

# Advanced Planning Strategies

*By Stan Miller and D. Scott Schrader  
Guest columnist: Rebecca H. Winburn*

## Medicaid Planning After the Deficit Reduction Act of 2005

On February 1, 2006, the House passed the final version of the Deficit Reduction Act of 2005 (DRA) which was signed into law by President Bush on February 8. The DRA includes some major changes to the Medicaid eligibility rules. This bill was controversial before its passage and continues to be so. The versions passed by the Senate and House are not identical because of a scrivener's error. This has resulted in a challenge to the constitutionality of the DRA in federal court by elder law attorney Jim Zeigler of Mobile, Alabama.

For purposes of this article, the author assumes that the DRA will either be held constitutional or will be properly reenacted and made retroactive to February 8, 2006, and therefore it is important to become familiar with these new rules.

For those attorneys who assist clients with Medicaid eligibility, some may be wondering whether this type practice will continue to be viable. While some practitioners will ultimately stop practicing elder law, others will see the opportunity to create new strategies and find new ways to help the elderly. Practitioners who don't do Medicaid planning should at least have a good understanding of the new Medicaid rules to prevent malpractice when advising the elderly about their estate planning and making gifts. Financial advisors should also be aware of the new provisions in DRA, especially those pertaining to the purchase of annuities.

The new rules under DRA regarding penalties for asset transfers are potentially harsh to those who unsuspectingly tithe to their church, help pay for grandchildren's college tuition, etc., while healthy and then suddenly become disabled. Hopefully, many practitioners conclude that the new restric-



CCH

a Wolters Kluwer business



**Stan Miller and D. Scott Schrader** are Shareholders in Miller & Schrader, P.A., a national estate planning law firm based in Little Rock, Arkansas, Principals of WealthCounsel, LLC and members of StoneTree Wealth Planning Group, LLC, a wealth planning consulting firm.



**Rebecca H. Winburn** joined Miller & Schrader, P.A. in 2003. Ms. Winburn's practice is concentrated in the area of Elder Law. She advises clients with respect to Medicaid planning, long-term care planning, guardianships and special needs trusts.

tions placed on those who might need nursing home care make our advocacy more important than ever.

## Overview of the New Medicaid Rules

---

The text of the Deficit Reduction Act of 2005 (P.L. 109-171) can be found on the Web at [www.thomas.loc.gov](http://www.thomas.loc.gov). More helpful though is a paper prepared by Elder Law attorneys Tim Takacs and David McGuffey which inserts the DRA changes into 42 USC §§1396p and 1396r-5. This paper can be downloaded in PDF format at Mr. Takacs' Web site at [www.tn-elderlaw.com/060208-dra1396p-1396r-5.pdf](http://www.tn-elderlaw.com/060208-dra1396p-1396r-5.pdf). 42 USC §1396p contains the Medicaid estate recovery and transfer of assets rules which were enacted in 1993 as part of the Omnibus Budget Reconciliation Act. 42 USC §1396r-5 contains the special Medicaid eligibility rules for spouses commonly known as the spousal impoverishment rules which were enacted in 1988 under the Medicare Catastrophic Coverage Act.

## Look-Back Period

---

The look-back period is the window of time preceding the application for Medicaid benefits in which transfers for less than fair market value must be reported on the Medicaid application. Under the old rules outright gifts were covered by a 36-month look-back period while gifts to trusts were covered by a 60-month look-back. Under the new rule, all gifts have a 60-month look-back period.<sup>2</sup> The new look-back provisions apply to transfers made on or after the date of enactment of DRA 2005. Transfers made before the date of enactment will still be treated under the old rules.<sup>3</sup>

## Start of Penalty Period

---

Section 6011(b)(2) is the harshest provision in the new law as it delays the starting date of the penalty period for gifts. Under the previous rules, the penalty period for making a gift started in the month the gift was made. This created a two-step analysis in the Medicaid application process. First, if the gift fell within the applicable look-back period, it had to be reported. Step two computed the penalty to find out when it ended. Even if a penalty had to be reported, if the resulting pen-

alty had already passed and the applicant was otherwise eligible, the individual could qualify for Medicaid benefits.

