a five-year lookback period prior to February 2011. The CMS should, therefore, clarify that the increased lookback period will in effect be “phased in” over a two year period (i.e., beginning in March 2009, 37 months of statements may be requested, in April 2009, 38 months of statements may be requested, etc.) and that it will take until February 8, 2011, before a full 5 years of statements relating to transfers made on or after February 8, 2006, may be requested.

The longer lookback period for transfers suggests that the elderly can predict their medical and financial circumstances five years into the future. It punishes unwitting elders who have helped their families with commonly made gifts and then experience medical events such as a stroke or Alzheimer’s disease. The DRA raises unacceptable new obstacles for vulnerable, frail elders and persons with disabilities to get care,

because the increased lookback period will require recordkeeping and documentation that is far beyond the ordinary practices of the elderly, especially poor and chronically ill elders. Elders may be denied admission to a nursing home simply because of inadequate recordkeeping. The harshest impact of this extended lookback period may be on applicants with dementia who will not be able to provide documentation or recall specific transactions which occurred up to five years earlier and on elderly who pay cash for most of their day-to-day expenses, retaining few or no records of their expenditures.

After DRA, Medicaid caseworkers will now have greater opportunities to deny Medicaid applications due to inadequate documentation. Furthermore, the increase in the lookback period will have a significant impact on the government's administrative overhead, as Medicaid caseworkers will be forced to examine five years of each applicant's financial records rather than the previous three years. Increased labor costs will reduce any purported savings in Medicaid expenditures. There is no reliable data to support the proposition that a longer lookback period will reduce the cost of the Medicaid program's share of nursing home care costs.

Some may consider as unclear the meaning of the term "disposal" of assets in the DRA language rather than the traditional "transfer" of assets used throughout the federal Medicaid Act. There is nothing in the DRA which defines the term "disposal" of assets, although the term already appears in 42 U.S.C. §1396p(c)(1)(A). At this point, this remains an unexplained distinction and it is unclear whether this disparity is meaningful.

##### *5. Practice Issues*

The primary planning opportunity that has been eliminated by the DRA's extension of the lookback period to five years for all transfers is the transfer of assets to an individual followed by a waiting period of three years to qualify for Medicaid. This planning approach will now require a waiting period of five years before the individual will qualify for Medicaid. Therefore, an individual would need to set aside enough money to pay for a full five years in a nursing home in order to protect the remaining portion of their assets. The additional two years of private pay increases the need to provide records to document these payments over the additional two-year period.

One fairly obvious result of the five-year lookback period will be an increased demand for home and community-based services which are generally considered to be less costly than nursing home services and represent a good option for those who medically qualify for home care services. Individuals who are not appropriate candidates for home care services, and who nevertheless choose this may suffer harm and possibly die as a result of receiving care in the wrong setting. Furthermore, the increased reliance on home care services will likely drive up the cost of such services, which in many parts of the country are already prohibitively expensive.

There may be an increased use of financial planners to maximize returns on investments and to make existing estates last as long as possible. Previously, an estate

remaining after a transfer of assets needed to last up to a maximum of three years in the case of non-trust transfers. People may turn in greater numbers to financial planners to maximize the return on the remaining estate, knowing that they must fund their care for an additional two years. Conceivably, increased use of financial planners and the search for higher rates of return may induce investments with a higher risk of loss. In some cases, this will increase the rate of return and achieve the desired result of extending the estate for a greater period of time. In other cases, it will result in a substantial loss of the individual's estate without sufficient time to "ride out" a bear market or similar decline in the overall investment portfolio, thereby rendering the estate penniless at a time when the individual is still within a penalty period.

Although sales of long-term care insurance have not matched predictions, there may be an increase in the purchase of long-term care insurance policies due to the DRA as individuals position themselves to sustain a five-year rather than a three-year lookback period. This assumes such individuals are insurable and can afford the premium for five years of coverage, which will be higher than a premium for three years of coverage. While elders may view the premiums on such policies to be prohibitively expensive, it will likely come down to a decision between paying these premiums for long-term care insurance or paying privately for long-term care in a nursing home for two additional years, if nursing home care is ever needed.

Elder Law attorneys, hospital discharge planners, nursing home personnel (admissions directors, social workers), geriatric care managers, doctors, long-term care insurance brokers, accountants, social services agencies and anyone else involved in providing services to the elderly will need to advise the elderly of the need to keep good records for a full five years in order to apply for Medicaid. Many elders may not receive this advice in a timely manner which may result in Medicaid denials.

#### B. COMMENCEMENT DATE OF PENALTY PERIOD, §6011(B)

##### 1. *Pre-DRA Law*

Before the DRA, the penalty period began on the date of the transfer or, at the option of the state, the month following the date of the transfer.

##### 2. *Post-DRA Law*

Under the DRA the penalty period will commence on the later to occur of the first day of the month in which the transfer was made or the date on which an individual is eligible for Medicaid benefits and would otherwise be receiving institutional level of care based on an approved application for such care but for the imposition of a penalty period.

##### 3. *Language of the DRA*

**42 USC §1396p(c)(1)(D)**

**(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.**

**(ii) In the case of a transfer of assets made on or after the date of enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.**

#### *4. Analysis and Issues*

One point that seems clear under the DRA commencement of penalty period rules is that an individual needs to be at or below the Medicaid resource level at two points in time: 1) to begin the running of the penalty period, and 2) when the individual applies for Medicaid benefits. This represents a departure from pre-DRA law whereby a penalty period could begin running whether or not the individual had above or below the resource level. The reason for the difference stems from the language in the DRA which states that the penalty period begins to run on “the date on which the individual is eligible for medical assistance under the State plan. . .” Previously, the penalty period began to run on “the first day of the first month during or after which assets have been transferred for less than fair market value. . . .” Thus, the only requirement to trigger a penalty under pre-DRA law was the act of making the transfer. Now, one must both make a transfer and be eligible for medical assistance (but for the transfer) before the penalty period begins to run. A determination that the individual was eligible for Medicaid on the date of the transfer could be made at the time of the filing of the Medicaid application once the penalty period has expired. This is similar to how Medicaid applications are currently processed for purposes of determining whether pre-DRA asset transfers have been made and imposing penalty periods on those transfers after the fact.

The next two points (must an individual reside in a nursing home in order to commence a penalty period under the DRA and must a Medicaid application be filed in order to commence a penalty period under the DRA) will be made clearer by first reviewing legislative history regarding the DRA commencement of penalty period rules. The DRA Conference Report (at 269) states that the Senate Bill had no such provision, but the House Bill would have amended §1917(c)(1)(D) of the Social Security Act by changing the start date of the penalty period to the later of the first day

of a month during or before which assets have been transferred for less than fair market value or the date on which the individual became eligible for Medicaid and is receiving long-term care services, whichever is later provided that it does not occur during any period of ineligibility as a result of an asset transfer policy. For transfers made prior to this Act's enactment, current law applies.

The conference agreement includes the House provision but specifies that the start date begins on the first day of a month during or after which assets have been transferred for less than fair market value or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy.

Must an individual be residing in a nursing home in order for a penalty period to begin and, further, must an individual be residing in a nursing home for the entire penalty period in order for a previously commenced penalty period to continue to run? The legislative history to the DRA does not support this conclusion. The CMS should issue regulations that clarify that an individual need NOT reside in a nursing home in order for a penalty period to begin or to continue to run. None of the language of the DRA, the House Bill, or the Conference Agreement could be interpreted to require that an individual would need to be residing in a nursing home in order to start or continue the running of a penalty period. The Conference Report specifies that one prong of the test for determining whether the penalty period commences is that the individual “. . . would otherwise be receiving institutional level care . . .” Institutional level care is defined in 42 U.S.C. §1396p(c)(1)(C) as nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home and community-based services furnished under a waiver granted under subsection (C) or (d) of 42 U.S.C §1396n. While nursing home residence could satisfy this prong of the test for determining whether a penalty period would commence under the DRA; so too could residence in a facility where nursing home level of services were being provided or certain waived home and community-based services provided in the community.

Must a Medicaid application be filed in order to begin the running of a penalty period? Here again CMS should issue regulations indicating that the answer is NO. The phrase “based on an application for such care” refers to a medical screening to determine whether the individual would otherwise be receiving institutional level care and does not mean the filing of an application for Medical assistance would be necessary (note that the language does not state “based on an approved application for Medical assistance”). The transfer penalty should begin when the individual's assets are at or below the Medicaid resource allowance and the individual is determined by a medical screening to need institutional level care. This interpretation is based upon the House language that was removed (“and is receiving services described in subparagraph (C)” – see above) compared to the language contained in the conference agreement (“and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care” – see above).

The change in the language seems to be focused on eliminating the requirement that an individual would have to be actually receiving institutional level care and instead focused on when the individual would be in need of such care. This change may have been made to appease nursing homes' concerns that, under the House Bill, the transfer penalty would not begin until someone was placed in a nursing home which would mean that the nursing homes would admit many residents who had made transfers, had no funds, and were ineligible for Medicaid. With the change made at reconciliation, the penalty can begin when the person is deemed in need of institutional level care, not when she is actually residing in a nursing home.

When combined with the "otherwise eligible" language of the DRA, an individual would need to have less than the Medicaid resource allowance and be determined to need (but not necessarily be receiving) institutional level care by way of a medical screening in order to begin the penalty period. States where medical pre-screening is not currently performed prior to the application for Medicaid benefits, will need to establish procedures to determine the individual's eligibility for institutional level care. When the Medicaid application is later filed, the applicant will have to prove that financial eligibility for Medicaid existed when the penalty period began to run and, again, when medical assistance is sought.

CMS has informally indicated that an individual must be residing in a nursing home and file a Medicaid application in order to trigger a disqualifying transfer under the DRA.

##### *5. Practice Issues*

Because many seniors will find themselves ineligible for Medicaid nursing home care, due to a previous transfer and failure to obtain the requisite medical screening, alternative ways to secure eligibility will have to be considered. The strategies which have been discussed are presented below.

If a parent makes a gift of \$20,000 to his son and then enters a nursing home, Medicaid will not be available for four months (assuming an average monthly cost of care of \$5,000), starting when he submits an application for Medicaid. Assume that he is otherwise eligible since he is receiving long-term care services in a nursing home and his assets are below the resource allowance. If his application is denied (because of the running of the disqualification period), his son can return \$10,000, which he proceeds to spend on the cost of his care at the nursing home at a rate of \$5,000 per month. After two months, the return of \$10,000 should reduce the penalty period from 4 to 2 months, and he should be eligible for Medicaid at that time.

Under federal law, an individual shall not be ineligible for Medicaid where "all assets transferred for less than fair market value have been returned to the individual." 42 U.S.C. §1396p(c)(2)(C)(iii). The State Medicaid Manual has clarified the meaning of "all assets" by permitting a partial return of funds to reverse a portion of an existing penalty period. State law must be consulted since there may be states that do not permit a partial return of funds to reverse an existing penalty period.

As in the past, long-term care insurance should be considered as a planning tool for individuals of modest means who cannot otherwise sustain themselves during a protracted penalty period which does not commence until they are already receiving institutional level care. However, such individuals may not be able to afford long-term care insurance or may have pre-existing conditions rendering them uninsurable.

One approach designed to preserve “crisis planning” under the DRA involves the use of a short-term immediate annuity in lieu of retaining a portion of the assets for spend-down during the penalty period. In this way, a person can become “otherwise eligible” by keeping less than the resource allowance, and still maintain a source of funding for payments to be made to the nursing home during the running of the penalty period. For example, an individual in need of nursing home care who has assets worth \$20,000 might, transfer \$10,000 to her children at the same time she purchases an immediate annuity that pays \$5,000 per month for a period of 2 months (not prohibited because it is a shorter term than the individual’s life expectancy). The following day the individual enters a nursing home, which costs \$5,000 per month. The penalty period, which commences upon the filing of an application for benefits, begins to run. The individual pays for the nursing home through the two-month penalty by using monthly annuity payments. At the end of the two-month penalty period, the individual reapplies with assets below the resource allowance and the two-month penalty period having expired.

Irrevocable grantor trusts remain viable, but only as an advance planning technique and only for individuals who can retain sufficient resources to pay for a full five years. Alternatively, the irrevocable grantor trust could be used in the following way: if a nursing home costs \$5,000 per month (in a state where the divisor is \$5,000/month), an individual with a home worth \$200,000 and liquid assets of \$300,000 could transfer his home into an irrevocable trust. Such a transfer would cause a 40 month penalty period commencing upon the individual’s being determined to need institutional level services and being otherwise eligible for medical assistance (i.e., having less than the Medicaid resource allowance). The remaining \$300,000 could be spent down on the cost of his care through the purchase of a DRA-compliant annuity or protected, in whole or in part, by additional planning involving exempt transfers.

Of course, there are a number of factors which must be considered, such as the loss of control and income, before a senior decides whether to divest and in what amount, if any. Planning must be structured in the best interests of the client. In practice, complete divestiture in advance is rarely an appropriate plan. Further, most seniors are unwilling to divest in advance of a long-term care crisis.

There are a number of options that should be explored in order to obtain Medicaid for the client in crisis, such as spousal planning, caregiver agreements, the use of DRA-compliant annuities or promissory notes, and the use of pooled trusts. In addition, a review of prior transfers not made for the purpose of qualifying for Medicaid should be analyzed.

