



New Medicaid Law Includes Punitive Asset Transfer Provisions and Other Rules that Dramatically Change the Landscape for Long-Term Care Planning

Although the federal rules for Medicaid eligibility have remained relatively constant over the past decade, that all changed when, on February 1, 2006, the United States House of Representatives took the final step in passing the Deficit Reduction Act of 2005. The new law changes Medicaid eligibility rules that will make it much harder for middle class citizens to access the Medicaid program to pay for nursing home, assisted living and other long-term care. Because nursing home costs in the Central Florida area can easily exceed \$70,000 per year, these changes will result in a significant hardship to many middle-income citizens who worked hard their whole lives to have a small retirement nest egg.

The law has an effective date of February 8, 2006, the date it was signed by President Bush, but many experts have questioned the legality of the bill because of a typographical error in the bill signed by the President. A lawsuit has been filed in federal court challenging the validity of the law, but while that case is working its way through the legal system, we wanted to provide this summary of the changes for our clients and friends of the firm. Until the courts decide differently, we are presuming an effective date of February 8, 2006 (unless otherwise noted below) for each of the new changes in the law.

Here's a list of the major changes, each of which will be discussed in more detail below. It is important to note at the outset, that while many of the changes do limit some of the planning techniques available, some of the changes actually create new planning opportunities that were previously not available under Florida's interpretation of federal law.

- Changes the "look-back" period to five years for **all** transfers
- Postpones the penalty start date for transfers within the five-year look-back
- Eliminates the "rounding-down" technique for monthly transfers
- Restricts the use of annuities
- Limits the value of Medicaid Applicant's homestead
- Requires use of the income-first rule in providing support to the Community Spouse
- Establishes new rules on the treatment of the "buy-in" at Continuing Care Retirement Communities
- Restricts the use of notes and loans
- Permits the purchase of a life estate in real property
- Expands of the Long-Term Care Partnership Program
- Requires states to implement a "hardship waiver" policy

1. Changes the “look-back” period to five years for all transfers

When applying for Medicaid benefits, the Department of Children and Families (Florida’s State Medicaid Agency) will now be permitted to review all financial transactions of a Medicaid applicant for the five year period preceding an application for Medicaid benefits. Transactions relevant during the 5 year look back period include not only transfers of assets (gifts), but also the sale of real property, personal property, stocks, bonds, and mutual funds, the closing of accounts and all other financial transactions. Under the previous law, the Department of Children and Families was limited to reviewing financial activity that occurred within the three year period preceding an application for Medicaid benefits, unless transfers were made to or from a trust. The new across-the-board 5-year look-back period is likely to create a paperwork nightmare for most people applying for Medicaid, who may now have to produce copies all financial transactions for the past 5 years.

2. Postponement of the penalty start date for transfers within the five-year look-back

When an elder gives away something of value without receiving something of equal value in return (which does not include love and affection), they will be deemed to have made an “uncompensated transfer,” otherwise known as a gift. If an uncompensated transfer occurred within the relevant look-back period, an individual will be penalized, which will result in a period of ineligibility (a/k/a “penalty period”) for Medicaid benefits. The penalty period is calculated by dividing the amount of the uncompensated transfer by the average cost of one month nursing home care at the private pay amount.

In the State of Florida, the average cost of nursing home care is approximately \$5,500 to \$6,500 per month. However, the Department of Children and Families has not adjusted the average cost of care for purposes of Medicaid applications for over ten years. As a result, when applying for Medicaid benefits in Florida, we are required to use the Department’s assigned average cost of care, which is currently set at \$3,300.

None of this was changed under the new federal law (although we hope the State of Florida will adjust the average cost of care used in the calculation in the near future). What has changed under the new law is how the penalty period is applied.

Let’s compare the impact of the penalty period under the old law and the new law. Under the old law, if an elder gave away \$33,000 on January 1, 2005, that would trigger a 10 month penalty period ($\$33,000 \div \$3,300 = 10$). This penalty period would begin to run in the month the gift was made (January 2005 in this example). If the elder later applied for Medicaid benefits on November 1, 2005, the penalty period would have expired on October 31, 2005 (ten months after the gift first occurred) and the elder would be eligible for Medicaid benefits on November 1, 2005, notwithstanding the earlier gift.

