Memorandum Explaining the Deficit Reduction Act of 2005
(Medicaid Provisions)

This memo previously appeared in The NAELA eBulletin -- January 2, 2006

By Brian Lindberg, Vincent Russo, and Charlie Sabatino
On behalf of the NAELA Medicaid Task Force

The following is a brief explanation of the key Medicaid provisions of the Deficit Reduction Act of 2005 (S. 1932) (hereinafter the "ACT"). It is only a statement of the Medicaid provisions. If the ACT is enacted, an analysis of the Medicaid provisions will be prepared by NAELA.

Status of Legislation
The United States Senate passed the ACT (also known as the Budget Reconciliation Bill) by a vote of 51 to 50, with the Vice President breaking the tie in favor of passage. However, the Bill was amended by three points of order relating to language that was not allowed in the Budget Reconciliation Bill. This means that the House will have to return to approve this slightly different Bill than the one they recently passed. It is not clear as to when they will vote on this Bill. The House is scheduled to return on January 31, 2006. It is possible (but unlikely) that the House will reconvene sooner than that time.

Please note that any transactions made before the date of enactment would be treated under existing Medicaid law (except for Section 6014 of the ACT regarding home equity).

Background
The Medicaid provisions are located at Chapter 2 -- Long-Term Care Under Medicaid Subchapter A -- Reform of Asset Transfer Rules and Subchapter B -- Expanded Access to Certain Benefits. For a link to the entire text of the ACT, go to Deficit Reduction Act of 2005 (Engrossed Amendment as Agreed to by Senate)[S.1932.EAS] at http://thomas.loc.gov/cgi-bin/query/z?c109:S.1932:

1. Lengthening Look-Back Period (Sec. 6011 (A))
   A. Explanation
   Section 6011 (a) would make the look-back period 60 months for all transfers (outright transfers as well as transfers to and from certain Trusts).

   The look-back period is analogous to a rear view mirror on a motor vehicle. It is the
period of time within which Medicaid is permitted to review financial transactions of the applicant to determine whether any of those actions would result in Medicaid disqualification. It begins with the date of application and goes backwards in time. Financial transactions further back in time (outside of the look-back period) are not part of the application process and cannot be a basis for Medicaid disqualification.

The current law is a two-tiered look-back period. For outright transfers, there is a 36 month look-back period. For transfers to a Trust, there is a 60 month look-back period. The language of the ACT would create a single-tier look-back period. All transfers, regardless of whether they were direct or to a Trust, would be subject to a 60 month look-back period.

B. Effective Date
The change in the look-back period would affect transfers made on or after the date of enactment of the ACT (Sec. 6011(c)).

This Section may be subject to the provisions of Section 6016 regarding effective dates of the ACT as well as the provisions regarding State implementation (discussed below). There appears to be contradictory language between the specific effective date language of this Section and the general provisions of Section 6016. It is not clear which provisions control.

2. Change In Beginning Date For Period Of Ineligibility (Sec. 6011(B))
A. Explanation
Section 6011(b)(2) adds a new clause in the case of a transfer of assets made on or after the date of enactment of the ACT, providing that the beginning date for the period of ineligibility 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 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.

Section 6011(b)(1) retains current law in the case of a transfer of assets made before the date of enactment of the ACT, such that the beginning date for the period of ineligibility 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.

B. Effective Date
Section 6011 (c) provides for a change in the transfer penalty start date which shall apply to transfers made on or after the date of enactment of the ACT, but Section 6016(e)(2)(B) applies to transfers made after the date of enactment of the ACT. This
leaves in question whether a transfer on the date of enactment is subject to the new rules.

This Section may be subject to the provisions of Section 6016 regarding effective dates of the ACT as well as the provisions regarding State implementation (discussed below). There appears to be contradictory language between the specific effective date language of this Section and the general provisions of Section 6016. It is not clear which provisions control.