There will be an increased focus on planning strategies available to spouses because the federal law's exemption from the penalty period rules for transfers between spouses was not modified by the DRA. Thus, it will be imperative to obtain enhanced community spouse resource allowance (CSRA) through fair hearing or court orders, notwithstanding the application in every state of the income-first rule. Furthermore, annuities purchased by community spouses in states where spousal refusal is not utilized will increase, notwithstanding the new rules pertaining to annuities. In states where spousal refusal is not honored by the Medicaid agency, litigation should be commenced to force states to comply with federal law in this area. See *Morenz v. Wilson-Coker*, 415 F.3d 230 (2nd Cir. 2005). Furthermore, post-eligibility transfers by community spouses do not appear to be affected by the DRA.

Transfers to protected individuals were not affected by the DRA provisions. Therefore, a greater effort should be made to identify and plan with caretaker children, a sibling with an equity interest in the home, spouses, and certified blind and disabled children.

The use of Personal Care Contracts should be considered in post-DRA planning. State law tends to vary greatly on the viability of such contracts, but in states where they are permitted, they can provide a useful way to provide for much needed care without creating a penalty period. While payments made to the caregiver under such contracts must be reported as income by the caregiver (resulting in higher income tax being due), payments made by the individual to the caregiver pursuant to a valid contract are not uncompensated transfers and therefore do not result in a penalty period.

Medicaid law provides that transfers made exclusively for purposes other than to qualify for Medicaid are not subject to the transfer penalty rules. This has been a difficult argument to sustain in a crisis planning case where the individual was already ill and the medical records disclosed a prior medical condition. In such cases, even where institutionalization did not occur for some time after the medical condition, the Medicaid agency presumed that the transfer was made for the purpose of qualifying for Medicaid even if it had not been. However, if individuals were to undertake planning while healthy and further in advance of the need for care (due to the stringent penalty period commencement date rules), one should review all transfers made by the individual in order to determine whether such transfers are exempt under this provision. There is significant evidence that congressional intent on this issue supports this approach.

### C. UNDUE HARDSHIP, §6011(D) & (E)

#### 1. Pre-DRA Law

For individuals who make a transfer for less than fair market value during an applicable lookback period, the federal law provides exceptions to the application of a penalty period for certain transfers or situations. 42 U.S.C. §1396p(c)(2). There is no

penalty for a transfer of a home to a spouse, minor or disabled child, sibling with an equity interest in the home, or caretaker child. Similarly, the transfer of other assets to a spouse or a trust established for the benefit of a minor or disabled child is not subject to a penalty. Additionally, where a Medicaid applicant can demonstrate that she intended to transfer an asset for fair market value, transferred the asset exclusively for a purpose other than to qualify for Medicaid; or, has had returned to her the assets she transferred, a penalty period will not be assessed. And finally, the federal Medicaid statute provides that a penalty period will not be assessed where the application of a penalty will result in *undue hardship*.

Prior to the passage of the DRA, the undue hardship provision of the statute merely provided that a penalty would not be applied where “the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.” 42 U.S.C. §1396p(c)(2)(D).

The standards specified by the Secretary, in delegating authority to CMS, published in §3258.10(C)(5) of the State Medicaid Manual, read as follows:

[Undue hardship exists] when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter or other necessities of life. Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict her lifestyle but would not put him/her at risk of serious deprivation. . . . You [i.e., the state] have considerable flexibility in deciding the circumstances under which you will not impose penalties under the transfer of assets provisions because of undue hardship. . . However, your undue hardship procedure must, at a minimum, provide for and discuss the following administrative requirements

- Notice to recipients that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted; and
- A process under which an adverse determination can be appealed.

Clearly, it has been difficult for Medicaid applicants to secure a favorable determination based on undue hardship due to the broad discretion provided to states by this provision. The burden of claiming and establishing hardship is placed on the individual who is, at the time the issue arises, already seriously and chronically impaired physically and possibly cognitively. Additionally, an assessment of whether the individual’s health or life will be endangered or whether she will lack the necessities of life as a practical matter depends on the evaluation of not only the person’s physical condition, but also that person’s whole social support system for as many months as a penalty would apply. Thus, in most cases, the undue hardship exception has essentially

been unavailable for Medicaid applicants assessed with a penalty period. There is significant evidence that congressional intent on this issue supports this approach.

## 2. *Post-DRA Law*

Section 6011(d) of the DRA adds language to the “undue hardship” penalty period exception found in 42 U.S.C. §1396p(c)(2)(D). An undue hardship *standard* is now identified, as are the specific elements of the *process* a state must follow in its mandatory provision of an undue hardship exception.

Immediately following the provisions on the extended lookback period and penalty period methodology in Section 6011, are amendments to the undue hardship provision. These amendments may at first glance appear designed to provide a balance against the harsh new transfer rules. Unfortunately, no balance is achieved by these amendments. Attorneys counseling Medicaid applicants must begin with the understanding that the new undue hardship provision is, substantively speaking, virtually no different from the standard that existed prior to the enactment of the DRA.

However, because many attorneys representing Medicaid applicants did not have need prior to the passage of the DRA to request an undue hardship waiver on behalf of their clients, it is vital that attorneys familiarize themselves with the scope of the waiver given the significant likelihood that the new transfer rules will force them to utilize the process.

## 3. *Language of the DRA*

### **42 U.S.C. 1396p(c)(2)(D)**

**(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that. . .**

**(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.**

**The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.**

### **Section 6011(d)**

**(d) Availability of Hardship Waivers - Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))-**

- (1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual -**
  - (A) of medical care such that the individual's health or life would be endangered; or**
  - (B) of food, clothing, shelter, or other necessities of life; and**
- (2) which provides for—**
  - (A) notice to recipients that an undue hardship exception exists;**
  - (B) a timely process for determining whether an undue hardship waiver will be granted; and**
  - (C) a process under which an adverse determination can be appealed.**

**Section 6011(e)**

**The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with consent of the individual or the personal representative of the individual.**

**While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.**

*4. Analysis and Issues*

Because the standard and procedure of the new hardship exception are simply mirrors of the pre-DRA hardship provisions, there has essentially been no change in the undue hardship exception to the penalty period application. The undue hardship provision of the statute as it existed prior to the DRA would likely have been interpreted by a court to include the very same standard and procedure that now exists under the DRA.

Generally, a federal administrative agency's informal interpretation of a statute (such as a policy manual) is entitled to deference as long as the agency has, among other things, the delegated authority to administer the statute and has given thorough consideration to a particular issue. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). An agency's interpretations are entitled to "mandatory" deference where there are "gaps" in the underlying statute, especially a complicated statute such as the Medicaid Act. *Community*

*Health Center v. Wilson-Coker*, 311 F.3d 132, 138 (2<sup>nd</sup> Cir. 2002); See also *S.D. v. Hood*, 391 F.3d 581, 590, n.6 (5<sup>th</sup> Cir. 2004) (“[R]elatively informal CMS interpretations of the Medicaid Act, such as the State Medicaid Manual, are entitled to respectful consideration in light of the agency’s significant expertise, the technical complexity of the Medicaid program, and the exceptionally broad authority conferred upon the Secretary under the Act”). The original undue hardship provision in the statute left an explicit gap for CMS to fill both the standard for and procedure relating to undue hardship, it is clear, to the extent there was any question to begin with, that CMS’s published policy on the subject of undue hardship was the controlling interpretation of the statutory provision on undue hardship prior to the enactment of the DRA. Because the DRA did nothing more than adopt verbatim CMS’s standard and procedure of undue hardship, the language amended to the statutory provision by the DRA did not add anything of substance.

The statutory authority now provided to nursing homes to file the undue hardship waiver does, in fact, represent a substantive change in the law’s undue hardship provision. However, some nursing homes already, include in their admission agreements authority to file a Medicaid application on behalf of a resident. Sometimes a facility may appeal an eligibility denial, and even seek an undue hardship waiver for a resident assessed a penalty period. See *Geriatric & Medical Services, Inc. v. Department of Public Welfare*, 616 A.2d 746 (Pa. 1992).

##### 5. Practice Issues

Perhaps the effect of the amendments to the undue hardship provision will not be commensurate with the impact the changes to the lookback period and penalty period methodology will produce. Because clients will undoubtedly be denied coverage by application of the harsh new transfer rules, how should attorneys proceed in light of Congress arguing that these protections do have meaning?

First, attorneys should familiarize themselves with the undue hardship standard and procedure already existing in their states, if their state has one at all. Many attorneys representing Medicaid applicants may not have had cause yet to seek an undue hardship waiver for one of their clients, but the changes to the transfer rules enacted by the DRA have dramatically increased the likelihood that they will have to. It is therefore imperative that attorneys identify their states’ current procedure so that they are, at the very least, aware of how to invoke the procedure when it becomes necessary to utilize it.

Second, attorneys must identify to what extent their state’s standard and procedure fall short of the federal mandate. In the event that a state is not in compliance, the question will become whether a penalty period may be assessed against a Medicaid applicant in the absence of an available hardship process. In *Estate of Schiola v. Colorado Department of Health Care Policy and Financing*, 51 P.3d 1080 (Colo. 2002), the Colorado Court of Appeals upheld a probate court’s dismissal of a claim against the estate of a deceased Medicaid beneficiary because the state did not comply with the federal law’s undue hardship procedure. Specifically, the state agency did not provide a notice to individuals affected by the proposed estate recovery of the availability of an undue hardship waiver, as required by Section 3810(D) of the State Medicaid Manual.

Third, attorneys should seek to shape the scope of their state's undue hardship procedures, whether directly through communication with the state agency or in the course of state administrative hearings. Although most state undue hardship procedures have been relatively dormant, applications for the waivers will increase dramatically with the new transfer rules, and some states may begin scrambling to piece together both a process and standard that are consistent enough in their combined application to ease the administrative burden of the agency. This may leave an opening for attorneys to influence the agency in the development of reasonable standards, whether through comments on regulations or direct communication with the agency. Attorneys should monitor as closely as possible the agency's developments on undue hardship.

Fourth, attorneys should familiarize themselves with the rights of nursing home residents under both state and federal law. The projected increase in penalty period assessments against Medicaid applicants will likely result in an increase in discharge actions by nursing homes. Nursing homes have the authority to discharge residents who cannot pay their bill, but the right is not unlimited. The most significant limitation is that the discharge cannot take place if it is not a safe one; i.e., the location to which the resident will be discharged is not one where the individual's needs will be met. 42 U.S.C. §1396r(c)(2)(C). All states must have a process by which a nursing facility resident may challenge a discharge, 42 U.S.C. §§1395-3(e)(3), 1396r(e)(3), so attorneys should understand how to file an appeal to maintain a resident's stay in a facility during a penalty period.

Alternatively, attorneys may consider looking to facilities in which their clients may be residing when a penalty period is assessed as partners in an undue hardship procedure. The new law provides "bed hold" payments to a nursing facility to hold a Medicaid bed for a Medicaid applicant seeking an undue hardship exception. Nursing homes, therefore, may be able to reduce their losses during the waiver process and will only stand to gain if the individual is granted a hardship waiver.

#### D. DISCLOSURE AND TREATMENT OF ANNUITIES, §6012

##### *1. Pre-DRA Law*

Section 3258.9(B) of the State Medicaid Manual states:

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of life expectancy of the beneficiary, the annuity can be deemed actuarially sound. . .

The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty.

Two examples in the State Medicaid Manual are: If a 65-year-old man with a life expectancy of nearly 15 years purchases a \$10,000 annuity with a 10-year term, the transfer of assets is actuarially sound. However, if an 80-year-old man with life expectancy of nearly seven years purchases the same annuity, “a payout of the annuity for approximately 3 years is considered a transfer of assets for less than fair market value and that amount is subject to a penalty.” This is the only test authorized by §3258.9(B) of the State Medicaid Manual to assess an annuity.

## 2. *Post-DRA Law*

### a. Disclosure and Notice (Section 6012(a))

Section 1917 of the Social Security Act (42 U.S.C. §1396p) is amended by redesignating subsection (e) as subsection (f) and adding a new subsection (e). For purposes of being eligible for long-term care services under Medicaid, the applicant or her spouse must, under §1396p(e)(1), disclose any interest in an annuity (or similar financial instrument that may be specified by the Secretary).

Such application or recertification form must include a statement that, in the case of disclosure concerning an annuity under §(c)(1)(F), the State becomes a remainder beneficiary under such annuity or similar financial instrument. Also, under §1396p(e)(2)(A), the State must notify the issuer of such an annuity of the right of the State as a preferred remainder beneficiary in the annuity.

Under §1396p(e)(2)(B), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure. The State must take such information into account in determining the amount of the State's obligations for medical assistance as well as the individual's eligibility for such assistance.

Under §1396p(e)(3), the Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value. Section 1396p(e)(4) permits the State to deny eligibility for medical assistance to an individual based on the income or resources derived from an annuity.

### b. State Named as Remainder Beneficiary (Section 6012(b))

Under §1396p(c)(1)(F), the purchase of an annuity is treated as the disposal of an asset for less than fair market value unless (1) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid

on behalf of the annuitant or (2) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

c. Annuities that are not “assets” with respect to transfers (Section 6012(c))

With respect to a transfer of assets, §1396p(c)(1)(G)(i) includes within the term “assets” an annuity purchased by or on behalf of an annuitant who has applied for medical assistance for nursing facility services or other long-term care services unless it is one of the retirement annuities described in §§(c)(1)(G)(i)(I) or (II). Subsection p(c)(1)(G)(ii) includes within the term “assets” a non-retirement annuity purchased on behalf of such an annuitant unless it is an annuity that is irrevocable, non-assignable, and actuarially sound (in accordance with Social Security actuarial publications) and that pays out in equal amounts during the term of the annuity, with no deferral or balloon payments made.

d. Effective Date (Section 6012(d))

The annuity provisions of the Deficit Reduction Act apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of the Act (February 8, 2006). These specific annuity provisions may be subject to the general effective date provisions of §§6016(e)(1) and (e)(2) as well as §6016(e)(3)’s extension of the effective date for State law amendment.