Under the new law, the result would be dramatically different. Now, the penalty period does not begin to run until the month of the gift or the date on which the individual is otherwise qualified for Medicaid, but for the application of the penalty period. So, what does all this legalese really mean? In short, it means that the penalty period for any gifts made after February 8, 2006 and within 5 years of a Medicaid application, the penalty period will begin to run **on the date of the Medicaid application**.

Let's take a gift of the same amount discussed above, but this time the gift is made on March 1, 2006 – after the effective date of the new law. The elder then needs to apply for Medicaid benefits one year later, March 1, 2007. As mentioned above, the penalty period will still be 10 months (the length of the penalty period does not change under the new law). But this time, the penalty period will not begin to run until the date of application – March 1, 2007. As a result, even though the application is filed 12 months after the gift occurred, the individual will be required to wait an additional 10 months before they will be eligible for Medicaid benefits.

The postponement of the penalty start date for transfers that occurred within the 5-year look-back period is likely to be the harshest of the new rules for many reasons. Will you be able to remember every transaction that occurred within 5 years of your application for Medicaid benefits? What about gifts made to charity, are they treated differently? How will the nursing home be paid during the prospective penalty period when the Medicaid applicant only has \$2,000 in assets? The bottom line right now is that we just don't know how these new rules will be implemented by the State of Florida. What we do know is that it is imperative to implement planning as early as possible, that you keep good financial records and keep those records for at least 5 years in case Medicaid is needed.

3. Elimination of the “rounding-down” technique for monthly transfers

This change, in combination with the prospective application of the penalty period discussed above, will have the biggest impact on the way we currently plan for Medicaid in Florida. Under the old law, as long as the gift made did not exceed \$3,200 no penalty would be imposed because we were permitted to “round-down” the transfer to the nearest whole number. $\$3,200 \div \$3,300 = 0.96$, which would be rounded down to zero – no penalty. Similarly, a transfer of \$6,500 would result in a one-month penalty period ($\$6,500 \div \$3,300 = 1.96$, which is rounded down to 1).

This rounding down permitted monthly, serial gifting that when used in combination with the application of the penalty period discussed above would allow us to gift \$6,500 per month for as many consecutive months as were necessary, without incurring a penalty beyond the month the gift was made.

Under the new law, however, rounding down of gifts is now prohibited. In addition, the new law also requires the aggregation of gifts that result in less than a one-month penalty. Consequently, gifting of \$3,200 in March will not be disregarded, but will instead be added to any gifts that occur in the next month (or any of the next 59 months in the 60 month look-back). If the total gifts exceed the \$3,300 divisor, then the resulting penalty would be applied prospectively after the date of application.

As a result of these changes in the law, there is no longer any benefit of monthly gifting – whether the gift is \$3,200 or \$6,500. In fact, such monthly gifting will now likely be more detrimental to eligibility than lump sum gifting.

4. Restriction on the use of annuities

There are generally two broad categories of annuities: deferred and immediate. A deferred annuity is an investment that you purchase from a life insurance company that permits your investment to grow income tax deferred. Although the annuity contract can have deferred surrender charges that will result in a penalty if you terminate the annuity too soon, under the terms of the annuity contract you have the ability to terminate the annuity any time you want. As a result, the money invested in the deferred annuity is considered an available asset for Medicaid purposes.

An immediately annuity, on the other hand, is not considered an asset for Medicaid purposes. An immediate annuity is similar to a pension that you receive after retirement. With an immediate annuity you are only eligible to receive the income stream and you do not have any ability to reach the principal. As a result, an immediate annuity is not considered an asset for Medicaid eligibility purposes, but the income derived from the annuity is counted.

The new law does not do anything to change deferred annuities – they are still considered assets for purposes of Medicaid eligibility. What is changed is the treatment of immediate annuities.

Under the old law, immediate annuities that were "actuarially sound" would not be considered an asset for purposes of Medicaid eligibility when they were also irrevocable and non-assignable. When determining actuarial soundness, the State of Florida only required the annuity to pay out in full over the actuarial life expectancy of the annuitant. The manner of the payments was not specified in the law. As a result, several states, including Florida, permitted what became known as "balloon annuities."

A balloon annuity is an immediate annuity that pays interest, plus a nominal amount of principal each month (typically between \$10.00 to \$100.00) over all but one month of the life expectancy of the annuitant, with the final month's payment being a balloon payment of the unpaid principal balance. In other words, an individual with a 60 month life expectancy could purchase a \$100,000 balloon annuity that would pay \$150 per month during months 1 through 59, with month 60 paying the balloon of \$99,410.