3. Availability of Hardship Waivers (Sec. 6011(D))
A. Explanation
Section 6011(d) requires each State to include a hardship waiver procedure in accordance with 42 U.S.C. § 1396p(c)(2)(D) to include a potential hardship imposed by the application of the transfer of assets provisions of Section 6011.

In order for such hardship provisions to apply, the application of the transfer of assets provisions would need to deprive the individual of either medical care such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life. Such procedure must provide for 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.

This subsection also enables a facility in which the institutionalized individual is residing to file an undue hardship waiver on behalf of the individual with the consent of the individual or the personal representative of the individual.

In addition, this subsection states that, while an application for an undue hardship waiver is pending, provided the application meets criteria established by the Secretary, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility for a maximum of thirty days.

B. Effective Date
Section 6011 (d) contains no specific effective date provision. See Section 6016 below regarding the general effective date.

4. Disclosure and Treatment of Annuities (Sec. 6012)
A. Explanation
Disclosure and Notice (Section 6012(a)). Section 1917 of the Social Security Act (42 U.S.C. § 1396p) is amended by re-designating 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 his or her spouse must disclose any interest in an annuity (or similar financial instrument that may be specified by the Secretary).
Such application or recertification form shall include a statement that the State becomes a remainder beneficiary under such annuity or similar financial instrument. Also, the State shall notify the issuer of the annuity of the right of the State to be a preferred remainder beneficiary in the annuity.

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. 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.

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.

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

Inclusion of Transfers to Purchase Balloon Annuities (Section 6012(c)). This change includes in the definition of "asset" transfers the purchase of balloon annuities by or on behalf of the annuitant who has applied for medical assistance for nursing facility services or other long term care services, UNLESS

(i) it is an annuity meeting requirements of certain Sections of 408 and 408A of the IRC, or

(ii) it is an annuity that is irrevocable, non-assignable, actuarially sound (based on Social Security tables) and pays out in equal installments during the term of the annuity with no deferral or balloon payments made.

B. Effective Date
The change in the Annuity rules shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of the ACT (Sec. 6012(d)).

This Section may be subject to the general provisions of Section 6016 as well as the provisions regarding State implementation (as discussed above). There appears to
contradictory language between the specific effective date language of this Section and
the general provisions of Section 6016. It is not clear which provisions override the
others.

5. Application of "Income-First" Rule in Applying Community Spouse's
   Income Before Assets in Providing Support of Community Spouse (Sec. 6013)
   A. Explanation
   Section 6013 provides that all states must now follow the "Income First" rule. This rule
   mandates that the states must consider all income of the institutionalized spouse that
   can be allocated to the community spouse, in order to bring the community spouse's
   income up to the minimum monthly maintenance needs allowance (MMMNA), before
   raising the community spouse's resource allowance to adequately provide for that
   income.

   B. Effective Date
   This mandate of the income first rule shall apply to transfers and allocations made on or
   after the date of enactment by individuals who become institutionalized spouses on or
   after such date (Sec. 6013(b)).

   This Section may be subject to the general provisions of Section 6016 as well as the
   provisions regarding State implementation (as discussed above). There appears to
   contradictory language between the specific effective date language of this Section and
   the general provisions of Section 6016. It is not clear which provisions override the
   others.

6. Disqualification for Long-Term Care Assistance for Individuals with
   Substantial Home Equity (Sec. 6014)
   A. Explanation
   Section 6014 provides for a denial of benefits for an individual who has equity in a
   home that exceeds $500,000. It allows states to increase the $500,000 limit to an
   amount not greater than $750,000. If a state decides to increase the amount above
   $500,000, it is allowed to do so without regard to federal statutory requirements that:

   (i) provisions shall be in effect throughout the state (state wideness under 42 U.S.C. §
   1396a), or

   (ii) assistance is available in the same amount, duration and scope to all individuals
   within the state (comparability under 42 U.S.C. § 1396a).