3. *Language of the DRA*

**42 U.S.C. §1396p(c)(1)(F)**

**(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless —**

**(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or**

**(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.”**

**42 U.S.C. §1396p(c)(1)(G)**

**(G) For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with**

respect to nursing facility services or other long-term care services under this title unless –

(i) the annuity is –

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from –

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity –

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.”

42 U.S.C. §1396p(e)

(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer

**from notifying persons with any other remainder interest of the State's remainder interest under such subsection.**

**(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.**

- (3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.**
- (4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1)."**

#### *4. Analysis and Issues*

Subsections (c)(1)(F) and (c)(1)(G) of 42 U.S.C. §1396p(c)(1) describe three instances where the purchase of an annuity will not be considered a "disposal of an asset for less than fair market value".

(1) Subsection (c)(1)(F) says that if the state is named as the remainder beneficiary in the first position (or in the second position after the community spouse or minor or disabled child), then the requirement that the purchase of an annuity be treated as the disposal of an asset for less than fair market value does not apply.

(2) Subsection (c)(1)(G)(i) says that if "an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services" is one of the retirement annuities," described in §(c)(1)(G)(i), then the requirement that the annuity be included as an "asset" with respect to a transfer of assets that purchased the annuity does not apply.

(3) Subsection (c)(1)(G)(ii) says that if such an annuity is irrevocable and non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made, then the requirement that the annuity be included as an "asset" with respect to a transfer of assets does not apply.

CMS may chose to treat subsections (F) and (G) of 42 U.S.C. §1396p(c)(1) as conjunctive and disjunctive provisions and the requirements of both paragraphs must be met before an annuity is not treated as a disposal of an asset for less than fair

market value. If CMS and the states formally adopt this position, this issue is ripe for litigation.

A better interpretation is that under §(c)(1)(F) the state be named as beneficiary in the first or second position applies only to annuities that do not meet the requirements of §(c)(1)(G). With respect to a transfer of assets, §(c)(1)(G) explicitly excludes from the term “assets” the retirement annuities described in §(c)(1)(G)(i) and the irrevocable and non-assignable actuarially sound annuities that meet the requirements of §(c)(1)(G)(ii)(III). Since such annuities are not “assets” with respect to a transfer of assets, they are not “assets” that can be disposed of for less than fair market value. Hence, §(c)(1)(F)’s requirement that the state be named as the remainder beneficiary in the first or second position applies only to annuities that are not excluded as “assets” pursuant to §§(c)(1)(G)(i) or (G)(ii).

This interpretation is consistent with the requirement of §1396p(e)(1) that the Medicaid “application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.” Paragraph (2) refers only to an “annuity under §(c)(1)(F).” It makes no reference to an annuity under §(c)(1)(G). This makes sense, because an annuity under §(c)(1)(F) must name the state as a preferred remainder beneficiary in order for the purchase of the annuity not to be treated as the disposal of an asset for less than fair market value. No such requirement applies to an annuity under §(c)(1)(G). Hence, the statement required by paragraph (2) of §1396p(e) is limited to only those annuities under §(c)(1)(F).

Why would paragraph (2) of §1396p(e) require that the statement that “the State becomes a remainder beneficiary under such an annuity” be included on applications or recertifications where there is an annuity under §(c)(1)(F) but not under §(c)(1)(G)? The only answer is that the state must be a remainder beneficiary unless the annuity satisfies the requirements of §(c)(1)(G). An annuity that meets the requirements of §(c)(1)(G) is not included within the term “assets.” Since such an annuity is not an “asset,” its purchase cannot be treated as the disposal of an asset for less than fair market value. Only an annuity that is an “asset” can be treated as the disposal of an asset for less than fair market value under §(c)(1)(F). However, §(c)(1)(G) explicitly excludes from the term “assets” the retirement annuities described in §(G)(i) and non-retirement annuities that are irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

Paragraph (1) of §1396p(e) requires that “the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or it is treated as an asset.” Since this disclosure requirement applies to all annuities, it applies equally to annuities under §(c)(1)(F) and §(c)(1)(G).

## 5. *Practice Issues*

- a. The DRA governs the treatment of annuities only with respect to transfer of assets.

Subsection (c)(1)(F) applies only when “the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value.” Subsection (c)(1)(G) explicitly defines the term “assets” only “with respect to a transfer of assets.” These subsections appear to be limited to the treatment of annuities for transfer of asset purposes.

- b. There are three ways that the purchase of an annuity won’t be penalized.

Subsection (c)(1)(G) provides two alternate ways for an annuity not to be an “asset” with respect to a transfer of assets. Annuities purchased with proceeds from the retirement accounts listed in §(c)(1)(G)(i) are not includible assets with respect to a transfer of assets. Alternatively, the purchase of non-retirement annuities that meet the requirements of §(c)(1)(G)(ii) are not included as assets with respect to a transfer of assets. The purchase of a retirement annuity that meets the requirements of §(c)(1)(G)(i) is not the transfer of an asset even if the annuity does not meet the requirements of §(c)(1)(G)(ii). Similarly, the purchase of a non-retirement annuity that meets the requirements of §(c)(1)(G)(ii) is not the transfer of an asset, even if the annuity does not meet the requirements of §(c)(1)(G)(i). CMS may chose to require that the exceptions under (c)(1)(F) be met if the annuity is not to be considered a transfer under the transfer of assets rule, regardless of whether the annuity meets the criteria of either (c)(1)(G)(i) or (ii).

- c. All non-retirement annuities will be counted as assets for purposes of the transfer of assets rules unless they are irrevocable and non-assignable.

Subsection (c)(1)(G)(ii)(I), considers all non-retirement annuities that are not both “irrevocable and non-assignable” as “assets” under the transfer of assets rules. Hence, in order not to be included as an asset with respect to a transfer of assets, non-retirement annuities must be “irrevocable and non-assignable.” If the non-retirement annuity cannot be made “irrevocable and non-assignable,” then §(c)(1)(F) requires that the state be named the remainder beneficiary in the first or second position. CMS may chose to require that in addition to meeting §(c)(1)(G)(ii), the exceptions under (c)(1)(F) must also be met if the annuity is not to be considered a transfer under the transfer of assets rule.

- d. The DRA requires that annuities also meet the actuarial standards published by the Office of the Chief Actuary of the Social Security Administration.

In order not to be included as an asset with respect to a transfer of assets, §(c)(1)(G)(ii)(II) requires that non-retirement annuities be “actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief

Actuary of the Social Security Administration).” The tables can be found at <http://www.ssa.gov/OACT/STATS/table4c6.html>.

- e. Acceptable annuities can allow for periodic payments made less frequently than every month as long as they “provide for payments in equal amounts.”

In order not to be included as an asset with respect to a transfer of assets, §(c)(1)(G)(ii)(III) requires that non-retirement annuities provide “for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.” Subsection (c)(1)(G)(ii)(III) says nothing about the frequency of the “payments in equal amounts.” Hence, payments every other month, quarterly, or annually should satisfy this requirement.

- f. The DRA provisions do not apply to annuities purchased by a third party on behalf of a Medicaid applicant / beneficiary or community spouse with funds that never belonged to the applicant/beneficiary or community spouse.

Section 1396p(c)(1) does not apply to an annuity purchased by a third party with funds that never belonged to the applicant/beneficiary or community spouse. Since such funds never belonged to the applicant/beneficiary or community spouse, they are not assets of the community spouse or the applicant and, hence, are not assets for purposes of §1396p(c)(1)’s transfer of asset provisions.

- g. The DRA provisions should not apply to annuities purchased by or on behalf of a community spouse.

Subsection (c)(1)(G) states that “the term ‘assets’ includes an annuity purchased *by or on behalf of an annuitant who has applied for medical assistance* with respect to nursing facility services or other long-term care services unless certain requirements are met. It should not apply to annuities purchased by or on behalf of a community spouse so long as the community spouse is the annuitant and has not applied for medical assistance. However, a purchase of an annuity by and for a community spouse may impact the institutionalized spouse’s Medicaid eligibility under pre-DRA rules. CMS may chose to apply the DRA provisions to annuities purchased by or on behalf of a community spouse for purposes of determining the eligibility of the Medicaid applicant spouse.

- h. The community spouse should be able to use her resource allowance to purchase an annuity without the purchase being treated as the disposal of an asset for less than fair market value.

Subsection (c)(1)(G) does not address how the purchase of an annuity that is not an “asset” will be treated when determining the community spouse resource allowance. However, provided that the annuity is a retirement annuity included in §(c)(1)(G)(i) or a non-retirement annuity that meets the requirements of §(c)(1)(G)(ii), it is not an “asset” with respect to transfer of asset rules. Hence, the purchase of such

an annuity for the community spouse with assets in excess of the community spouse resource allowance cannot under §(c)(1)(G) be treated as a disqualifying transfer. Since there is no transfer of an asset, there can be no “disposal of an asset for less than fair market value” under §(c)(1)(F). CMS may chose that the provisions under §(c)(1)(F) also apply to annuities purchased by or on behalf of a community spouse for purposes of determining the eligibility of the Medicaid applicant spouse.

- i. States should not require that the state be named as the preferred remainder beneficiary for a retirement annuity.

Unless there is a community spouse or minor or disabled child, §(c)(1)(F)(i) requires for annuities not described by §(c)(1)(G) that “the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant.”

Further, at the option of the owner, the annuity certainly could name the state as the remainder beneficiary for the total amount of the annuity. However, §(c)(1)(F)(i) includes no language authorizing the state to condition eligibility on naming the state as the preferred remainder beneficiary for anything more than “the total amount of medical assistance paid.”

- j. For non-retirement annuities, even if a spouse or minor or disabled child is named as remainderman, the annuity contract must state that they cannot dispose of their interest for less than fair market value.

Subsection (c)(1)(F)(ii) requires that the state “is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.” Subparagraph (A) of §1396p(e)(2) requires that, “In the case of disclosure concerning an annuity under §(c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity. . .” Hence, the language of such an annuity must specify that the State be named in the first position if the community spouse or minor or disabled child disposes of their remainder for less than fair market value.

## E. INCOME-FIRST, §6013

### 1. Pre-DRA Law

In the Medicare Catastrophic Coverage Act (MCCA) of 1988,<sup>15</sup> Congress provided certain protections to couples in which one spouse has been institutionalized

---

15. Pub. L. No. 100-360, Stat. 683 (1988); and subsequent technical amendments found in the Family Support Act of 1988, Pub. L. No. 100-485, 102 Stat. 2243; miscellaneous Medicaid Technical Amendments, Pub. L. No. 101-239, 103 Stat. 2106, 6411(e) (OBRA 1989), codified at 42 U.S.C. §1396p(c); and amendments contained in Pub. L. No. 101-508, 4714, 104 Stat. 1388 (OBRA 1990), codified at 42 U.S.C. §1396r-5.

and the other spouse — the “community spouse” — continues to reside at home. The provisions protect a minimum level of the couple’s resources and income to provide the community spouse with the ability to meet basic living expenses.

With respect to resources, the state takes a “snapshot” of the couple’s countable resources on the date that the ill spouse is institutionalized. In general, the community spouse is entitled to retain a portion of these resources, known as the “community spouse resource allowance” (CSRA), which is equal to one-half of the couple’s total countable resources, but not less than \$19,908 nor more than \$99,540 (in 2006).<sup>16</sup> In some states, the community spouse is permitted to retain the maximum resource allowance even if it exceeds one-half of the couple’s resources.

In addition to the CSRA, the community spouse is entitled to keep all of her monthly income regardless of the amount. The community spouse might also be entitled to a share of the institutionalized spouse’s income if the community spouse’s income fell below certain federally mandated levels, known as the community spouse “minimum monthly maintenance needs allowance” (MMMNA).<sup>17</sup> The MMMNA is calculated according to a formula that includes the community spouse’s housing costs. As of January 1, 2006, the MMMNA is set at a minimum of \$1,603.75 and a maximum of \$2,488.50 per month.<sup>18</sup> The community spouse may receive income in excess of the MMMNA cap if it can be demonstrated at a hearing that “due to exceptional circumstances resulting in significant financial duress,” the additional income is required.<sup>19</sup>

Once the MMMNA is determined, if the community spouse’s own income from all sources is insufficient to meet the MMMNA, there are two options to satisfy the shortfall. The first option involves a deduction from the institutionalized spouse’s income to cover the shortfall. After the institutionalized spouse qualifies for Medicaid, the state will deduct from her income an amount sufficient to satisfy the community spouse’s MMMNA. This deduction is made automatically during the Medicaid application process and requires no special procedure or request by either spouse.

The second option to satisfy the shortfall involves either spouse requesting a fair hearing to permit the community spouse to retain resources in excess of the CSRA to generate sufficient income to meet the MMMNA. Federal law provides that:

if either spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse’s income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under §(f)(2),

---

16. These figures reflect adjustments as of January 2006 and are revised annually. See 42 U.S.C. §1396r-5(f)(2)(A).

17. 42 U.S.C. §1396r-5(d).

18. Similar to the CSRA figures, the MMMNA cap is adjusted annually.

19. 42 U.S.C. §1396r-5(e)(2)(B).

an amount adequate to provide such a minimum monthly maintenance needs allowance.<sup>20</sup>

Since its enactment in 1988, states have differed in their interpretation of this language. Some states interpreted this language to mean that the community spouse was entitled to an increased CSRA regardless of the amount of income of the institutionalized spouse. Those states adopting this position are referred to as “resource-first” states. Other states took the position that the community spouse is only entitled to an increased CSRA if the institutionalized spouse’s income is insufficient to meet her MMMNA. These states were referred to as “income-first” states.