Under the new law, if a balloon annuity is created on or after February 8, 2006, the Medicaid applicant will be deemed to have made a transfer of assets that will result in a period of ineligibility based on the amount invested in the annuity. As a result, balloon annuities are no longer viable under the new law.

It is important to remember, however, that although balloon annuities are abolished under the new law, traditional immediate annuity planning remains viable. As such, if an immediate annuity makes equal periodic payments over the actuarial life expectancy of the annuitant (or a shorter period), it will not be considered a transfer of assets. It will, however, be required to meet the new beneficiary designation requirements discussed below.

So, what about annuities (balloon or equal periodic payments) that were created PRIOR to February 8, 2006? Those annuities will generally be grandfathered in and will not be affected by the new law, with one caveat. Under the new law, all immediate annuities created by the Medicaid applicant must name the State of Florida as the irrevocable beneficiary of the annuity to the extent of Medicaid payments made for the benefit of the individual. The only exception to this irrevocable beneficiary designation is when the Medicaid applicant is survived by a spouse or minor or disabled child. As a result of this new requirement, the preparation of customized beneficiary designation forms will be of critical importance to be sure no more is paid back to the State than necessary.

If the annuity does not name the State of Florida as the irrevocable beneficiary, the annuity will be considered an **available asset** for Medicaid purposes. Although we are not certain, it is anticipated that any annuity created prior to February 8, 2006 will have to verify at the next annual recertification of Medicaid benefits that the State of Florida is named the irrevocable primary beneficiary (unless one of the exceptions noted above is met), or the annuity will be considered an available asset.

5. Limitations on the value of Medicaid Applicant's homestead

One of the long-time hallmarks of homestead protection in Florida has been the unavailability of the primary residence as an asset for Medicaid qualification purposes. Under both federal and state law, the homestead property was exempt, regardless of its value, as long as the Medicaid applicant had an intent to return home (which was generally presumed) or a spouse or minor/disabled child of the Medicaid applicant lived in the home.

Under the new federal law, however, the homestead property will only be treated as exempt – or unavailable – for Medicaid qualification purposes when the equity in the property is \$500,000 or lower. If the equity in the home is in excess of the \$500,000 limitation, the amount in excess will be considered an available asset. With the escalation of property values over the past couple of years, this new provision in the federal law could have a devastating impact on homestead property in Florida.

In an effort to help limit the number of families that may be affected by the new law, the federal government has given the states authority to extend the equity limitation up to \$750,000. In addition, the federal law maintains the unlimited homestead value exemption when the Medicaid applicant's spouse or minor/disabled child resides in the home. The law does not, however, take in to account other vulnerable people who may live in the home, such as elderly siblings, grandchildren or other relatives or close friends.

Again, we will know more about how the State of Florida will implement the federal law when it issues its implementing regulations in the next several months. However, the one thing we know for certain is that we can no longer rely on the absolute protection of homestead property in Florida.

6. Requiring use of the income-first rule in providing support to the Community Spouse

Under the old law, if the spouse of Medicaid applicant still lived at home (referred to as the “Community Spouse”) and received income that was below the minimum amount permitted by federal law, we could raise her income through one of two methods known as the “income first” and “resource first” tests. When using the “income first” technique, we simply pulled income from the nursing home spouse and gave it to the Community Spouse to raise her income to the amount permitted by Medicaid regulations.

However, by using the “resource first” technique, we were able to exempt assets in excess of the \$99,540 asset limitation that were necessary to produce income to raise the Community Spouse’s income to the amount permitted by Medicaid regulations. By using this technique, it was not unusual to allow the Community Spouse to keep \$300,000 or more in assets, while still obtaining Medicaid benefits for her spouse.

The federal law does not abolish either the “income first” or “resource first” techniques. Instead, the federal law mandates the use of the “income first” technique. If the Community Spouse can raise her income to the amount permitted by Medicaid regulations by utilizing income of the nursing home spouse, then she will not be able to keep any assets in excess of the \$99,540 limitation. However, if the Community Spouse’s income still does not meet the amount permitted under Medicaid regulations after full utilization of the nursing home spouse’s income, we may still be able to exempt assets in excess of the \$99,540 limitation to the extent they are needed to produce income.