The old rules lent themselves to a Medicaid planning method commonly known as half-a-loaf planning whereby a person could gift approximately half of their assets and keep the remaining half to privately pay for their cost of care during the penalty period. This technique was effective for those still at home but soon to need nursing home care and for those who were already institutionalized and who could privately pay for care during the penalty period.

Under the new rules, the penalty does not start until the applicant is institutionalized, applies for Medicaid, and would be eligible except for the imposition of the penalty period.<sup>4</sup> The new rules apparently intend to end half-a-loaf planning by making it impossible to get around the penalty period unless you make it past the entire five-year look-back. Only time will tell if Congress really stopped half-a-loaf gifting.

## Hardship Waivers

---

Perhaps to lessen the harshness of the delay in the penalty period, Section 6011(d) provides for hardship waivers which each state must provide when the transfer of asset rules would deprive the applicant of (1) medical care to prevent endangering an individual's life; or (2) food, clothing, shelter or other necessities of life.<sup>5</sup> The states must (1) provide the applicant with notice that an undue hardship exception exists; (2) provide a timely process for determining whether an undue hardship waiver will be granted; and (3) have an appeal process for an adverse determination.<sup>6</sup> Additionally, the rules permit a nursing facility to file an undue hardship waiver application on behalf of the facility resident and permit the state to provide payments for up to 30 days to the facility to hold the bed for the individual.<sup>7</sup>

## Annuities

---

Under the previous rules, properly structured annuities could be used in many states to convert excess assets into an income stream for an institutionalized individual or the community spouse so as to render the institutionalized individual eligible for Medicaid coverage. The annuity pro-

visions of DRA were meant to stop the use of balloon annuities which were allowed in some states as this practice was considered abusive.

Section 6012 of the Act limits the use of annuities in Medicaid planning. First, the new rules under DRA require that any interest the applicant or community spouse owns in an annuity (or similar financial instrument, as may be specified by the Secretary) be reported on the Medicaid application or on a recertification form, regardless of whether the annuity is irrevocable or is treated as an asset.<sup>8</sup>

Secondly, and most importantly, the new rules require that the state be named (1) a preferred remainder beneficiary in the first position for the amount of medical assistance provided to the individual; or (2) in the second position after a community spouse or minor or disabled child and be named in the first position if the community spouse or representative of the minor child disposes of the annuity remainder for less than fair market value.<sup>9</sup>

At its option, the state may require the issuer to notify the state when there is a change in the amount of income or principal that is being withdrawn from the contract at the time of the most recent disclosure (*i.e.*, on application or recertification).<sup>10</sup> States may use this information in determining the amount of the state's obligations for medical assistance and are not prevented from denying eligibility for medical assistance based on the income or resources derived from an annuity.<sup>11</sup>

Regarding the definition of an annuity, the Secretary may specify what a "similar financial instrument" is under the Act and may provide guidance to states on categories of transactions that may be treated as a transfer of assets for less than fair market value.<sup>12</sup>

Under the old rules, balloon annuities were allowed in some states, but under DRA, the purchase of balloon annuities will be treated as a transfer of assets unless the annuity (1) is an annuity described in subsection (b) or (q) of Code Sec. 408; or (2) is purchased with proceeds from a Code Sec. 408(a), (c) or (p) account, or from a Code Sec. 408(k) simplified employee pension or from a Roth IRA account; or (3) is irrevocable and nonassignable, is actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.<sup>13</sup> The annuity rules will apply to

transactions and purchases of annuities occurring on or after the enactment date of DRA.<sup>14</sup>

Now that the annuity rules have been greatly clarified, the annuity industry will likely accept this gift from Congress and develop annuity products which comply with DRA.

## **Income First Rule**

Under the spousal impoverishment rules, a community spouse (CS) is allowed to have a minimum income allowance called the Minimum Monthly Maintenance Needs Allowance (MMMNA) and a resource allowance called the Community Spouse Resource Allowance (CSRA). The maximum CSRA allowed in 2006 is half of the couple's countable resources up to the maximum of \$99,540. If a community spouse does not have the minimum income allowance from his/her own income, he/she can ask to have the income allowance raised either from a transfer of the institutionalized spouse's (IS) income (income first approach) or by asking that excess resources above the CSRA be protected to produce income (resource first approach) for the community spouse.