CMS did not promulgate regulations to address the conflicting positions taken by the states on this issue. Rather, it issued memoranda stating that since the federal law is ambiguous on this point, states had the option to require the income deduction first or to “apply some other reasonable interpretation of the law until we have issued final regulations which specifically address this issue.”<sup>21</sup> As a result, there was great variation among the states in how CSRAs were determined.

In addition, there were many lawsuits brought to challenge states that required the income-first approach. The United States Courts of Appeals for the Sixth and Third Circuits upheld the income-first rule. On the other hand, the Wisconsin Court of Appeals invalidated a Wisconsin income-first statute, causing the United States Supreme Court to review the issue. In the meantime, CMS, intending to codify its prior position, proposed regulations on August 20, 2001 “to allow States the threshold choice of using either the income-first or resources-first method when determining whether the community spouse has sufficient income to meet minimum monthly maintenance needs.” 66 Fed. Reg. 46763, 46765 (2001).

Before CMS could finalize its proposed regulations, however, the United States Supreme Court issued its decision on February 20, 2002, holding that “the income-first method is a permissible means of implementing the Act” and basically affirming the CMS position that states should have the leeway to choose either method. *Wisconsin Dept. of Health and Family Servs. v. Blumer*, 534 US 473 (2002). Since the *Blumer* decision, many more states have adopted the income-first methodology; however, some states continued their use of “resources-first.”

## 2. Post-DRA Law

The DRA requires all states to adopt the income-first methodology. Specifically, Section 6013 of the DRA requires states to consider that all income of the institutionalized spouse that could be made available to a community spouse, in

---

20. 42 U.S.C. §1396r-5(e)(2)(C).

21. HCFA Memorandum dated March 3, 1994, from Sally K. Richardson, Director, Medicaid Bureau, to all Regional Directors. For excerpts of the HCFA Memorandum, see *The Elder Law Report*, Vol. VI, No. 1 (July/August 1994).

accordance with the calculation of the community spouse monthly income allowance, has been made available before the state allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.<sup>22</sup>

The requirement to use income-first applies to “transfers and allocations made on or after the date of enactment of this Act by individuals who become institutionalized spouses on or after such date.”<sup>23</sup> Note that income-first methodology will only be required where institutionalization occurred on or after February 8, 2006 (date of enactment). Thus, in resource-first states, individuals applying for Medicaid two years from now, for example, may still be able to require a resource-first methodology, if institutionalization occurred prior to February 8, 2006. In those states, couples may need to be advised of the potential loss of this valuable strategy for the preservation of resources for the community spouse, if the institutionalized spouse were to return home for a few months and were then institutionalized again.

Some states may view the income-first provision as subject to the general effective date language in Section 6016 of the DRA, which allows an extension for implementation when state law changes are required. However, Section 6016 conflicts with the effective date language in Section 6013(b) applicable to income-first.

According to the DRA language mandating income-first quoted above, the state Medicaid agency must consider “all income of the institutionalized spouse that *could be made available* to a community spouse.” In response to a query whether such government benefits as Social Security and VA benefits “could be made available” given the prohibition against assignment of such benefit checks, the Second Circuit Appeals Court in *Robbins v. DeBuono*, 218 F.3d 197 (2<sup>nd</sup> Cir. 2000) concluded that deeming Social Security benefits of an institutionalized spouse to a community spouse in an income-first state violates the anti-alienation provisions of the Social Security Act.<sup>24</sup> However, since *Robbins* was decided, the U.S. Supreme Court in *Keffeler* has interpreted the anti-alienation provisions of the Social Security Act narrowly, requiring that the forbidden legal process be closer to “execution, levy, attachment and garnishment . . . and at a minimum would require utilization of some judicial or quasi-judicial mechanism. . . .”<sup>25</sup>

In a *Robbins*-like challenge in Massachusetts post-*Keffeler*, the Massachusetts Federal District Court held that the “deeming” process used by the Commonwealth of Massachusetts in determining Medicaid eligibility has even less resemblance to any ‘legal process’ recognized by the Supreme Court than the process used by the State of Washington in *Keffeler*” and granted summary judgment for the defendants. In a footnote, the Court also stated that “the Second Circuit has recognized that the

---

22. 42 U.S.C. 1396r-5(d)(6).

23. Section 6013(b) of the DRA.

24. 42 U.S.C. §407(a).

25. *Washington State Department of Social and Health Services v. Guardianship Estate of Keffeler*, 537 U.S. 371, 385 (2003).

Supreme Court's more recent decision [in *Keffeler*] throws a shadow over *Robbins*. See *Binder & Binder, P.C. v. Barnhart, Commissioner of Social Security Administration*, 399 F.3d 128, 134 (2<sup>nd</sup> Cir. 2005).<sup>26</sup>

A recent New York Appellate Division decision reached a different conclusion. In *Matter of Tomack*, 2006 NY Slip Op 01683 (App. Div. March 9, 2006), the court distinguished between holdings in *Robbins* and *Keffler*. The court held that Social Security income cannot be allocated from an institutionalized spouse to a community spouse when determining Medicaid eligibility. Thus, the income-first rule and the treatment of Social Security income are subject to varying interpretations on a state-by-state basis.

### 3. Language of the DRA

**42 U.S.C. §1396r-5(d) is amended by adding the following new subparagraph:**

**(6) APPLICATION OF “INCOME FIRST” RULE TO REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE. —For purposes of this subsection and sections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.**

### 4. Analysis and Issues

The change to income-first will reduce the number of cases where it is possible to request a hearing to enable the community spouse to keep additional resources in excess of the normal CSRA. Such hearings will still be possible where both spouses have low Social Security or pension income and depend on their investment income to maintain themselves. In such cases, even if the community spouse receives all of the institutionalized income, it may be insufficient to bring the community spouse's income up to the MMMNA. The community spouse should then be able to retain additional resources to generate the necessary income after presenting the income and resource figures at a hearing.

It is then crucial that the state use a fair rate of interest to determine the amount of the increased CSRA. Many states require proof of the actual income earned by the additional resources; other states impute a fixed rate based on an index. When Massachusetts became a resource-first state as a result of state legislation supported by

---

26. *Bianconi v. Preston*, 383 F.Supp.2d 276, at 278 n.1, (D.Mass.2005).

elder advocates, the Medicaid agency changed its regulations to require the use of “the highest rate quoted in the Bank Rate Monitor Index”<sup>27</sup> to calculate the amount of additional resources a community spouse could keep. The highest interest rate reported in this index was the five-year CD rate, currently running at about 3.87%, a rate that bore no relationship to the actual interest earned by the elder’s resources. Even after the state changed to income-first in January 2003, it has continued to use this abnormally high rate of interest as a way of forcing couples to spend more of their resources before qualifying for Medicaid. Elder advocates in Massachusetts are challenging the use of this interest rate in court and supporting state legislation to require a money market rate of interest.

Under income-first, most CSRA hearings occur when the community spouse resides in an assisted living facility or at home with full-time home health care. In both situations, the community spouse is likely to be able to claim “exceptional circumstances resulting in significant financial duress” pursuant to 42 USC 1396r-5 (e)(2)(B), which applies an increased MMMNA beyond the statutory cap. For example, in Massachusetts, a community spouse who resides in an assisted living facility and pays \$4,000 per month in room, board and care charges may request that her actual monthly expenses be used to calculate the increased MMMNA. By establishing an MMMNA in such cases of \$5,000-\$7,000 (after the inclusion of other medical expenses), additional resources are usually required to supplement the couple’s income, even under the income-first methodology.

##### 5. *Practice Issues*

Elder advocates pushed for resource-first as the best means to protect a community spouse from impoverishment upon the institutionalized spouse’s subsequent death. With the switch to income-first, other planning strategies designed to protect resources for the community spouse will take priority.

In the majority of cases, community spouses will be able to purchase an annuity to protect their assets. Unfortunately, the annuity payments often merely replace the income of the institutionalized spouse to which the community spouse would have been entitled had she not purchased the annuity. Even in such circumstances, however, at least the annuity payments survive the institutionalized spouse’s death when in many cases the institutionalized spouse’s income does not survive.

Purchasing an annuity may also require the sale of appreciated securities causing a significant income tax liability that could have been avoided by an increased CSRA under resource-first. Where the excess resources are qualified retirement funds held in the name of the institutionalized spouse, an additional income tax liability may be created. If the circumstances allow, additional tax liabilities may be reduced by withdrawing qualified retirement funds over more than one taxable year.

---

27. 130 CMR 520.017.

Since community spouses will not be able to keep additional resources under the increased CSRA approach, more community spouses will consider spousal refusal. Federal Medicaid law provides that the institutionalized spouse will be entitled to Medicaid when one of the following requirements is met:

1. the institutionalized spouse has assigned to the state any rights to support from the community spouse;
2. the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment, but the state has the right to bring a support action against a community spouse without such assignment; or
3. the state determines that denial of eligibility would work an undue hardship.<sup>28</sup>

In 2005, the Court of Appeals for the Second Circuit in *Morenz v. Wilson-Coker*, 415 F.3d 230 (2<sup>nd</sup> Cir. 2005), affirmed the right of the institutionalized spouse to be approved for Medicaid, even when the community spouse has excess resources, as long as the institutionalized spouse assigns to the state all rights to support from the community spouse. Thus, spousal refusal is likely to be used more often now that income-first is mandated.

Federal Medicaid law provides for an exception to the CSRA limitation on the resources of a community spouse when “a court has entered an order against an institutionalized spouse for the support of the community spouse.”<sup>29</sup> Where states have implemented the income-first rule foreclosing the increased resource allowance for most couples, seeking court-ordered support may be an appropriate alternative option.

CMS and some states have taken the position that they will not honor court orders that *preserve* a community spouse’s already owned resources, only those that order a *transfer* of resources from the institutionalized spouse to the community spouse.<sup>30</sup> In other words, if a community spouse obtains a court order requiring the institutionalized spouse to transfer all of his \$100,000 of countable resources, the CMS obligates the state Medicaid agency to accept this amount as the CSRA, even if it, plus whatever the community spouse had in her own name, is greater than any amount ordered under the ordinary CSRA rules. On the other hand, if the same \$100,000 was already in the name of the community spouse, the Medicaid state agency is not required to accept a court order stating that the community spouse is entitled to retain those resources for her support in lieu of the normally calculated CSRA.

---

28. 42 U.S.C. §1396r-5(c)(3).

29. 42 U.S.C. §1396r-5(f)(3).

30. See letter of Sally K. Richardson, Director, Medicaid Bureau, Department of Health and Human Services, to Sue Kelly, Deputy Commissioner, Division of Health and Long Term Care, New York State Department of Social Services, December 8, 1994 reprinted in part in Landsman, Ron, “Going to Court to Improve Spousal Benefits, Part I” *The Elder Law Report*; Vol.X, Nos.1/2 (September 1998), p. 5.

When the community spouse finds that neither the income allowance determined under the standard formula nor that resulting from an administrative hearing would be sufficient, she can seek a court order awarding income. Pursuant to 42 U.S.C. §1396r-5(d)(5).

If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

CMS has confirmed that where a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the monthly income allowance determined by the state Medicaid agency cannot be less than the amount ordered by the court.<sup>31</sup>

Some states were concerned about the frequency with which community spouses were obtaining court orders directing the payment of income from institutionalized spouses to themselves in amounts exceeding the amounts that would ordinarily be allowed under the usual Medicaid formula. New York's Medicaid program claimed that the judicial standard for ordering support should be governed by the same standard as that imposed in Medicaid administrative hearings to adjust income allowances. The issue was litigated in New York, and the court held that "the standard for spousal income orders would be drawn in part from the federal Medicaid standard—an amount sufficient to allow the community spouse to avoid poverty, not to maintain the spouse's prior standard of living or lifestyle. Moreover, partly importing the ALJ standard, it required that there be a showing of exceptional circumstances to obtain the amount sought."<sup>32</sup> Connecticut and Nevada have taken a similar approach to New York in trying to impose Medicaid standards in the judicial arena.

These states, however, appear to be the exception. The majority of states appear to comply with federal law, adopting the language in 42 U.S.C. §1396r-5(d)(5) in the state regulations, almost verbatim without restrictions.<sup>33</sup>

Seeking a court order of support against an institutionalized spouse may be a viable option for increasing the amounts of income and/or resources that a community spouse may have available for her support, in light of the change to income-first.

---

31. *Id.*

32. Landsman, Ron M., "Going to Court to Improve Spousal Benefits, Part II, *The Elder Law Report*, Vol.X, No.5(December 1998), p. 5 describing the holding in *Gomprecht v. Gomprecht*, 86 N.Y.2d 47, 629 N.Y.S.2d 190, 652 N.E.2d 936 (1995). Community spouses were unsuccessful in their federal court case challenging this holding. See *Jenkins v. Fields*, No. 95 Civ. 9603(JSM), 1996 Medicare & Medicaid Guide (CCH) ¶44,198 (S.D.N.Y.May 1, 1996).

33. See Landsman, Ron M., "Going to Court to Improve Spousal Benefits, Part II, *The Elder Law Report*, Vol.X, No.5 (December 1998), pp. 1, 5 for a detailed discussion of how various states have implemented these federal provisions.

## F. HOME EQUITY CAP UNDER THE DRA, §6014

*1. Pre-DRA Law*

Prior to the DRA, there was no limit on the value of property used as a principal residence. Simply stated, a Medicaid applicant's principal residence was an exempt resource regardless of value. The exemption extended to the land or buildings surrounding the residence itself. 42 U.S.C. §1382b(a)(1), 20 C.F.R. §116.1212. Additionally, the residence continues to be exempt if the individual is not residing in the residence but intends to return to it. 20 CFR §416.1212(c).