7. New rules on the treatment of the “buy-in” at Continuing Care Retirement Communities

For people who are residents in a Continuing Care Retirement Community (“CCRC”), this next change may catch some families by surprise. A Continuing Care Retirement Community is a retirement community that provides the full continuum of care for its residents: independent living, assisted living and nursing home care. Typically a resident in a CCRC pays a lump sum “buy-in”/entrance fee when they move in to the community, which among other things, guarantees the right of the resident to live in the facility for the remainder of their lifetime – regardless of whether they run out of money before their death.

This entrance fee to the CCRC may be refundable, partially refundable or not refundable at the death of the resident (or if the resident decides to leave the community prior to their death). Under the old law, whether the entrance fee was refundable or not, it was not considered an asset for purposes of Medicaid eligibility – even when the CCRC contract permitted the use of the entrance fee toward the monthly cost of care at the facility, thereby reducing the amount refundable at the death of the resident.

However, under the new law the lump sum entrance fee paid upon admission to a CCRC will be considered **an available asset** for Medicaid eligibility purposes when three criteria are met: (1) the individual may use the entrance fee to help subsidize his care in the CCRC; (2) the individual is eligible for a refund of any remaining entrance fee when he dies or leaves the community; and (3) the entrance fee does not confer an ownership interest in the CCRC.

Because refundable entrance fees will now be considered available assets for purposes of Medicaid eligibility, it will be important to consider alternatives for the utilization of entrance fees when implementing a long-term care asset protection plan.

8. Restricting the use of notes, loans and mortgages

Under prior federal law, neither statutes nor regulations provided any specific guidelines on the terms of notes, loans or mortgages for Medicaid eligibility. As a result, some states permitted notes, loans and mortgages that were actuarial sound (as described under the annuity discussion above), and some did not.

In Florida, we were able to use actuarially sound notes, loans and mortgages for many years as an asset protection planning technique. However, in March 2005, the State of Florida abolished the use of notes, loans and mortgages, by deeming almost all notes, loans and mortgages as available assets, notwithstanding their irrevocability or actuarial soundness.

The new federal law, however, now provides specific guidelines on the issuance of notes, loans and mortgages in determining whether they will be deemed available for Medicaid eligibility purposes. Under the new law, notes, loans and mortgages will generally be considered as available assets when determining eligibility for Medicaid benefits **unless** the note, loan or mortgage is actuarially sound, provides for equal, periodic payments and is not self-canceling.

As a result of the new law, the use of notes, loans and mortgages in Florida may actually be resurrected. We will know more once the State issues its implementing regulations for the new law.

9. Permitting the purchase of a life estate in real property

This change to the federal law is another area that may actually increase planning opportunities in Florida. Although the old law contained provisions for the valuation of life estates in real property (the right to live in a home and/or enjoy the benefits of that property for the rest of one's life, with the remainder interest passing to a third party – typically a family member), it was somewhat ambiguous about how the purchase of life estates would be treated for Medicaid eligibility. As a result of the ambiguity, states implemented the rules regarding life estates very differently.

In Florida, we were able to exempt the value of a life estate in real property for Medicaid purposes, as long as the Medicaid applicant owned the underlying property in fee simple BEFORE they gave away the remainder of the property, retaining the life estate interest. However, if the individual attempted to buy a life estate in their child's home (or the home of any other person), that purchase, regardless of its actuarial soundness, would be deemed as a transfer of assets with a corresponding penalty period for Medicaid purposes.

The new federal law, however, now specifically addresses the treatment of life estate interests in real property that are purchased in the home of another individual. Under the new law, the Medicaid applicant can purchase a life estate in a family member's home and that purchase will NOT be considered a gift for Medicaid purposes, as long as the purchase of the life estate is actuarially sound (does not exceed the life expectancy of the Medicaid applicant) and the Medicaid applicant lives in the home for **at least one year** after the date of purchase.

10. Expansion of the Long-Term Care Partnership Program

Again, this change to the federal law will actually create another opportunity for long-term care asset protection planning that did not exist under the old law. The Long-Term Care Partnership Program is actually being resurrected after a nearly 13 year dormancy. Before the passage of OBRA 1993, the last federal change to the Medicaid eligibility law, only four states implemented a long-term care partnership plan. However, any state that did not implement a partnership program prior to 1993 was precluded from implementation at a later date.