States were allowed to mandate the use of either the income first or resource first approach after the Supreme Court's decision in *Wisconsin v. Blumer*.<sup>15</sup> States generally prefer to use the income first rule because it forces a spend-down of the resources in excess of the CSRA thereby delaying Medicaid eligibility. In some states a resource first rule is used because it provides more income protection for the community spouse in the long run since the institutionalized spouse's income might end or be greatly decreased upon the institutionalized spouse's death. Under the income first rule, the excess resources will have been spent and will not be available to produce income for the CS after his/her income is reduced by the death of the IS.

DRA mandates that states now use the income first rule.<sup>16</sup> This rule will apply to transfers and allocations made on or after the date of enactment of the DRA by individuals who become institutionalized spouses on or after the enactment date.<sup>17</sup>

## **Additional Reforms**

### **Promissory Notes, Loans and Mortgages**

Under the old rules, promissory notes, loans and mortgages could be structured so that they would

not be a countable resource. DRA now treats promissory notes, loans and mortgages as a transfer of assets for less than fair market value unless they meet all of the following requirements: (1) have a repayment term that is actuarially sound; (2) provide for payments in equal amounts during the term of the loan, with no deferral and no balloon payments; and (3) prohibit the cancellation of the balance of the loan on the death of the lender.<sup>18</sup>

Notes, loans and mortgages which do not meet the mandated requirements will be a countable asset up to the value of the outstanding balance due as of the date of the Medicaid application.<sup>19</sup>

### **Life Estates**

For individuals who do not own their own home, a common pre-DRA planning strategy was the purchase of a life estate in another individual's home to convert excess resources into an exempt resource. The purchased life estate then immediately became an exempt resource as the life estate holder's home. The details of using this strategy varied from state to state.

Under DRA, a life estate purchased in another individual's home will be a countable resource unless the purchaser resides in the home for a period of at least one year after the date of the purchase.<sup>20</sup> Although purchase of a life estate will no longer be helpful in crisis Medicaid planning, it will likely continue to be a staple of Medicaid preplanning, especially with families that want to care for their parents as long as they are reasonably able to do so.

### **Rounding Down and Multiple Fractional Transfers**

Under the pre-DRA rules, many states computed the penalty period and then round down the penalty to the nearest month. For example, a penalty of 4.5 months would be rounded down to four months. Rounding down allowed individuals to transfer assets monthly in the amount of 1.9 times the state divisor and only incur a one-month penalty thereby almost doubling the amount that could be transferred. Under DRA, states are no longer allowed to round down and must impose partial months of ineligibility.<sup>21</sup>

DRA also allows states to treat multiple fractional transfers of assets in more than one month for less than fair market value as one transfer when computing the penalty period.<sup>22</sup> DRA effectively ends the practice of gifting 1.9 times the divisor

each month to create successive one month penalty periods which do not overlap so that they are treated as separate transfers.

The effective dates for rules covered under DRA §6016 (Additional Reforms) apply to payments made under 42 USC §1396 *et seq.* for calendar quarters beginning on or after the date of enactment of DRA regardless of whether final regulations have been promulgated by the states.<sup>23</sup> However, the DRA amendments will not apply to the following: (1) services furnished before the date of enactment; (2) with respect to assets disposed of on or before the date of enactment; or (3) with respect to trusts established on or before the date of enactment of DRA.<sup>24</sup> If a state must pass its own enabling legislation, there will be additional time before the DRA becomes effective and those states will not be considered out of compliance with the Act.<sup>25</sup>

### **Substantial Home Equity Limitations**

Under the old rules of Medicaid eligibility, an individual's home was an exempt asset regardless of the value. Under DRA, an individual whose equity interest in his/her home exceeds \$500,000 may not be eligible for Medicaid benefits.<sup>26</sup> States may elect to increase this amount up to a maximum of \$750,000.<sup>27</sup> The home equity limitation will be increased each year based on the consumer price index to account for inflation. The home equity limitation will not apply if a spouse or minor, blind or disabled child lawfully resides in the home.<sup>28</sup> Reverse mortgages and home equity loans will be allowed to reduce an individual's home equity.<sup>29</sup> The home equity rule applies to individuals who were either determined eligible or filed an application for nursing facility services on or after January 1, 2006.<sup>30</sup> It appears that this rule will have an unfair impact on some areas of the east and west coasts where property values for modest homes may be over a million dollars.