   Section 6014(a)(F)(1)(C) also directs that the $500,000 limit be increased annually,
   starting in 2011, based on a percentage increase in the consumer price index, urban
   consumers, rounded to the nearest $1,000.
Section 6014(a)(F)(1)(C)(2)(B) provides exceptions to the general rule requiring denial of assistance. The denial shall not apply to an individual whose spouse or child under twenty-one, blind or disabled is lawfully residing in the home.

Section 6014(a)(F)(1)(C)(3) permits individuals to use a reverse annuity mortgage or home equity to reduce their total equity.

Section 6014(a)(F)(1)(C)(4) requires the Secretary to establish a process to waive the application of the denial of eligibility in cases of demonstrated hardship.

B. Effective Date
The change in the Medicaid eligibility rules as to Substantial Home Equity shall apply to individuals whose eligibility is based upon a Medicaid application filed on or after January 1, 2006 (Sec. 6014(b)). This Section may be subject to the general provisions of Section 6016 as well as the provisions regarding State implementation (as discussed above). There appears to be contradictory language between the specific effective date language of this Section and the general provisions of Section 6016. It is not clear which provisions override the others.

7. Enforceability of Continuing Care Retirement Communities (Ccrc) and Life Care Community Admission Contracts (Sec. 6015)
A. Explanation
Section 6015 deals with the disclosure of resources in an application for admission to a Continuing Care Retirement Community or a Life Care Community and the treatment of entrance fees that are held by such entities.

The statute does not define "Continuing Care Retirement Community" or "Life Care Community" and relies on the states to determine what entities meet these definitions. In general, however, these entities offer an individual "life care" in one setting. An individual moves onto a campus where independent living, assisted living and nursing home care are available as the individual's care needs change.

Oftentimes, such entities require an applicant to provide personal financial information as part of the admissions process. Also as a prerequisite to admission, the entity may require the applicant to pay an entrance deposit that could cost hundreds of thousands of dollars (this is separate from the monthly fees a resident must also pay to the entity). Some entities promise that the entrance fee is partially or completely refundable when the resident dies or moves out. Under current law, the entrance deposit may be treated as analogous to a home (as a home is often sold to get the funds to pay for the deposit), and may therefore be considered unavailable for Medicaid purposes.

The new law makes two changes affecting such entities, as follows:
First, the entity's residential contract may require a resident to spend on his or her care the resources declared on the resident's admission application before applying for Medicaid.

Second, if a resident is eligible for a refund of an entrance fee held by the facility, then such fee is considered as an available resource for Medicaid to the extent 1) that the resident has the ability to use the entrance fee, or the contract provides for the use of the entrance fee, to pay for care if other resources of the individual are insufficient to pay for such care, 2) the individual is eligible for a refund when the individual dies or terminates the contract and leaves the community, and 3) the entrance fee does not provide an ownership interest in the community.

B. Effective Date
The effective date of this section shall be determined by the general rule as set forth in Sec. 6016.

8. Impose Partial Months of Ineligibility (Sec. 6016 (A))
A. Explanation
Section 6016(a) provides that States are no longer allowed to round down the penalty period to the lowest whole number. Rather, the penalty will, in essence, be a per diem penalty. For example, if a transfer is made creating a transfer penalty period of 4.25 months, the applicant will be ineligible for 4 months and 8 days.

B. Effective Date
The per diem penalty applies to transfers made "before the date of the enactment of the Deficit Reduction Act of 2005" and "after the date of the enactment of the Deficit Reduction Act. Section 6016 (e)(2)(B) states that "The amendments made by this section shall not apply ... with respect to assets disposed on or before the enactment of this Act. In short, there seems to be a conflict as to whether the per diem penalty applies to transfers made before the date of the Act.

