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NEW MEDICAID RULES WILL IMPACT ESTATE PLANNING FOR LONG-TERM HEALTH CARE

-by Roger A. McEowen*

Overview

On February 8, 2006, the President signed into law the Deficit Reduction Act of 2005.¹ The Act is designed to cut the federal budget deficit. Among other provisions, the Act contains fundamental changes to the Medicaid eligibility rules and long-term care coverage. The new rules will impact significantly estate plans where preservation of family business assets is a major objective.² That is a common estate planning objective for farm and ranch families.

Summary of the Act

In a nutshell, here is what the Act does:

(1) Extends Medicaid's "lookback" period for all asset transfers from three to five years³ and changes the start of the penalty period for transferred assets from the date of the transfer to the date when the individual transferring the assets enters the nursing home and would otherwise be eligible for Medicaid coverage.⁴ In other words, the penalty period does not begin until the nursing home resident is out of funds – i.e., cannot afford to pay the nursing home.

(2) Makes any individual with home equity above \$500,000 ineligible for Medicaid (unless the applicant's spouse resides in the home or the home is occupied by a child under age 21, blind or disabled), although states may raise the threshold to up to \$750,000.⁵

(3) Establishes new rules for the treatment of annuities, including a requirement that the state be named as the remainder beneficiary.⁶

(4) Allows Continuing Care Retirement Communities (CCRCs) to require residents to spend down their declared resources before applying for medical assistance, and sets forth rules under which an individual's CCRC entrance fee is considered an available resource for Medicaid eligibility purposes.⁷

(5) Requires all states to apply the so-called "income-first" rule to community spouses who appeal for an increased resource allowance based on their need for more funds invested to meet their minimum income requirements.⁸

(6) Extends long-term care partnership programs to any state requesting that such programs be available in the state.

(7) Closes certain asset transfer "loopholes" such as the following:

(a) The purchase of a life estate would be included in the definition of "assets" unless the purchaser resides in the home for at least one year after the date of purchase.⁹

(b) Funds to purchase a promissory note, loan or mortgage would be included among assets unless the repayment terms are actuarially sound, provide for equal payments and prohibit the cancellation of the balance upon the lender's death.¹⁰

(c) States are barred from "rounding down" fractional periods of ineligibility when determining ineligibility periods resulting from asset transfers.¹¹

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(d) States are permitted to treat multiple transfers of assets as a single transfer and begin any penalty period on the earliest date that would apply to such transfers.¹²

The “Lookback” Period and the Penalty Period Start Date

The Medicaid asset transfer rules specify a period during which a penalty may apply to an individual with respect to a transfer made during the look-back period for which the individual does not receive something of equal value in exchange. This “penalty period” is determined by dividing the amount of the transfer by the average monthly cost of nursing home care in the individual’s state. The resulting figure is the number of months the individual’s penalty period will last. Previously, a penalty period would begin on the date on which an uncompensated transfer was made. Under that approach, many transfers made during the look-back period did not actually give rise to assessment of a penalty, even when inadequate compensation was received in exchange. Under the Act, the penalty period begins the date on which the individual has applied and is otherwise qualified for Medicaid. The result, in many instances, will be dramatically different, as illustrated by the following example:

Example:

(Prior law) Nelle applies for Medicaid coverage of her long-term nursing home care on February 1, 2006, and is otherwise qualified for coverage. Nelle discloses when she applies that she made a \$11,000 gift to each of two grandchildren on July 1, 2003. Assume that the average monthly cost of nursing home care in Nelle’s state is \$4,000. Nelle’s transfer was uncompensated and occurred during her 36-month look-back period. Thus, a penalty period calculation must be employed. Dividing the amount of the transfer by the average monthly cost of care results in a quotient of 5.5 ($\$22,000/\$4,000 = 5.5$), which represents the number of months Nelle’s penalty period will last. However, Nelle’s penalty period would begin on July 1, 2003 (the date of the transfer) and would run through mid-November 2003 (five and one-half months).¹³ As a result, Nelle’s penalty period had already expired by the time she applied for Medicaid on February 1, 2006.¹⁴

(Current law) Assume the same facts as above, except that Nelle applies for Medicaid coverage on March 1, 2009, and made the gifts to the grandchildren on July 1, 2006. The new law produces a different result. While the calculation of the penalty period remains the same, the 5.5 month penalty period does not begin running until March 1, 2009.¹⁵ Thus, while Nelle is eligible for Medicaid coverage as of March 1, 2009, she will be denied Medicaid coverage until mid-August of 2009. That raises a significant question as to how Nelle is going to pay for her nursing home care during the penalty period. Because she is otherwise eligible as of March 1, 2009, she has very minimal assets. Nelle’s family will have to cover the cost of her nursing home care during the penalty period or the nursing home may attempt to discharge her for failure to pay for services.¹⁶