It has long been appropriate to convert non-exempt resources, such as cash, into enhanced value in one's residence without interfering with or jeopardizing Medicaid eligibility. For example, a person could use the cash to satisfy a mortgage, make improvements, and provide maintenance.

The residence was given an elevated, protected status entirely in keeping with our nation's social values, which dramatically encourage home ownership and provide incentives to maintain home ownership. Transfer of the residence to specific individuals, again without limitation on value, is allowed to any of the following without jeopardizing Medicaid eligibility:

1. The spouse.
2. A minor, blind, or disabled child.
3. A sibling who has any equity interest in the residence and who resided in it for at least one year before the Medicaid applicant became institutionalized.
4. An adult, non-disabled child who resided in the home for at least two years before the applicant became institutionalized and who "provided care to such individual which permitted such individual to reside at home rather than in an institution or facility."

(42 USC §1396p(c)(2)(A))

*2. Post-DRA Law*

The DRA imposes a \$500,000 cap on the value of an exempt residence when the owner is institutionalized and residing in a nursing home. Section 6014(a). States are given the option of increasing the level of protection to no more than \$750,000. States may exercise this option, but the federal law provides them no incentive to do so. The home equity limit of \$500,000 will remain static until 2011, at which point it will increase annually with the Consumer Price Index. While this provision may have little practical effect on most seniors because their homes are worth less than \$500,000, the cap will hurt those whose homes have appreciated greatly since their date of purchase.

For example, a home in a typical Michigan community may be worth \$250,000 but a similar residence located in California may be valued at \$800,000 or higher. This legislation discriminates regionally against those who, by good fortune, good choice, or good luck, live in areas where homes have increased in value over the years.

There are exceptions. If an applicant's spouse, minor, blind, or disabled child is living in the home the cap does not apply.

Eligibility may be granted, and the home equity cap waived, "in the case of a demonstrated hardship." Section 6014(a)(4). The Secretary is required to establish the process and criteria to determine when this exception applies. Such criteria must be established immediately, given the January 1, 2006, implementation date of the home equity cap. It is unclear what a state agency will do when eligibility is denied and a hardship waiver is requested. Eligibility may be granted, pending review of the waiver request. On due process grounds alone, this outcome should be inevitable since the Secretary is required to establish the process and, until she does so, no process exists.

### 3. *Language of the DRA*

**(a) In General-** Section 1917 of the Social Security Act, as amended by section 6012(a), is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

**(f) (1)**

**(A) Notwithstanding any other provision of this title, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds \$500,000.**

**(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for '\$500,000', an amount that exceeds such amount, but does not exceed \$750,000.**

**(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.**

**(2) Paragraph (1) shall not apply with respect to an individual if—**

**(A) the spouse of such individual, or**

**(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, is lawfully residing in the individual's home.**

**(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.**

**(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.**

#### *4. Analysis and Issues*

This provision of the law is already in effect. The DRA specifically states that the home equity provisions apply to individuals who are determined eligible for medical assistance with regard to nursing facility services or other long-term care services if they file an application on or after January 1, 2006. Section 6014(b). It will particularly affect single elders, predominantly women who have no living spouse.

Actual implementation at the state and local level await action by state Medicaid programs. Given the explicit application of the equity cap to applications filed on or after January 1, 2006, countless applications will be approved regardless of home equity values where eligibility workers have no knowledge of the DRA. Unknown is what state Medicaid programs will do with applications successfully filed after January 1 and before actual "hands on" implementation. Some states may await annual re-determination to examine home equity limits and presumably deny ongoing eligibility. Others may be more aggressive and conduct reviews of such applications after implementation. Still others may quietly "grandfather" such applications to avoid administrative costs and possible litigation.

#### *5. Practice Issues*

The DRA indicates that "nothing... shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity in the home." This provision is ingenuous, at best. It is as unrealistic as it is punishing. A reverse mortgage is unavailable if the individual is already in a nursing home. If such a mortgage has been obtained, it will likely result in the forced sale of the residence. Virtually every reverse mortgage calls for the acceleration and satisfaction of total indebtedness when an individual has permanently ceased to reside in her home. Typically, this is a maximum of one year after the individual moves out of the home for any reason.

When the residence is sold, it is converted into cash, a non-exempt resource. Medicaid eligibility would therefore be lost. The entire estate is exposed and will likely be lost.

A home equity loan is little better, given the immediate monthly repayment responsibility. Once loan proceeds are exhausted, default on the loan or a forced sale is likely to follow. Even if rented, in many communities the rent will not cover home equity loan payments, property taxes, and other expenses borne by the homeowner. Forced sale will again be inevitable and the entire value of the residence will be lost.

The only home equity loans that will be available to isolated, middle and low income elders in such circumstances are from substandard lenders. Many elders, typically widows, will have no one to protect them. They will be increasingly vulnerable, obtaining loans with excessive closing costs and needlessly high rates. Foreclosures are inevitable in such circumstances.

In some instances, an entrance fee to a Continuing Care Retirement Community (CCRC) effectively purchases an ownership interest which might be valued in excess of \$500,000. Terms of the CCRC agreement may constrain the resident from any action (short of termination or death) to reduce the size or value of that interest. Such interests may not be problematic, however, as they will not likely satisfy a forthcoming definition of “equity interest.”

#### G. IMPLICATIONS OF THE CCRC PROVISIONS OF THE DRA, §6015

##### 1. Pre-DRA Law

The Maryland Court of Appeals’ decision in *Oak Crest v. Murphy*, 379 Md. 229 (2004), provides a comprehensive summary of pre-DRA law in relation to Continuing Care Retirement Communities (CCRCs). In *Oak Crest*, a CCRC, brought a breach of contract and fraud action against a resident for qualifying for Medicaid without the CCRC’s permission. As a condition of entry, the resident and his wife had signed an agreement not to divest assets if the sale or transfer would result in their net worth falling below the minimum necessary to be a resident of the community. On appeal from a Summary Judgment dismissal of *Oak Crest*’s case, the Maryland Court of Appeals held that: 1) the agreement violated state law<sup>34</sup> precluding Medicaid-certified nursing facilities from requiring a resident to pay private pay rates if he qualified for Medicaid, and (2) a nursing home within a Medicaid-participating CCRC is governed by Medicaid law. Although *Oak Crest* was decided under Maryland state law, the relevant state law is nearly identical to federal law.<sup>35</sup>

Addressing the policy implications of the decision, the Maryland Court of Appeals concluded “If our enforcement of the statute creates unfairness or endangers the financial health of the CCRCs, the address for relief should be made to the [legislature].”<sup>36</sup> It appears that the authors of the DRA’s CCRC provisions took this directive to heart.

The Maryland Court of Appeals found contract provisions barring Medicaid until other resources were exhausted constituted an illegal pre-payment requirement.<sup>37</sup> The Circuit Court for Baltimore County announced, in granting Defendant’s Motion for

---

34. MD Code, Health-General, §19-345, The Nursing Home Residents’ Bill of Rights.

35. “Although we have based our decision in this case solely on State law, there are Federal statutes and regulations of similar import.” *Oak Crest v. Murphy*, 379 Md. 229 (2004) n.6.

36. 379 MD. 229 at 249.

37. *Oak Crest v. Murphy*, 379 Md. 229 (2004).

Summary Judgment, that a CCRC “cannot accept the benefits of Medicaid without complying with the rules and regulations that come with it.”<sup>38</sup>

a. Prohibition on Requiring Waiver of Federal Rights

Federal Medicaid law, 42 U.S.C. §1396r(c)(5)(A)(i), prohibits a nursing facility from requiring “oral or written assurance that [applicants for residence] are not eligible for, *or will not apply for*, benefits under this title [Medicaid].” (Emphasis added).<sup>39</sup> Additionally, 42 U.S.C. §1320a-7b (d)(2003) provides:

Whoever knowingly and willfully –

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX [42 USCS §1396 *et seq.*], any . . . money . . . or other consideration . . .

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient’s continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

i. A CCRC With A Nursing Home Is A Skilled Nursing Facility

Federal Medicaid regulations provide that: “Facility means a skilled nursing facility (SNF) or a nursing facility (NF) . . .”

For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the ‘facility’ is always the entity which participates in the [Medicaid] program, whether that entity is composed of all of, or a distinct part of a larger institution.

42 CFR 483.5 (emphasis added).

38. Oak Crest v. Murphy, , 03-C-02-006364.

39. Maryland Ann. Code, Health-General §19-345(b)(1), part of the Maryland Nursing Home Residents Bill of Rights, states: “A Medicaid certified facility may not: (i) include in the admission contract of a resident any requirement that, to stay at the facility, the resident will be required to pay for any period of time *or amount of money* as a private pay resident for any period when the resident is eligible for Medicaid benefits.” (Emphasis added).

*See also* COMAR 10.07.09.05 B(3) (“A nursing facility may not . . . charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under Medicaid, . . . money . . . or other consideration as a precondition of admission or . . . continued stay in the nursing facility”). Furthermore, the financial obligation of a Medicaid recipient is limited to the amount of the recipient’s funds that are considered available by Medicaid. MD. CODE ANN., HEALTH GEN. II, §19-344(c)(3).

## ii. Prohibition of Pre-Payment Requirements

Federal and state law prohibitions against “pre-payment contracts” support an important public policy, as a New York Court concluded when faced with a nursing home agreement similar to that in *Oak Crest v. Murphy*. There, in order to gain admission to a Medicaid participating nursing home, the applicant and her son, as his mother’s “Sponsor,” signed an admission contract which required 18 months of private pay prior to application for Medicaid.<sup>40</sup> The resident paid for three months at the private pay rate, then applied and eventually qualified for Medicaid. The nursing home sued, claiming that the resident was obligated under the agreement for the difference between the Medicaid payments and the private pay rate.<sup>41</sup> The Court held the agreement illegal and unenforceable because it violated State and Federal law (42 U.S.C. §1396h).<sup>42</sup>

In voiding the nursing home contract, the Court relied upon public policy considerations. The Court first acknowledged that, as matter of contract, “a party may waive a rule of law, a statute, or even a constitutional provision enacted for her benefit or protection, so long as only a private right is involved.”<sup>43</sup> But, rights or benefits that are “based upon public policy considerations which negatively affect the public interest . . . may not be waived.”<sup>44</sup> The Court held that the rights abridged by the nursing home’s illegal admission contract are important public rights, as evidenced by the statute (cited above) making the prohibited agreement a felony under Federal law. Therefore, the agreement was determined to be void as against public policy.<sup>45</sup>

## b. Treatment of Entrance Fees as Exempt Assets

The Maryland Attorney General’s treatment of entrance fees illustrates states’ typical and logical treatment of entrance fees prior to the DRA. In 1994, the Maryland Attorney General unequivocally classified CCRC entrance fees as unavailable to the resident and therefore not countable. The Maryland Attorney General’s Office has consistently excluded entrance fees in determining Medicaid eligibility, for two reasons:

---

40. The contract provided that, in consideration of admission, the resident and Sponsor agreed to pay the nursing home its full private pay rate for services rendered until (a) the resident had been a patient in the Facility for at least 18 months, and (b) the patient and Sponsor had paid all private pay sums due for the first 18 months. *Glengariff Corporation v. Snook*, 471 N.Y.S. 2d 973 (1984).

41. *Id.* at 975.

42. 42 U.S.C. §1396h is the predecessor to 42 U.S.C. 1320a-7b (d)(2).

43. 471 N.Y.S. 2d 973 at 974 (1984).

44. *Id.* at 970.

45. *Id.* at 971. Stating the overriding public policy concern, the Court warned: “if the clause in the contract be deemed an effective waiver, such ‘waivers’ will rapidly find their way into all nursing home contracts, thereby rendering the public’s protection of Medicaid recipients and their families totally ineffective.” *Id.*

(1) the Office believes it appropriate to treat the fee, normally the result of selling one's home, as a home exclusion and (2) the office considers such fees non-liquid resources and non-transferable, leaving them without value on the open market. The Maryland Attorney General has stated that entrance fees are correctly assigned a zero value as a countable resource for Medicaid eligibility purposes.

The fee is neither countable nor available. It is only a resource if one can sell it and the entrance fee cannot be sold. The resident does not retain control of the entrance fee, nor is it marketable. Therefore, it is not an available, countable resource. 20 CFR 416.1201. In determining Medicaid eligibility, federal law requires that most states use the SSI rules.<sup>46</sup> 42 U.S.C. §1396a(a)(10)(C)(i). According to the SSI rules, the entrance fee is a non-liquid non-marketable resource; therefore, it is not countable and not available.

### 2. *Post-DRA Law*

Federal law as it exists under the DRA has been amended with regard to countable assets to include entrance fees. Additionally, CCRCs may require residents to spend down all "resources declared for the purpose of admission before applying for medical assistance." 42 U.S.C. §1396r. Aside from being a rollover of exempt housing, the entrance fee can be viewed as payment for services to be rendered for value as a condition precedent to admission to the CCRC.

Confining funds for its own use, a CCRC violates prohibitions on illegal prepayment. By both requiring and holding the entrance fee, the community violates the proscription against "receiving, in addition to any amount otherwise required to be paid under the State Plan, any . . . other consideration as a precondition of . . . continued stay in the facility." 42 U.S.C. §1396r (c)(5)(A)(iii). Under the DRA, the CCRC cannot only retain the entrance fee, but also has a "right" to money the resident has accumulated. The right retained by the CCRC to distribute funds at any time is tantamount to an illegal prepayment requirement for admission to the facility and will surely result in residents being forced to forego their right to Medicaid benefits.