9. Multiple Transfers Into One Penalty Period (Sec. 6016(B))
A. Explanation
Section 6016(b) adds a new paragraph (H) to 42 U.S.C. § 1396p(c)(1). It applies to "multiple fractional transfers of assets in more than 1 month for less than fair market value" by the community spouse or institutionalized spouse after the enactment date. The term "multiple fractional transfers" is ambiguous but presumably it applies to transfers made in successive months. For purposes of determining the period of ineligibility, Paragraph (H) gives states discretion to treat as one transfer, the total cumulative uncompensated value of all assets transferred by the individual or spouse during all months on or after the look-back date in 42 U.S.C. § 1396p(c)(1)(B). The period of ineligibility begins on the earliest date which would apply under 42 U.S.C. § 1396p(c)(1)(D).
B. Effective Date
There is no specific effective date provision, so the general provisions of Section 6016 control.

**10. Inclusion of Certain Notes and Loans (Sec. 6016(C))**

A. Explanation
Section 6016(C) adds additional language with respect to transfers of assets so that "assets" include 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, (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 these requirements, 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.

B. Effective Date
There is no specific effective date provision, so the general provisions of Section 6016 control.

**11. Inclusion of Transfers to Purchase Life Estates (Sec. 6016(D))**

A. Explanation
Section 6016(d) amends 42 U.S.C. § 1396p(c)(1) to provide that funds used to purchase a life interest in the home of another individual will be regarded as assets which have been transferred unless the purchaser resides in the home for a period of at least one year after the date of purchase.

B. Effective Date
Section 6011(d) contains no specific effective date provision. See 6016 regarding the general effective date.

**12. Effective Date of Amendments (Sec. 6016)**

A. Explanation
(i) Section 6016(e)(1) provides that the amendments made by this Section shall apply to payments under Title XIX of the Social Security Act for calendar quarters beginning on or after the enactment, and final regulations do not need to be in place by such date.

(ii) Section 6016(e)(2) provides exceptions to the amendments made by this Section. It shall not apply to medical assistance provided prior to enactment and to assets disposed of or trusts established on or before the date of enactment.
(iii) Section 6016 (e) (3) extends the effective date for state law amendment. If any State Plan requires state legislation to implement this Act, then a limited amount of time is allowed for the states to do so.

The effective date language of this Act is identical to the language of the Omnibus Budget Reconciliation Act of 1993. If a State has to pass its own enabling legislation, then there may be additional time before the ACT becomes effective in that State.

13. Expansion of State Long-Term Care Partnership Program (Sec. 6021)
A. Explanation
Upon enactment, States may amend their Medicaid state plan to provide for qualified State long-term care insurance partnership programs.

A "qualified State long-term care insurance partnership" is defined in sec. 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 insurance policy [IRC sec. 7702B(b)]

3. The policy meets 9 identified sections of the Long-Term Care Insurance Model Act and 19 identified sections of the Model Regulation of the National Association of Insurance Commissioners (NAIC). The State's Insurance Commissioner must certify the policy as meeting the requirements. There is also a process permitting DHSS to adopt future revisions of the NAIC Model Act and Regulations.

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 Secretary of the U. S. Department of Health and Human Services that include when benefits have been paid, the amount, and the termination of benefits, and such other information as the Secretary
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 (CT, CA, IN, and NY), 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 must consult with NAIC and several other constituencies in developing reporting regulations. DHSS must also 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 partnership programs. The data set must have a centralized electronic query and report-generating mechanism.

DHSS 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, DHSS must: (1) report annually to Congress on the partnership programs, including its impact on access to 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, that will focus on consumer information and education. The ACT appropriates to DHSS $3 million a year from FY 2006 through 2010 for the Clearinghouse.

B. Effective Date
The Amendments regarding state long term care partnerships take effect on October 1, 2007, and apply to long-term care insurance policies sold on or after that date.

This summary was prepared by members of the NAELE Medicaid Task Force Vincent J. Russo (Chair), Gregory French, Mark Heffner, A. Frank Johns, Morris Klein, Whitney Lewendon, Leonard Mondschein, Eric MacDonald, and Tim Nay); and members of the NAELE Public Policy Committee, Charles Sabatino (Chair), Daniel G. Fish, and Brian Lindberg, NAELE Public Policy Consultant.