The example illustrates that, under the new law, individuals in need of long-term care will be penalized for any gifts they have made during the extended look-back period, regardless of the purpose of the gift. It is immaterial that a moderate gift was made exclusively for a purpose other than to qualify for Medicaid, and

it essentially discourages any gift giving by individuals who have even a remote chance of needing long-term care coverage within the next five years.

Home Equity

The Act prohibits Medicaid eligibility for an applicant that has home equity in excess of \$500,000.¹⁷ States may increase the threshold to \$750,000, and may limit the increase to certain parts of the state. Thus, a state may consider that individuals living in large cities in the state will have homes with higher values than those in less populated regions of the state. From a planning perspective, anyone with a house with equity above the threshold will have to sell the home in order to get Medicaid coverage. While the law permits nursing home residents to reduce the equity through reverse mortgages and home equity loans, such loans are generally not available to nursing home residents who no longer live in the property to be mortgaged.¹⁸

Annuities

If a Medicaid applicant has any interest in an annuity, the purchase of the annuity will be treated as an uncompensated transfer subject to a penalty period unless the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid for on behalf of the Medicaid applicant, or the state is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child.

“Income-First” Rule

Federal law does not require that a married couple impoverish themselves before one spouse may gain eligibility for Medicaid. Instead, the spouse of a Medicaid enrollee, called a “community spouse,” is entitled to a specific portion of the combined income and assets owned by the couple. Generally, a community spouse is entitled to half of the couple’s combined resources (up to a maximum of \$99,540 in 2006), and at least the first \$1,603.75 (through June 30, 2006) of the combined monthly income. If the community spouse’s own monthly income, separate from the institutionalized spouse’s, is less than \$1,603.75, the old rules allowed the spouse either to receive a portion of the institutionalized spouse’s income or to retain a greater portion of the couple’s resources. Many community spouses opted for a greater share of the resources in order to ensure an adequate amount of savings for themselves. The new rules require, however, that where the community spouse’s income is less than the minimum, the community spouse must use a share of the institutionalized spouse’s income to raise the community spouse’s income to the minimum (the “income-first” method), instead of getting an additional share of the couple’s assets. In accordance with a U.S. Supreme Court ruling in 2002,¹⁹ states have had the authority to impose the income-first method, but some still allowed community spouses the choice. The new rules now *require* that the income be used first.

Effective Date

The changes to the transfer rules are generally effective for transfers made after February 8, 2006. However, the Act gives the states a grace period to come into compliance if state legislation is required. Each state administers its Medicaid program in accordance with its state Medicaid plan, a plan the Center for Medicare & Medicaid Services (CMS) must approve in order for the state to receive federal reimbursement for coverage of Medicaid

services. Some states grant wide discretion to their state Medicaid directors to make necessary changes to the state Medicaid plan, but some states require state legislation before modifications can be made to the plan. For the latter states, the effective date of the new transfer rules will be the date the state legislature authorizes the necessary modification of the state plan.²⁰

Planning Strategies

While the new asset transfer rules complicate traditional asset preservation techniques, transfers made more than five years before a Medicaid application are not penalized. That raises questions about what should be done with the transferred assets – for example, whether they are gifts to the children or funds the children should set aside for the parents in the event the parents need assistance. Consequently, the use of contractual family agreements concerning the use of the funds may be necessary. Alternatively, the assets could be held in trust for the entire family's benefit.

Clearly, the Congress has taken a policy approach with the new asset transfer rules that will encourage those who can afford to and who can medically qualify to purchase long-term care insurance. Those who cannot afford the premiums for a lifetime (lifetime coverage is generally preferred) may be able to pay the premiums for a long enough period of time to cover any penalty period triggered by transferring assets. Alternatively, perhaps the children could pay the premiums (as a means of assuring inheritance of the preserved assets).