### 3. *Language of the DRA*

(a) Admission Policies of Nursing Facilities-Section 1919(c)(5) of the Social Security Act (42 U.S.C. 1396r(c)(5)) is amended—

- (1) in subparagraph (A)(i)(II), by inserting 'subject to clause (v),' after '(II)'; and
- (2) by adding at the end of subparagraph (B) the following new clause:  
**(v) TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITIES ADMISSION CONTRACTS- Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c)**

---

46. A few states have exercised the option provided by 42 U.S.C. §1396a(f) to apply eligibility methodologies more restrictive than the Supplemental Security Income program.

**and (d) of section 1924, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.**

(b) Treatment of Entrance Fees- Section 1917 of such Act (42 U.S.C. 1396p), as amended by sections 6012(a) and 6014(a), is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

**(g) TREATMENT OF ENTRANCE FEES OF INDIVIDUALS RESIDING IN CONTINUING CARE RETIREMENT COMMUNITIES-**

(1) IN GENERAL- For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) TREATMENT OF ENTRANCE FEE- For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

**(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;**

**(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and**

**(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.**

#### *4. Analysis and Issues*

The DRA requires applicants to waive federal rights to Medicaid by throwing out prohibitions on pre-payment requirements, and deprives residents from being allowed exempt transfers. “[C]ontracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such a community, may require residents to

spend on their care resources declared for the purpose of admission before applying for medical assistance.”<sup>47</sup> It remains unclear whether, an individual can be legally required to spend all the money she reported at application on the cost of care.

The DRA classifies entrance fees as available when all of the following are met: (1) “the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;” (2) “the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the [CCRC]. . . and leaves the community; and” (3) “the entrance fee does not confer an ownership interest in the [CCRC].”<sup>48</sup>

#### a. Must Be Available

The first criterion requires that the funds be available for the resident to pay for care, CCRC entrance contracts fail this requirement. If the fee were available then the resident could access the money without asking anyone’s permission. Generally, if the fee is accessible by the resident (which is often not the case), it is only after all other funds have been exhausted and then only to pay the CCRC’s fees.

*Non-Liquid:* For purposes of Medicaid eligibility, most states must use the SSI rules to determine Medicaid eligibility. 42 U.S.C. 1396a(a)(10)(C)(i). Social Security is the only agency that can determine eligibility rules, and SSI governs Medicaid in nearly every jurisdiction.<sup>49</sup> According to SSI rules, a resource is defined as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert into cash to be used for her support and maintenance. 20 CFR §416.1201(a). If a resource cannot be liquidated within 20 working days, it is a non-liquid resource. 20 CFR §416.120 1 (c); Social Security Administration, POMS §SI 01110.300.

It is uncertain whether, according to any existing contract, the funds are actually available. No one has looked at one of these contracts to determine whether the funds are truly ‘available.’ The Social Security Administration has confirmed that they “have not evaluated specifically how [CCRC contracts] would be considered under SSI program rules.”<sup>50</sup>

#### b. Refundable

The refundable entrance fee is subject to many conditions which limit the ability of a resident to have it refunded. If a couple enters a CCRC and one spouse remains in the CCRC while the other leaves, the fee is often deemed paid on behalf of the remaining resident. Additionally, a fee is not refundable until a qualified new resident has signed an

---

47. Deficit Reduction Act, S. 1932, Title VI, Subtitle A, Sec. 6015(a)(2).

48. Deficit Reduction Act, S. 1932, Title VI, Subtitle A, Sec. 6015(b).

49. ‘209b’ states are the exception to the majority.

50. Letter from Social Security to Jason A. Frank, Esquire, June 14, 2005.

agreement for the vacating tenant's exact unit, and paid his entrance fee in full. Moreover, the CCRC is not obliged to return the fee within any set period of time.

c. Must Not Convey a Property Interest

An entrance fee paid on behalf of a resident may convey an equitable property interest in the CCRC. The entrance fee is most often paid from the proceeds of selling one's home. For this reason, the Maryland Attorney General's Office had excluded entrance fees from being classified as countable, available resources.<sup>51</sup>

Under some contracts, the CCRC unit must be 'resold' before the resident may receive any refund amount. If the unit is not sold quickly, the resident may have the discretion to lower the entrance fee for that unit, just as a homeowner may lower the asking price of her home. Even if the resident is not considered an owner of her unit, she certainly is more than a mere tenant. Though the CCRCs claim the resident has no ownership interest in the unit, she clearly does.

When an individual sells her home and uses the proceeds to pay the entrance fee, she is converting the value of the home from being exempt to non-exempt though CCRC's do not notify residents of this significant loss of an exempt asset under Medicaid law.

Applying the three-part analysis given, one comes to a different conclusion. This conclusion is the same one that the Maryland Attorney General's Office came to many years ago: the fee is neither countable nor available.

d. Other Issues

The DRA also raises serious constitutional issues in the way the law was amended. This legislation creates gross inequity under the law. Making the entrance fee available only to the management of CCRCs (and not nursing homes, assisted living facilities, or individuals) is tantamount to an illegal prepayment requirement, which will surely delay eligible individuals from exercising their rights to Medicaid. State action is satisfied because the facility must be state licensed.

The consequences of this legislation were never evaluated. It was premature to issue legislation based on general statements, and without authority. Before such legislation was passed, SSI should have at least reviewed the relevant contracts.

In addition, prohibiting pre-payment requirements protects seniors. Allowing CCRCs to access the entrance fee for their own use is tantamount to an illegal pre-payment requirement. This will inevitably force seniors to forego their rights to Medicaid.

---

51. Considering how the entrance fee is typically obtained, and "[b]ecause the home exclusion is intended to protect the residence of an institutionalized person and the person's spouse, the exclusion is applicable to this entrance [fee]". Maryland Medical Assistance Manual, Release MR-67, Page No. 800-825, Appendix I.

*U.S. Constitutional Issues:* There are 5<sup>th</sup> and 14<sup>th</sup> Amendment Due Process and Equal Protection violations in this legislation.<sup>52</sup> One cannot be required to waive Medicaid rights to control one's own assets unless she lives in a CCRC where she will be required to give all money to the CCRC. If one lives elsewhere, she is not required to waive such rights. This is a denial of due process and equal protection<sup>53</sup>.

### 5. Practice Issues

The following four practice suggestions appear permissible under the DRA. They may not be necessary.

1. The applicant may want to consider transferring assets before she applies for admission into a CCRC and has to complete a list of available resources.
2. When an applicant must leave the independent living unit for additional care (assisted or nursing), she may want to consider leaving the CCRC and obtain a refund of the entrance fee as quickly as possible.
3. When applying for admission to a CCRC, an applicant may want to report only the minimum income and assets necessary to gain admission. The following guidelines should help with calculations:
  - a. Assets of two to three times the entrance fee; and
  - b. Monthly income at least equal to the independent living fee in non-asset based income, such as social security or pension.
4. Purchase a Long-Term Care Partnership Insurance policy with enough benefits to cover the entrance fee. If the applicant has a qualified plan,<sup>54</sup> the insurance company will pay her bill, and in addition, every dollar paid in benefits increases her Medicaid exempt assets, dollar for dollar to include and potentially exceed the entrance fee.

## H. OTHER OPERATIONAL CHANGES IN THE IMPOSITION OF TRANSFER PENALTIES, §6016

### H-1. Requirement to Impose Partial Months of Ineligibility, §6016(A)

#### 1. Pre-DRA Law

When calculating the length of the penalty period where assets are transferred for less than fair market value, pre-DRA law allowed states to “round down,” that is not

---

52. “[N]or be deprived of life, liberty, or property, without due process of law.” U.S. CONST. AMEND. V. “[N]or shall any State deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. AMEND. XIV.

53. “[N]or shall any State “deprive any person within its jurisdiction the equal protection of the laws.” U.S. CONST. AMEND. XIV

54. What is considered a “qualified plan” is to be determined by each state.

include in the ineligibility period the fractional amount (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a state with an average private stay in a nursing home of \$4,100, an ineligibility period for an improper transfer of \$53,000 could be 12.92 months (i.e.,  $\$53,000/\$4,100= 12.92$ ). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states permitted the rounding down of the quotient to an ineligibility period of only 12 months.

## 2. *Post-DRA Law*

After the DRA, states will no longer be permitted to round down to the nearest whole number; they will be required to impose a penalty period for the fractional portion derived from the calculation used to determine the length of the penalty period. In the example above, that would require imposition of a 12.92 month penalty period instead of a penalty period rounded down to 12 months.

## 3. *Language of the DRA*

### **42 USC 1396p(c)(1)(E)**

**(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to –**

**(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by**

**(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.**

**(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to**

**(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by**

**(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.**

**(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced-**

**(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and**

**(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.**

**(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.**

#### *4. Analysis and Issues*

The fundamental concern with reference to the partial month penalty was not the partial month added at the end of a calculated penalty, but rather the capacity to utilize the rounding down to enhance the amount of assets that could be transferred during a comparable period of time.

Under pre-DRA law, the basic Medicaid rule regarding the transfer of assets was that if an applicant transfers assets, she will be ineligible for Medicaid for a period of time beginning on the date of the transfer. The penalty period, or the actual number of months of ineligibility, is determined by dividing the value of the transferred assets by the monthly cost of care established by the state. Using a divisor of \$4,100 (the amount used in the Conference Report), if an applicant made gifts totaling \$53,000, she would be ineligible for Medicaid for 12.92 months ( $\$53,000 \div \$4,100 = 12.92$ ).

Many states treated partial month penalties by rounding down the partial month penalty period to the lower whole month. Where states did not grant Medicaid eligibility on a per diem basis (i.e., if an applicant was eligible on any day of the month they would be eligible for the entire month), this was reasonable and appropriate to prevent the imposition of a penalty for having given away less than the state's monthly cost of care figure. For example, if an applicant had made a \$100 monthly donation to her church, it would be grossly unfair to deny her Medicaid for an entire month.

The perceived abuse in rounding down can be explained by the following example: An \$8,200 transfer has two full months of penalty ( $\$8,200 \div \$4,100 = 2$ ). However, the application of the rounding down had the unexpected result that an \$8,100 transfer only had a one month penalty ( $\$8,100 \div \$4,100 = 1.97$ ). Where the state did not impose a .97 month penalty, the .97 was rounded down to the previous full month. The result was that by giving away more than the monthly cost of care but less than two full months, the penalty was one month instead of two. However, it was not the one, rounded down month that was perceived abusive, but the cumulative effect of continuous transfers of identical amounts. The reason for this was the

application of another Medicaid eligibility rule that calculated the penalty by aggregating all transfers made during the lookback period except those that do not overlap (see Section 3258.5.I of the State Medicaid Manual). Since an \$8,100 gift was rounded down to a one month penalty, there is no overlap with a gift made the very next month of \$8,100. The result was that in a ten-month period, by staggering monthly transfers of \$8,100, a cumulative transfer of \$81,000 could be made. However, if the entire \$81,000 had been transferred in a single month, the penalty period would be 19.75 months.

It would appear that the ability to stagger transfers to enhance the total amount transferable within a given time frame is no longer viable. Additionally, in theory, the imposition of a partial month penalty should create no greater hardship than in any other situation. The rule will become critical in cases where states do grant partial months of eligibility. For example, if the fractional penalty is .15, and the state does not grant partial month eligibility, an applicant could be denied an entire month of nursing home care for an insignificant partial month penalty. The question may come up in the calculation of responsibility for partial days.

## H-2. Accumulation of Multiple Transfers, §6016(b)

### 1. *Pre-DRA Law*

Under pre-DRA law (and CMS guidance), when a number of assets were transferred for less than fair market value on or after the look-back date during the same month, the penalty period was calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. When a number of transfers are made during different months, the results depend upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty periods for each transfer do not overlap, states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

### 2. *Post-DRA Law*

Under post-DRA law, for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer.

States will be allowed to begin such penalty periods on the earliest date that would apply to such transfers.

### 3. *Language of the DRA*

**42 U.S.C 1396p(c)(1)**, as amended by subsection (b) of section 6012, is amended by adding the following:

**(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by-**

**(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and**

**(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.**

### 4. *Analysis and Issues*

This is one of the more difficult provisions from which to infer Congress' intent. It could be viewed as simply a reiteration of prior law, particularly applicable in stringing together multiple transfers of fractional interests in one property (i.e., series of deeds of fractional interests in one parcel of land). However, with the commencement of the penalty period calculation to its new starting point, and the elimination of the rounding down calculation, this modification seems to effect no change in the calculation under the DRA schematic. Further, application of the rule could result in collapsing all fractional transfers to the first transfer where, if it occurred beyond the lookback period, it could effectively eliminate the penalty for the subsequently transferred fractional interests.

## H-3. Promissory Notes, Loans, and Mortgages §6016(c)

### 1. *Pre-DRA law*

Much like annuities, actuarial soundness, based on an individual's life expectancy, was a common test to determine whether a loan made by a Medicaid applicant constituted a transfer for less than fair market value, though neither the Medicaid statute nor State Medicaid Manual made any mention of loans. If a loan is

not otherwise countable as a resource (a determination most states make by referring to the Supplemental Security Income rules, POMS §SI 01120.220(B)(2), “Policy—Determining When a Loan Counts as a Resource—For the Lender,”) states have often determined whether a transfer for less than fair market value occurred by referencing the same actuarial tables used for annuities. Some states have gone beyond actuarial soundness. Vermont, for example, in addition to consulting the actuarial tables, has required applicants to provide information behind the purpose of a loan. *Roach v. Morse*, 440 F.3d 53 (2nd Cir. 2006). Additionally, Pennsylvania, among other things, has required applicants to provide documentation tending to show that the borrower is healthy enough to live as long as the life expectancy tables predict. *Ptashkin v. Department of Public Welfare*, 731 A.2d 238, 243-244 (Pa. 1999). Ultimately, however, neither the Medicaid statute nor State Medicaid Manual contained any guidance on how states should evaluate loans for purposes of applying a penalty for a transfer for less than fair market value.