### **Treatment of Entrance Fees of Individuals Residing in Continuing Care Retirement Communities**

Under the old rules, a deposit to a continuing care retirement community (CCRC) was analogous to

the equity in a home and was therefore treated as an exempt asset. Another common feature of CCRCs is the requirement that when an individual enters a CCRC he/she must disclose resources on the application for admission.

First, under the DRA, CCRCs may require individuals to spend for their care the resources that were declared on the resident's application to the CCRC before filing an application for Medicaid benefits.<sup>31</sup> Secondly, the DRA mandates that an individual's entrance fee to a CCRC will be an available, countable resource to the extent that (1) the individual may use the entrance fee to pay for care if the individual's income and resources become insufficient to pay for care; (2) the individual may get a refund of the entrance fee upon death or termination of the CCRC contract; and (3) the entrance fee does not confer an ownership interest in the CCRC.<sup>32</sup>

## **Expansion of State Long-Term Care Partnership Program**

The second portion of the changes to Medicaid under §6021 of the DRA relates to long-term care insurance. These provisions allow states to adopt a "qualified State Long-term care insurance partnership program."<sup>33</sup> Under such a program, states would encourage the purchase of long-term care insurance by allowing "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"<sup>34</sup> which meets the requirements specified under DRA.

There are seven requirements that must be met for a long-term care insurance policy to qualify under these provisions. First, the policy must cover "an insured who was a resident of such State when coverage first became effective under the policy."<sup>35</sup>

Secondly, the policy must meet the requirements of Code Sec. 7702(b) for a qualified long-term care insurance policy.<sup>36</sup>

Third, qualified policies must meet nine identified sections of the Long-Term Care Insurance Model Act and 19 identified provisions of the National Association of Insurance Commissioners (NAIC). The policy must also be certified by the State's Insurance Commissioners as meeting all of the requirements.<sup>37</sup>

Fourth, for purchasers under the age of 61, the long-term care policy must provide compound annual inflation protection. For purchasers from 61 up to 75 years of age, the policy must provide some level of inflation protection. For purchasers over 75, the policy may provide some inflation protection but is not required to.<sup>38</sup>

Fifth, state Medicaid agencies must coordinate with their state insurance department to ensure that those licensed to sell long-term care insurance receive proper training and that they demonstrate an understanding of how such policies relate to "other public and private coverage of long-term care."<sup>39</sup>

Sixth, companies that issue long-term care insurance must report regularly to the Secretary and notify the Secretary regarding when benefits have been paid under the policy, the amount of benefits paid, when the policy terminates, and any other information the Secretary decides is appropriate.<sup>40</sup>

And finally, states may not impose requirements on policies covered by the partnership that it does not impose on all long-term care insurance policies.<sup>41</sup>

States which have already adopted a partnership program are grandfathered as long as their partnership provides for consumer protection standards that are no less stringent than standards applicable as of December 31, 2005.<sup>42</sup>

The Secretary of the Department of Health and Human Services (DHHS) must consult with the National Association of Insurance Commissioners and others before promulgating reporting regulations.<sup>43</sup> The Secretary must also consult with NAIC and the states to develop recommendations to Congress for the authorization and funding of a uniform minimum data set to be reported electronically by all who issue long-term care insurance.<sup>44</sup>

No later than January 1, 2007, DHHS must develop standards for uniform reciprocal recognition of long-term care policies to permit interstate portability of policies purchased under a state partnership program although states may elect to be exempt from the standards by so notifying the Secretary in writing.<sup>45</sup> DHHS must annually report to Congress on the impact of the partnership programs on access to care, on Medicare and Medicaid expenditures and it must establish a National Clearinghouse for Long-Term Care Information.<sup>46</sup>

## Conclusion

Those who are creative will develop new Medicaid planning strategies in the coming months and years. Expect to see more litigation, especially for hardship waiver cases and to increase the community spouse allowances. DRA will also bring a surge in sales of long-term care insurance so we must become knowledgeable on this topic.

