

**Description of
The House and Senate Budget Proposals for Medicaid “Reform”
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Some of the following information is drawn from the House Commerce and Energy Committee and Senate Finance Committee websites.

House Proposal

<http://thomas.loc.gov/cgi-bin/query/query> (Search bill # H.R. 4241)

[(H.R. 4241) Not yet passed by the House]

The House is considering legislation that would include the following significant changes to Medicaid Long-Term Care financing.

Section 3111. Lengthening Look-Back period; change in beginning date for period of ineligibility.

Section 3111 (a) would lengthen the general look-back date to 60 months (as is already the case with certain trusts) for income and assets disposed of by the individual after this Act's date of enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply.

Section 3111 (b) would change the start date of the ineligibility period for all transfers made on or after the date of the enactment, to either

- (1) the first day of a month during or before which assets have been transferred for less than fair market value, or
- (2) the date on which the individual is eligible for medical assistance under the state plan and is receiving certain long-term care services,

whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy. These services would include (1) nursing facility care; (2) services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; (3) Section 1915(c) home and community-based waiver services; (4) home health services; and, (5) personal care furnished in a home or other locations. At state option, they may also include other state plan long-term care services.

Section 3111 (d) specifies the criteria by which an application for an undue hardship waiver would be approved by codifying CMS guidance on state procedure. Approval would be subject to a finding that the application of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered, or that the individual would be deprived of food, clothing, shelter, or other necessities of life.

Section 3111(d) would also permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Section 3112. Disclosure and treatment of annuities and of large transactions.

Section 3112 would require individuals, at the initial application or re-certification for certain Medicaid long-term care services, to disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a non-countable assets) and full information concerning any transaction involving the transfer or disposal of assets during the previous 60 month period, if the transaction exceeded \$100,000, without regard to whether the transfer or disposal was for fair market value.

The state would be designated as the remainder beneficiary under such an annuity or similar financial instrument, subject to the following provisions:

- (A) For institutionalized individuals who receive certain Medicaid covered long-term care services, the state would become the remainder beneficiary in the first position of an annuity (in which the individual has an interest) for the total amount paid by Medicaid on behalf of the individual. This provision would not apply when a spouse, child under age 21, or child who is blind or disabled is a named beneficiary;
- (B) In the case of disclosure concerning an annuity, the state would notify the annuity's issuer of the state's right as a preferred remainder beneficiary in the annuity for Medicaid services furnished to the individual. This provision would not prevent the issuer from notifying persons with any other remainder of the state's interest in the remainder;
- (C) The state may require an issuer to notify when there is a change in the amount of income or principal being withdrawn from the amount being withdrawn at the time of the most recent disclosure, as specified above. A state would take such information into account when determining the amount of the state's obligations for Medicaid or the individual's eligibility. Such a change in amount would be deemed as a transfer of an asset for less than fair market value unless the individual demonstrates, to the state's satisfaction, that the asset transfer was for fair market value.

Section 3112 would apply to transactions (including the purchase of an annuity) occurring on or

after the date of the enactment.

Section 3113. Application of “income-first” rule in applying community spouse’s income before assets in providing support of community spouse.

Section 3113 would require that any transfer or allocation made from an institutionalized spouse to meet an income need of a community spouse be first made from income of the institutionalized spouse, thus codifying the “income-first” method. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated. Section 3113 would apply to transfers and allocations made on or after the date of this Act’s enactment by individuals who become institutionalized spouses on or after such date.

Section 3114. Disqualification for long-term care assistance for individuals with substantial home equity.

Section 3114 would exclude from Medicaid eligibility for nursing facility or other long-term care services, those individuals with an equity interest in their home of greater than half-a-million dollars (\$500,000). Section 3114 would not apply to individuals whose spouse, child under age 21, or child who is blind or disabled lawfully resides in the individual’s home. Section 3114 would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Section 3115. Enforceability of continuing care retirement communities (CCRC) and life care community admission contracts.

Section 3115 would allow a continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to require in their admissions contracts that residents spend their resources (subject to Medicaid’s rules concerning the resources allowance for a community spouse), declared for the purposes of admission, on their care before they apply for Medicaid.

Section 3115 would also allow entrance fees for CCRCs or life care communities to be countable resources for purposes of the Medicaid eligibility determination if the following conditions are met:

- (A) the individual would have the ability to use the entrance fee, or the contract provides that the entrance fee could be used, to pay for care should other resources or income of the individual be insufficient to pay for care;
- (B) the individual would be eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contract and leaves the community; and

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

Senate Proposal

[The Senate passed its version (S. 1932) on Thursday, November 3, by a vote of 52 to 47]
<http://thomas.loc.gov/cgi-bin/bdquery/z?d109:s.01932>

6011 (a) Requirement to Impose Partial Months of Ineligibility

Current Law

This provision would require that a state may not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

6011 (b) Authority for States to Accumulate Multiple Transfers into One Penalty Period

This provision would provide that 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 would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

6011 (c) Inclusion of Transfer of Certain Notes and Loans Assets

This provision would make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit 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 these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

6011 (d) Treatment of Annuities

(1) Inclusions of Transfers to Purchase Balloon Annuities

This provision would include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of

the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

(2) Requirement for State to be Named as a Remainder Beneficiary

This provision would amend require that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

(3) Inclusion of Certain Annuities in an Estate

This provision would include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

6011 (e) Inclusion of Transfers to Purchase Life Estates

This provision would redefine the term ‘assets,’ with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for at least one year after the date of purchase.

6011 (f) Protection Against Undue Hardship

This provision would require that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care so that the individual’s health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

6011 (g) Effective Dates

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act’s enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of

enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements 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 enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature.

Section 6012. State long-term care partnerships

This provision would exempt two groups of persons with certain long-term care insurance plans from Medicaid estate recovery. They would include individuals who received Medicaid: (1) under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below and (2) under a current LTC insurance partnership program in one of the 5 states (in which the state received approval for state plan amendments as of May 14, 1993 allowing for the disregard of any assets or resources to the extent that payments are made under a *LTC insurance policy* or because an individual has received (or is entitled to receive) benefits under a *LTC insurance policy*) and the Medicaid state plan satisfies requirements B through G described below as long as the LTC insurance policy was sold on or after 2 years after enactment.

This provision would define *LTC insurance policies* as including, but not limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term “Qualified State LTC Insurance Partnership,” would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another state’s Qualified LTC Insurance Partnership” or a long-term care insurance policy in 2 above, the same as the state treats benefits paid under such a policy under the state’s plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed \$250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest \$100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of

misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold; (F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and (G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective. *LTC insurance policies* would be required to meet requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such LTC insurance partnerships;

Minimum reporting requirements. These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures and federal Medicare expenditures.

Medicare

Medicare. Medicare is untouched by the House plan. The Senate measure would save \$5.8 billion, mixing cuts to insurance companies with additional funding for doctor payments, among other provisions.