Constitutional Challenge

Shortly after the President signed the Act into law, a complaint was filed in the United States District Court for the Southern District of Alabama challenging the Act's constitutionality.²¹ The complaint alleges that the version of the bill that the President signed was not the version as passed by the House and, as such, violates Article 1, Section 7 of the U.S. Constitution which specifies that a bill only becomes law after passing both the House and Senate and being signed by the President.²² For the lawsuit to be successful, the plaintiff will have to overcome an 1892 U.S. Supreme Court opinion where the Court ruled that, once a bill is deposited in the public archives, a court should not look behind the President's signature to question whether it in fact passed both bodies of the Congress.²³

Footnotes

¹ S. 1932, Pub. L. No. 109-171.

² The Congressional Budget Office has estimated that at least 120,000 individuals will be denied Medicaid coverage or have their eligibility delayed as a result of the Act. Letter from Donald B. Marron, Acting Director of the Congressional Budget Office, to Congressman John M. Spratt, Jr., Jan. 27, 2006.

³ Act, § 6011(a), *amending* 42 U.S.C. § 1396p(c)(1)(B)(i)).

⁴ Act, § 6011(b), *amending* 42 U.S.C. § 1396p(c)(1)(D).

⁵ Act, § 6014, *amending* 42 U.S.C. § 1396p by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) new subsection (f)(1)(A) and (f)(1)(B). The dollar amounts are indexed for inflation beginning in 2011 in \$1,000 increments.

⁶ Act, § 6012(a), *amending* 42 U.S.C. § 1396p by redesignating subsection (e) as (f) and by inserting after subsection (d) new subsection (e).

⁷ Act, § 6015, *amending* 42 U.S.C. § 1396r(c)(5).

⁸ Act, § 6013, *amending* 42 U.S.C. § 1396r-5(d).

⁹ Act, § 6016, *amending* 42 U.S.C. § 1396p(c)(1) by adding

subsection (J).

¹⁰ Act, § 6016(c), *amending* 42 U.S.C. § 1396p(c)(1) by adding subsection (I).

¹¹ Act, § 6016(a), *amending* 42 U.S.C. § 1396p(c)(1)(E) by adding subsection (iv).

¹² Act, § 6016(b), *amending* 42 U.S.C. § 1396p(c)(1).

¹³ Many states have historically assessed a penalty that, in effect, disregards any half-month penalty period. Thus, in the example, it is likely that Nelle's penalty period would only be for five months.

¹⁴ The example illustrates that, under prior law, a moderate transfer in the distant portion of the look-back period would, technically, result in a penalty, but the penalty was not prospective.

¹⁵ Under the Act, states do not have the discretion to choose to not impose a fractional penalty period (i.e., "round-down" a penalty period). States must impose any applicable fractional penalty period. Act, § 6016(a), *amending*, 42 U.S.C. § 1396p(c)(1)(E).

¹⁶ The Act requires each state to implement a hardship waiver exception to the transfer penalties if the applicant, or the nursing home on the applicant's behalf, can show that imposition of the penalty will put the nursing home resident at risk due to the lack of medical care, food, clothing, shelter or other necessities of life. Act, § 6011(d). Surely, eviction from the facility would qualify as hardship under these provisions. However, a facility cannot evict a resident without finding another suitable place for the resident to live. If none will take the resident without a means to pay, perhaps eviction is not a risk and the conditions of the hardship waiver won't be met.

¹⁷ Almost certainly, arguments over how to measure the value of home equity will arise. Likewise, will discounts for lack of marketability, and fees and costs be allowed?

¹⁸ One strategy may be to have an older person qualify for a home equity line of credit while still healthy and residing in the home. The credit line would not need to be drawn upon, but would be available in the event of nursing home care.

¹⁹ Wisconsin Dept. of Health and Family Services v. Blumer, 534 U.S. 473 (2002).

²⁰ The Act specifies that in states where state conforming legislation is required, the states have until the first day of the first calendar quarter beginning after the end of the legislature's next session (or the end of the next year of a two-year session) to come into compliance.

²¹ Zeigler v. Gonzales, No. 2006-80 (S.D. Ala. filed Feb. 13, 2006).

²² Under the version of the bill as passed by the Senate, oxygen equipment used in the home was to be paid for by Medicare for only up to 36 months and other durable equipment used by Medicare beneficiaries would be covered for 13 months. When the bill was sent to the House, a Senate clerk mistakenly put the 36 month cap in place of the 13 month cap for durable equipment – thereby providing up to 36 month coverage for both oxygen and durable equipment (at an additional cost of \$2 billion). The House approved this version of the bill. But, on return to the Senate, the clerk corrected the error to reflect the Senate-passed version, and the President signed the bill.

²³ Field v. Clark, 143 U.S. 649 (1892)