At a minimum, attorneys who have elderly clients should become familiar with the new laws so as not to inadvertently advise a course of action that later causes a hardship for the client. With an explosion of aging Boomers, it would be nice if our country addressed the need to overhaul our outdated healthcare delivery system. But I digress ... for now, just learn the new rules—for your clients' benefit and for your own protection.

### ENDNOTES

<sup>1</sup> Deficit Reduction Act of 2005 (P.L. 109-171).

<sup>2</sup> S.1932, §6011(a).

<sup>3</sup> S.1932, §6011(c).

<sup>4</sup> S.1932, §6011(b).

<sup>5</sup> S.1932, §6011(d)(1)

<sup>6</sup> S.1932, §6011(d)(2).

<sup>7</sup> S.1932, §6011(e).

<sup>8</sup> S.1932, §6012(a).

<sup>9</sup> S.1932, §6012(b).

<sup>10</sup> S.1932, §6012(a).

<sup>11</sup> S.1932, §6012(a).

<sup>12</sup> *Id.*

<sup>13</sup> S.1932, §6012(c).

<sup>14</sup> S.1932, §6012(d).

<sup>15</sup> *Wisconsin v. Blumer*, 534 US 473

(2002).

<sup>16</sup> S.1932, §6013(a).

<sup>17</sup> S.1932, §6013(b).

<sup>18</sup> S.1932, §6016 (c).

<sup>19</sup> S.1932, §6016(c).

<sup>20</sup> S.1932, §6016(d).

<sup>21</sup> S.1932, §6016(a).

<sup>22</sup> S.1932, §6016(b).

<sup>23</sup> S.1932, §6016(e)(1).

<sup>24</sup> S.1932, §6016(e)(2).

<sup>25</sup> S.1932, §6016(e)(3).

<sup>26</sup> S.1932, §6014(a).

<sup>27</sup> S.1932, §6014(a).

<sup>28</sup> S.1932, §6014(a).

<sup>29</sup> S.1932, §6014(a).

<sup>30</sup> S.1932, §6014(b).

<sup>31</sup> S.1932, §6015(a).

<sup>32</sup> S.1932, §6015 (b).

<sup>33</sup> S.1932, §6021(a).

<sup>34</sup> S.1932, §6021(a)(1)(A)(iii).

<sup>35</sup> S.1932, §6021(a)(1)(A)(iii)(I).

<sup>36</sup> S.1932, §6021(a)(1)(A)(iii)(II).

<sup>37</sup> S.1932, §6021(a)(1)(A)(iii)(III).

<sup>38</sup> S.1932, §6021(a)(1)(A)(iii)(IV).

<sup>39</sup> S.1932, §6021(a)(1)(A)(iii)(V).

<sup>40</sup> S.1932, §6021(a)(1)(A)(iii)(VI).

<sup>41</sup> S.1932, §6021(a)(1)(A)(iii)(VII).

<sup>42</sup> S.1932, §6021(a) (1)(A)(iv).

<sup>43</sup> S.1932, §6021(a) (1)(A)(v).

<sup>44</sup> S.1932, §6021(a) (1)(A)(vi).

<sup>45</sup> S.1932, §6021(b).

<sup>46</sup> S.1932, §6021(c).

This article is reprinted with the publisher's permission from the JOURNAL OF PRACTICAL ESTATE PLANNING, a bi-monthly journal published by CCH INCORPORATED. Copying or distribution without the publisher's permission is prohibited. To subscribe to the JOURNAL OF PRACTICAL ESTATE PLANNING or other CCH Journals please call 800-449-8114 or visit [www.tax.cchgroup.com](http://www.tax.cchgroup.com).

All views expressed in the articles and columns are those of the author and not necessarily those of CCH INCORPORATED or any other person.