## 2. *Post-DRA law*

The DRA clarifies Medicaid’s treatment of loans. Under the new rules, the outstanding balance of a loan that is not otherwise countable as a resource will be considered a transfer for less than fair market value unless the loan: (1) provides for equal installments, (2) will be satisfied during the lifetime of the Medicaid applicant/lender; and (3) prohibits cancellation upon lender’s death.

## 3. *Language of the DRA*

### 42 U.S.C. §1396p(c)(1)(I)

#### (c) Taking into account certain transfers of assets

##### (1) \*\*\*

**(I) purposes of this paragraph with respect to a transfer of assets, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—**

**(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);**

**(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and**

**(iii) prohibits the cancellation of the balance upon the death of the lender.**

**In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding**

**balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).**

*4. Analysis and Issues*

On the one hand, these rules establish a safe harbor, since states may not go beyond these criteria in deciding whether a particular loan constitutes a transfer for fair market value. For example, in both the *Roach* and *Ptashkin* cases cited above, the state Medicaid agencies were applying tests, toward the loans that will not be allowed under these new rules. Granted, in both cases the promissory notes contained balloon payments (and also, in the *Ptashkin* case, a clause canceling the loan upon the death of the lender). However, the now-illegal tests were applied in those cases independent of these latter characteristics of the promissory notes.

On the other hand, the rules may be a detriment to Medicaid applicants who have made loans to their families. Many intra-family loans are in the form of "demand notes" that do not provide for repayment terms according to a fixed schedule, which would mean they would fail the test now contained in the Medicaid statute. The value of the transfer would be determined by the term of the instrument. For instance, if an individual made a \$10,000 loan to a son to start a construction business that provided a 4% interest rate payable "on demand" and the loan had been outstanding for 2 years without any payment at the time of application, it would result in a transfer penalty of \$10,856 at the end of its second year.

The language of the DRA indicates that the new rules only apply to notes, loans or mortgages made prior to the effective date of the DRA. Therefore, notes, loans, or mortgages made prior to February 8, 2006, should be considered "assets disposed of prior to the date of enactment" and evaluated under the old rules. The valuation of the balance outstanding at the time of application, however, casts some doubt over this interpretation. Advocates will need to keep this limitation in mind, and CMS policy should give clear instruction to states as they begin implementing this provision.

*5. Practice Issues:*

Any attorney helping a client structure a loan within the family will simply have to be mindful of these rules. To avoid having a loan considered a transfer of assets, the loan must simply be an equal payment, installment loan that will be paid back within the statistical life-expectancy of the lender.

In some states, the new rules will indeed require a change in the way in which clients are counseled on loans. However, the new rules do not prohibit loans altogether and clients will still be able to make a loan to a needy family member, provided that the promissory note is DRA-compliant. However, because the loan must be paid in equal installments during the life expectancy of the lender, this will mean that lender/client will receive a higher installment payment than she would have received prior to the DRA. These installment payments, which will be counted as income, will likely put the client's income over the income limit for Medicaid

coverage, and may, depending on the size of the loan, place her income close to the private rate of care in the facility. The client in the latter situation may end up being ineligible for Medicaid.

There are other issues that may affect the counsel given to clients on loans which will require clarification from the relevant federal and state agencies, including:

- a) Can a cancellation-on-death provision be unilaterally waived by the maker of the note when a mentally incapacitated parent requires Medicaid help for nursing home care to avoid having a transfer penalty imposed?
- b) Does the prohibition on a loan being cancelable at death require an actual term in the agreement or will silence suffice?
- c) If the agreement meets the 3-prong test but by verbal agreement (a) payment(s) were deferred or a balloon payment is made, will states be able to treat the remaining loan balance as a transfer?
- d) If a defaulting debtor is bankrupt, will a stay pending bankruptcy result in a determination that there is no “outstanding balance due” at the time of the lender’s application for Medicaid? Will states be given other options to consider? Note also the exemption from transfer penalty when an individual intends to dispose of the asset for fair market value in 42 U.S.C. §1396p(c)(2)(C).

Clients and planners will be able to adapt to clear, uniform eligibility rules. For now, the focus will need to be on working with the federal and state administrators to implement these rules in a fair and predictable way.

#### H-4. Inclusions of Transfers to Purchase Life Estates §6016(d)

##### 1. *Pre-DRA Law*

Under pre-DRA law, the purchase of a life estate interest in another individual’s home was not a transfer of assets if the purchase was for full consideration, regardless of whether the purchaser resided in the home.

##### 2. *Post-DRA Law*

Under the DRA, the purchase of a life estate interest in another individual’s home will be treated as a transfer of assets if the purchaser does not reside in the home for a period of at least one year after the date of the purchase, even if the purchase was for full consideration.

##### 3. *Language of the DRA*

#### **42 U.S.C. 1396p(c)(1)(J) now reads:**

**For purposes of this paragraph with respect to a transfer of assets, the term “assets” includes the purchase of a life estate interest in another individual’s home unless the purchaser resides**

**in the home for a period of at least 1 year after the date of the purchase.**

#### *4. Analysis and Issues*

In the past, there had been some question as to whether a purchase of a life interest in another person's home for full consideration would be treated as a transfer by the local Medicaid agency. Under the DRA, there is a safe harbor rule for the purchase of a life interest in another person's home. It is now clear that if the purchaser resides in the home for at least one year after the purchase of the home for full consideration, the purchase will not be considered a transfer for purposes of Medicaid eligibility.

##### *a. Residency Rule*

The statute does not require that the purchaser live in the residence for 365 consecutive days. A plain reading of the statute provides that the purchaser will qualify for this safe harbor rule if the one year test is met by residing in the home 365 days regardless of whether the days of residence are consecutive or not and regardless of when the one year residency rule is met. The Center for Medicare and Medicaid (CMS) should confirm this position to standardize treatment among the states.

Example #1: a parent purchases a life estate interest in a child's home for full consideration and moves into the child's home. Six months later, the parent is hospitalized and then receives rehabilitation in a facility for a period of three months. The parent then returns to the home and resides there for another six months. At that point, the parent has met the one year residency requirement.

Example #2: a parent purchases a life estate interest in a child's home for full consideration and moves into the child's home and resides there for two years. Subsequently, the parent moves into an assisted living community for a period of six years, and then into a nursing facility. The parent has met the one year residency requirement even though it was a number of years prior to entering the nursing facility.

##### *b. Valuation*

This new provision does not change the rule that the purchase of a life estate interest must be for full consideration or else it will be considered a transfer of assets. At a practical level, two valuations are required. First, the entire interest in the real estate must be valued. Second, the life estate interest must be valued. The latter valuation raises an issue as to which method or methods will be acceptable to the local Medicaid agency. Under current Medicaid law, the HCFA (CMS) tables are applied to determine whether a Medicaid disqualifying transfer has been made. Applying the HCFA (CMS) tables, there is a greater value placed on a life estate interest than other tables, such as the IRS tables, for valuing gifts. It is likely that the local Medicaid agency will apply the HCFA (CMS) tables.

### 5. Practice Issues

One view of this change in the law is that we now have a safe harbor rule which eliminates subjective intent and replaces it with a factual residency test for purposes of determining whether the purchase of a life estate should be treated as a transfer. This provision gives the senior another option which will allow the senior to remain in the community. Under pre-DRA and existing law, a child could move into the parent's home and care for the parent for two years and then the transfer of the home at the time of institutionalization would be exempt under the Medicaid transfer penalty rules. Now, it is clear that the senior will have another choice: to move in with her child and purchase a life estate interest.

#### a. Shortening of a Penalty Period

This provision will provide a planning option for seniors who are attempting to stay in the community and protect their assets. For example, seniors may consider purchasing a life estate interest in a child's home, and then the senior moves into the child's home. After one year, the money paid to the child will not be subject to the transfer penalty rules, as long as the purchase was for full consideration.

#### b. Tax Consequences

One potential adverse consequence is the tax impact on the seller (for example, a child) who sells a life estate interest to a purchaser (for example, a parent) which would be subject to the capital gains tax rules. If the seller meets the qualifications of Section 121 of the Internal Revenue Code, then the gain on the sale of the life estate interest would be offset by the use of the \$250,000 capital gains exclusion to the extent of the gain attributable to the life estate interest in the property. For example, if the gain on the sale of the life estate interest was \$200,000 and the life estate interest was 50% of the value of the property, then \$100,000 of the capital gain can be offset by the \$250,000 capital gain exclusion.

Under this new rule, there will be an incentive for a child to take care of a parent for at least one year who may well need nursing home care after that time as a way to protect some or all of the parent's assets. The parent may well benefit from this new planning option by staying out of a nursing home for a period of time (at least one year).

### I. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM, §6021

#### 1. Pre-DRA Law

Prior to the DRA, only California, Connecticut, Indiana, and New York were authorized to offer Partnership policies in their respective states. These four states

were grandfathered when OBRA-93 was enacted.<sup>55</sup> OBRA-93 prohibited other states from adopting Partnership-type policies.<sup>56</sup>

## 2. *Post-DRA Law*

All states may now amend their state plans to provide for a partnership program. The four original Partnership states are “grandfathered” as long as they maintain consumer protection standards which are no less stringent than they were on December 31, 2005. There is some question about whether Massachusetts should be grandfathered.

## 3. *Language of the DRA*

Section 6021 of the DRA, codified at 42 U.S.C. §1396p(b)(1) and (5), provides:

### **(a) EXPANSION AUTHORITY-**

**(1) IN GENERAL-** Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

#### **(A) in paragraph (1)(C)—**

**(i) in clause (ii), by inserting ‘and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))’ after ‘1993,’; and**

**(ii) by adding at the end the following new clauses:**

**(iii) For purposes of this paragraph, the term ‘qualified State long-term care insurance partnership’ means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:**

**(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.**

**(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.**

**(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).**

---

55. 42 U.S.C. §1396p(b)(1)(C)(ii)

56. 42 U.S.C. §1396p(b)(1)(C)(i)

- (IV) If the policy is sold to an individual who—**
- (aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;**
  - (bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and**
  - (cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.**
- (V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.**
- (VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.**
- (VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.**

**In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term 'long-term care insurance policy' includes a certificate issued under a group insurance contract.**

**(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer**

protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.'; and

(B) by adding at the end the following:

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

- (VI) Section 7 (relating to unintentional lapse).**
  - (VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.**
  - (VIII) Section 9 (relating to required disclosure of rating practices to consumer).**
  - (IX) Section 11 (relating to prohibitions against post-claims underwriting).**
  - (X) Section 12 (relating to minimum standards).**
  - (XI) Section 14 (relating to application forms and replacement coverage).**
  - (XII) Section 15 (relating to reporting requirements).**
  - (XIII) Section 22 (relating to filing requirements for marketing).**
  - (XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.**
  - (XV) Section 24 (relating to suitability).**
  - (XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).**
  - (XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).**
  - (XVIII) Section 29 (relating to standard format outline of coverage).**
  - (XIX) Section 30 (relating to requirement to deliver shopper's guide).**
- (ii) In the case of the model Act, the following:**
- (I) Section 6C (relating to preexisting conditions).**
  - (II) Section 6D (relating to prior hospitalization).**
  - (III) The provisions of section 8 relating to contingent nonforfeiture benefits.**
  - (IV) Section 6F (relating to right to return).**
  - (V) Section 6G (relating to outline of coverage).**
  - (VI) Section 6H (relating to requirements for certificates under group plans).**
  - (VII) Section 6J (relating to policy summary).**
  - (VIII) Section 6K (relating to monthly reports on accelerated death benefits).**
  - (IX) Section 7 (relating to incontestability period).**

**(B) For purposes of this paragraph and paragraph (1)(C)—**

**(i) the terms ‘model regulation’ and ‘model Act’ mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);**

**(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and**

**(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.**

**(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.**

**(2) STATE REPORTING REQUIREMENTS-** Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

**(3) EFFECTIVE DATE-** A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

**(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES-** In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

(1) benefits paid under such policies will be treated the same by all such States; and

(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

**(c) ANNUAL REPORTS TO CONGRESS-**

(1) **IN GENERAL-** The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

(2) **APPROPRIATION-** Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, \$1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

**(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION-**

(1) **ESTABLISHMENT-** The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.

(2) **DUTIES-**

(A) **IN GENERAL-** The National Clearinghouse for Long-Term Care Information shall—

(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-

**specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;**

**(ii) provide objective information to assist consumers with the decision making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and**

**(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.**

**(B) REQUIREMENT-** In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

**(3) APPROPRIATION-** Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$3,000,000 for each of fiscal years 2006 through 2010.

#### *4. Analysis and Issues*

A “qualified State long-term care insurance partnership” is defined in §6021 as an approved state plan amendment “that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy” but only if the following seven requirements are met:

1. The policy covers a resident of the state at the time coverage first becomes effective.
2. The policy meets the IRS requirements for a qualified Long Term Care (LTC) insurance policy [IRC §7702B(b)].
3. The policy meets nine identified sections of the LTC Insurance Model Act and nineteen identified sections of the Model Regulation of the National Association of Insurance Commissioners (NAIC) as adopted as of October 2000 [See Table 1]. The state’s Insurance Commissioner must certify the policy as meeting the requirements. There also is a process requiring Department of Health and Human Services (HHS) to review future revisions of the NAIC Model Act and Regulations within 12 months of promulgation. If the Secretary of DHSS determines that such changes “would improve qualified State LTC insurance partnerships,” then the Secretary shall incorporate the changes into the federal requirements.