The Long-Term Care Partnership Program is a joint effort between the government and individuals to share the cost of long-term care in a way that will be mutually beneficial for both parties. In short, the partnership program permits individuals to purchase certain qualified long-term care insurance policies to help pay for their long-term care needs. In exchange, the federal government will raise the asset limitations for Medicaid eligibility purposes to allow the individual to keep more assets and qualify for Medicaid benefits.

Specifically, the new law provides that any individual who purchases a qualified long-term care insurance policy in a state that implements a Long-Term Care Partnership Plan will be able to maintain assets in an amount equal to the insurance benefit payments that are made to or on behalf of that individual over the term of the insurance policy. For example, although the normal asset limitation for Medicaid eligibility for a single person is \$2,000, if that individual has a long-term care insurance policy that pays out \$180,000 over a 3-year period, that individual will be permitted to maintain the \$180,000 in assets and still qualify for Medicaid benefits.

There are several specific criteria that are required for the insurance policy to be qualified for the partnership program and we will not likely have policies available in Florida until the end of this year or the beginning of 2007. Once available, however, these policies will be one of the best ways we can help plan for our long-term care needs and can be used in conjunction with other long-term care asset protection planning techniques to reach the maximum possible benefit.

11. Requiring States to implement a “hardship waiver” policy

The final change to the federal law is the specific requirement that states must implement a “hardship waiver” policy to address the potential denial of Medicaid benefits because of an uncompensated transfer made during the 5-year look-back period when the imposition of a penalty period would cause an “undue hardship” to the Medicaid applicant. The federal law defines an undue hardship as a hardship that would deprive the individual of food, clothing, shelter or other necessities of life, or would deprive the individual of medical care such that the individual’s life or health would be endangered.

Each state is required by the new law to create a formal hearing procedure to process the requests for a hardship waiver. Because nursing homes may have the most at risk with the denial of Medicaid of someone who no longer has any assets to pay the nursing home bill, the new law permits nursing home representatives to file for and represent the nursing home resident at the hearing for the hardship waiver determination.

Although the hardship waiver policy is a step in the right direction, the new law does not do anything to change current law that any transfer within the look-back period will be presumed to have been made with the intent to qualify for Medicaid benefits – whether that transfer was made to a charity, for a child’s medical expenses, a grandchild’s schooling or any other purpose. In addition, based on the definition of “hardship” quoted above, if the individual is in a nursing home and that nursing home cannot discharge the resident because no other facility will take them (who would take a non-paying resident?) and they cannot be discharged to home, it is unlikely that the individual will meet the deprivation of food, clothing, shelter or medical care such that their life or health would be in danger as required by federal law.

As a result, we are not overly optimistic that the hardship waiver policy – even after implementation in Florida – will provide much of a saving grace for Medicaid applicants who make gifts for purposes other than to qualify for Medicaid.

Conclusion

This brief summary covers all the major changes contained in the Deficit Reduction Act of 2005. Although the new law does take away many of the planning opportunities that were previously available, it also opens up other opportunities that were not been previously permitted under Florida law. The biggest message sent by the new law is that planning in advance of need is now more important than ever and that working with a qualified expert in long-term care asset protection planning is now more important than ever.

We strongly encourage everyone who does not currently have a long-term care plan in place to consider meeting with a Board Certified Elder Law attorney who can help them determine which, if any, planning options are right for them.

Copyright © 2006 by Randy C. Bryan, J.D., a Board Certified Elder Law Attorney by the Florida Bar, who is also a member of the Academy of Florida Elder Law Attorneys, Florida Bar’s Elder Law Committee, the National Academy of Elder Law Attorneys, the National Network of Estate Planning Attorneys and WealthCounsel. This handout does not constitute legal advice, nor does it create an attorney-client relationship. Instead, it is prepared as a public service to clients and friends of THE LAW OFFICES OF HOYT & BRYAN, LLC. Because it is designed only as a brief overview of the Medicaid law changes and not as a substitute for legal advice, it does not tell you everything you will need to know about this subject. Future implementation of and changes in the law cannot be predicted, and statements in this summary are based solely on the law as it exists on February 8, 2006. If you have a specific question on this issue, it is very important to seek professional advice. If you need a Board Certified Elder Law Attorney, you may call our office at the number listed below or the Florida Bar Referral Service, a non-profit public service project of the Florida Bar Association at 1-800-342-8011.