4. The policy provides for “compound annual inflation protection” for individuals under age 61 as of the date of purchase, and provides “some level of inflation protection” for individual 61 through 75. At age 76 and older, inflation protection is entirely optional.
5. The state Medicaid Agency “provides information and technical assistance to the State insurance department on the insurance department’s role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.”
6. The insurer provides regular reports to the DHHS Secretary that include when benefits have been paid, the amount, and the termination of benefits, and such other information as the Secretary determines.
7. The state does not impose requirements on partnership policies that it does not impose on all long-term care insurance policies.

For the four states that already have approved partnership programs (Connecticut, California, Indiana, and New York), the above requirements are deemed to have been met if the Secretary determines that the state’s consumer protection standards are no less stringent than the standards applicable in the state as of December 31, 2005.

DHHS is required to consult with NAIC and several other constituencies in developing reporting regulations. DHHS must also develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTC insurance policies under partnership programs. The data set must have a centralized electronic query and report-generating mechanism. States are free to require issuers of qualified and/or nonqualified LTC policies in the state to report information or data to the state beyond what is required by this Act.

DHHS must develop standards for “uniform reciprocal recognition” of partnership policies across state lines, so that “benefits paid under such policies will be treated the same by all such States.” However, states will have the option of exempting themselves from the standards by notifying the secretary in writing of the state’s election to be exempt.

Finally, DHHS must: (1) report annually to Congress on the partnership programs, including its impact on access to long-term care and on Medicare and Medicaid expenditures and (2) establish a National Clearinghouse for Long-Term Care Information, by means of contract or interagency agreement. The Act appropriates \$1 million per year through FY 2010 for purposes of the annual report to Congress, and \$3 million a year from through FY 2010 for the Clearinghouse.

The National Clearinghouse for Long-Term Care Information shall

- educate consumers with respect to the availability and limitations of coverage for LTC under the Medicaid program and provide contact information for obtaining State-specific information on LTC coverage,

including eligibility and estate recovery requirements under State Medicaid programs;

- provide objective information to assist consumers with the decision-making process for determining whether to purchase LTC insurance or to pursue other private market alternatives for purchasing LTC and provide contact information for additional objective resources on planning for LTC needs; and
- maintain a list of states with State LTC Insurance Partnerships under the Medicaid program that provide reciprocal recognition of LTC insurance policies issued under such partnerships.

In providing information to consumers on LTC in accordance with this subsection, the clearinghouse cannot advocate in favor of a specific LTC insurance provider or a specific LTC insurance policy.

State plan amendments providing for qualified Long-Term Care Partnerships are effective on or after the date specified by the state plan amendment, but that date can be no earlier than the first day of the calendar quarter in which the plan amendment is submitted to DHHS.

NAELA has supported the expansion of the LTC Partnership Program option to all states, and this section of the Act is generally seen as a positive change in the law. However, implementation will depend in large part on how willing the private LTC insurance industry is to market products that meet the requirements of the Act, as well as how quickly federal and state administrators promulgate regulations to create Partnerships.

The Model Act and Regulation can be read and downloaded from the AIC web site at: [http://www.naic.org/index\\_committees.htm](http://www.naic.org/index_committees.htm)

### Model Act Provisions

#### Applicable to Qualified State Long-Term Care Insurance Partnerships

1. Section 6C relating to preexisting conditions.
2. Section 6D relating to prior hospitalization.
3. Section 8 only those provisions relating to contingent nonforfeiture benefits.
4. Section 6F relating to right to return.
5. Section 6G relating to outline of coverage.
6. Section 6H relating to requirements for certificates under group plans.
7. Section 6J relating to policy summary.
8. Section 6K relating to monthly reports on accelerated death benefits.
9. Section 7 relating to incontestability period.

### Model Regulation Provisions

#### Applicable to Qualified State Long-Term Care Insurance Partnerships

1. Section 6A relating to guaranteed renewal or non-cancellability (other than paragraph 5 thereof), and 6B.
2. Section 6B relating to 6a, and the prohibitions on limitations and exclusions (other than paragraph 7 thereof).
3. Section 6C relating to extension of benefits.
4. Section 6D relating to continuation or conversion of coverage.
5. Section 6E relating to discontinuance and replacement of policies.
6. Section 7 relating to unintentional lapse.
7. Section 8 relating to disclosure (other than sections 8F, SG, SH, and 8I thereof).
8. Section 9 relating to required disclosure of rating practices to consumer.
9. Section 11 relating to prohibitions against post-claims underwriting.
10. Section 12 relating to minimum standards.
11. Section 14 relating to application forms and replacement coverage.
12. Section 15 relating to reporting requirements.
13. Section 22 relating to filing requirements for marketing.
14. Section 23 relating to standards for marketing, including inaccurate completion of medical histories (other than paragraphs 1, 6, and 9 of section 23C).
15. Section 24 relating to suitability.
16. Section 25 relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates.
17. Section 26 only those provisions relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision.
18. Section 29 relating to standard format outline of coverage.
19. Section 30 relating to requirement to deliver shopper's guide.

#### J. EFFECTIVE DATES FOR PROVISIONS OF THE DRA

##### 1. *Pre-DRA Law*

No comparable provision.

##### 2. *Post-DRA Law*

As noted above, the DRA was signed and became law on February 8, 2006. Transfers made on or after February 8, 2006, are subject to the DRA. Transfers completed prior to the date of enactment are generally subject to the pre-DRA rules.

The DRA language highlights the provisions relating to the effective dates of each of the new provisions, beginning in the order in which the provisions will appear in the amended statute.

3. *Language of the DRA*

**42 U.S.C. §1396p (b)**

**(b) Adjustment or recovery of medical assistance correctly paid under a State plan**

**(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:**

**(C)**

**(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.**

**(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))<sup>57</sup> which provided for the disregard of any assets or resources—**

**(I) to the extent that payments are made under a long-term care insurance policy; or**

**(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.**

**(iii) For purposes of this paragraph, the term “qualified State long-term care insurance partnership” means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an**

---

57. Deficit Reduction Act, Pub. L. No. 109-171, §6021(a)(1)(A)(i).

**amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:**

- (I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.**
- (II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.**
- (III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).**

**42 U.S.C. §1396p (b)**

**(5)(B) For purposes of this paragraph and paragraph (1)(C)—**

**(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.**

**[(3) EFFECTIVE DATE- A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.<sup>58</sup>]**

**42 U.S.C. §1396p (c)(1)(B)**

**(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or**

---

58. Bracketed language is Deficit Reduction Act, Pub. L. No. 109-171, §6021(a)(3).

after the date of the enactment of the Deficit Reduction Act of 2005,<sup>59</sup> 60 months) before the date specified in clause (ii).

**42 U.S.C. §1396p (c)(1)(D)**

**(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date<sup>60</sup> specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.**

**(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.<sup>61</sup>**

**Non-Codified Effective Date Provisions:**

Deficit Reduction Act, §6012, new annuity rules (42 U.S.C. §1396p(c)(1)(G) and (H)). §6012(d):

**(d) Effective Date-** The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

Deficit Reduction Act, §6013 (a), application of income-first rule to revision of community spouse resource allowance (42 U.S.C. §1396r-5(d)(6)). §6013(b):

**(b) Effective Date-** The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

Deficit Reduction Act, §6014(a) (counting home equity above \$500,000 as a resource) (42 U.S.C. §1396p(f)). §6014(b):

**(b) Effective Date-** The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-

59. Deficit Reduction Act, Pub. L. No. 109-171, §6011(a). The effective date is the date of enactment. See §6011(c).

60. Deficit Reduction Act, Pub. L. No. 109-171, §6011(b)(1). The effective date is the date the of enactment. See §6011(c). See Conf. Rep. 109-362, §6011(b)(1).

61. Deficit Reduction Act, Pub. L. No. 109-171, §6011(b)(2). The effective date is the date the of enactment. See §6011(c). See Conf. Rep. 109-362, §6011(b)(2).

**term care services based on an application filed on or after January 1, 2006.**

Deficit Reduction Act, §6016(a) – (d) (prohibiting states from rounding down the penalty period, authorizing states to accumulate multiple transfers into one penalty period, promissory notes, and life estate purchases). §6016(e)—these provisions are effective for transactions taking place after enactment:

**§6016(e): Effective Dates-**

**(e) EFFECTIVE DATES-**

**(1) IN GENERAL-** Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

**(2) EXCEPTIONS-** The amendments made by this section shall not apply—

**(A)** to medical assistance provided for services furnished before the date of enactment;

**(B)** with respect to assets disposed of on or before the date of enactment of this Act; or

**(C)** with respect to trusts established on or before the date of enactment of this Act.

**(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT-** In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

*4. Analysis and Issues*

a. Income-First Rule.

With regard to the new income-first rule, an institutionalized spouse is a married individual who became institutionalized or will likely be institutionalized for more than 30 continuous days. 42 U. S. C. §1396r-5(h). In states that were formerly

resource-first, planning around the DRA enactment date in this context for spouses institutionalized post-DRA will consist of finding a history of a pre-DRA 30-day period of institutionalization. See 42 U. S. C. §1396r-5(c)(1). In cases where the 30-day period precedes the February 8, 2006, effective date of the DRA, the resource-first approach may still be applied.

b. State Long-Term Care Insurance Partnership.

In states that elect to seek an amendment to their state plan to provide for a qualified state long-term care insurance partnership, the provision of the DRA §6021(a)(3) quoted above as to the effective date is self-explanatory and should not present difficulties for the Elder Law attorney who is advising a client on making a long-term care insurance purchase. Before advising a client considering the purchase of such a policy, the attorney should know whether: (1) the state in which he or she practices has sought and obtained an amendment to the state plan, and (2) that the policy has or has not been certified by the State insurance commissioner as a qualified long-term care insurance policy.<sup>62</sup>

Joining the state long-term care insurance partnership program remains optional on the part of the states. Compliance by the states with other Medicaid provisions of the DRA, however, is mandatory immediately. Some practitioners have opined that under §6016(e)(3) all of the DRA provisions will not be effective in those states that require state enabling legislation until the necessary state legislation is enacted. Arguably, however, only the implementation of the DRA provisions in §6016 (relating, among other things, to the partial month penalty rules, accumulation of multiple transfers and life estate purchases) may be delayed pending state legislation, while the rest of the provisions appear to be binding on all states immediately upon the date of enactment of DRA.

c. State Enactment

For the transactions described in §6016, the DRA imposes a deadline on state legislation that amends the state plan of the first day of the first calendar quarter beginning after the end of the state legislature's next session. If a state's next legislative session begins in September 2006 and ends in December 2006, for example, the deadline is January 1, 2007. On the other hand, if the session ends in January 2007, then the deadline will be April 1, 2007. See DRA, §6016(e)(3).

For states that must enact complying legislation for the §6016 transfers, it is likely that the legislation will relate back to transfers that occurred on or after February 8, 2006.

---

62. See "Long-Term Care Insurance Partnership Programs," AARP Public Policy Institute, March 2006, at [http://www.aarp.org/research/longtermcare/insurance/fs124\\_ltc\\_06.html](http://www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html).

#### d. Home Equity

With regard to the home equity limits, Congress determined that for applications for benefits made on or after January 1, 2006, states must count home equity above \$500,000 (or, at state option, \$750,000), as a resource. As a result, an individual with home equity above \$500,000 who filed an application on January 15, 2006, and was approved for benefits on January 20, 2006, may face termination of benefits on subsequent recertification or review of the individual's continued eligibility.

#### 5. Practice Issues

Practitioners must use caution in advising clients as to the effective date of the DRA changes in their states. Initially, in many states, we can expect Medicaid agencies to delay implementation of the DRA changes due to the substantial transition that will be necessary: rules and policies must be revised; caseworkers trained on the application of the new statutory requirements; computer systems reprogrammed; and application forms and processes modified. On the other hand, some states may be anxious to begin applying some of these changes and will look for the fastest ways to begin implementation. Ultimately, we can probably expect states to let some non-DRA compliant applications slip through until they have completed the necessary transition. It remains to be seen whether states will make all of the DRA changes retroactive to February 8, 2006, for applications filed after the transition period is completed. Because of the retroactivity issue, practitioners should not advise clients to utilize "pre-DRA" planning strategies until the state Medicaid agency makes an official announcement.

#### CONCLUSION

The DRA's changes to the Medicaid eligibility rules for long-term care are both radical and extensive. Indeed, Congress' modifications may be fairly characterized as an assault on the nation's middle and low-income aged and people with disabilities. But as the foregoing makes clear, the changes are also very complicated ones, and several of the new statutory provisions may be open to different interpretations. This poses a serious problem for seniors and people with disabilities, especially those without legal counsel. It is one thing to be operating under narrow eligibility rules, but quite another to be operating in an unpredictable environment.

It is therefore vital that Elder Law attorneys understand the potential issues facing the states' implementation of the new DRA rules and share information with each other regarding those developments. In this way, nearly all of the potential pitfalls for both clients and attorneys may be revealed, and areas where litigation may be useful and necessary may also be identified.

This analysis of the DRA is a starting point for a consistent and informed dialogue throughout the Elder Law community regarding the new Medicaid eligibility rules for long-term care. It was the hope of the authors and editors that this analysis, would enable Elder Law attorneys to challenge any federal and state efforts to go

beyond the new standards. There is little doubt that there will be unforeseen problems and issues stemming from the states' adoption of the new eligibility rules. Medicaid, however, still exists as a provider of long-term care coverage, and we must continue to ensure the availability of this program for those it serves.