Report of the
Joint Legislative Audit and Review Commission
To the Governor and
The General Assembly of Virginia

Special Report: Recent Federal Changes Affecting Asset Sheltering for Medicaid Long-Term Care

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In Brief

Recent Federal Changes Affecting Asset Sheltering for Medicaid Long-Term Care

There has been concern that some individuals were using loopholes in the law to shelter assets in order to qualify for Medicaid long-term care (LTC) services. The federal Deficit Reduction Act of 2005 (DRA) included provisions intended to restrict this practice. HJR 97 and SJR 122 of the 2006 General Assembly Session directed the Department of Medical Assistance Services and JLARC to monitor these new federal restrictions.

The DRA provisions expected to have the most impact in Virginia are the lengthening of the look-back period, a change in the method of calculating the penalty period, a requirement that the Commonwealth be named a remainder beneficiary on annuities, and the evaluation of purchases of life estates as uncompensated transfers. The General Assembly may wish to direct further actions to complement several of these provisions. Virginia has already implemented State programs similar to other DRA provisions.

The DRA did not address the purchase of U.S. Savings Bonds, payments to family members for care provided, transfers of homes to family members in certain circumstances, or the failure to disclose assets as a means of sheltering assets. Therefore, there may be an increase in the use of these methods by Virginians in order to qualify for Medicaid LTC services.

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This report is available on the JLARC website at http://jlarc.state.va.us

COMMONWEALTH of VIRGINIA

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Senator Norment:

House Joint Resolution 97 and Senate Joint Resolution 122 enacted by the 2006 General Assembly directed JLARC and the Department of Medical Assistance Services (DMAS) to assess the restrictions on the sheltering of assets in order to qualify for Medicaid long-term care services imposed by the federal Deficit Reduction Act of 2005. Staff were directed to review asset-sheltering practices by Virginians and recommend how to limit the financial impact of these practices on the Commonwealth.

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Special Report: Recent Federal Changes Affecting Asset Sheltering for Medicaid Long-Term Care

In Summary

The federal Deficit Reduction Act of 2005 (DRA) intends to limit many of the methods individuals have used to shelter their assets and qualify for Medicaid long-term care services. This review by the Department of Medical Assistance Services (DMAS) and Joint Legislative Audit and Review Commission (JLARC) assessed the changes in the DRA with respect to methods used in Virginia to shelter assets, as well as State-level changes that are required to implement DRA provisions. Key findings and related recommendations include the following:

- The DRA lengthens the look-back period for uncompensated asset transfers, moves back the beginning date for penalty periods, and imposes partial months of ineligibility for Medicaid long-term care services.

- The DRA gives states the option of counting multiple asset transfers as one for purposes of determining Medicaid long-term care eligibility, and the Department of Medical Assistance Services is drafting regulations to adopt this optional provision.

- The DRA requires that the Commonwealth be named the remainder beneficiary on all annuities purchased on or after February 8, 2006, and on annuities to which elective changes are made after this date. Issuers of annuities could be required to inform the State when annuitants make an elective change to their annuity.

- The DRA requires that funds used to purchase a life estate on or after February 8, 2006, must be evaluated as an asset transfer for Medicaid eligibility purposes. DMAS could pursue the authority to consider the value of all life estates in determining Medicaid eligibility.

- The DRA does not affect individuals' ability to shelter their assets through the use of U.S. Savings Bonds, compensation for care provided by family and friends, transfers of homes to family members in certain circumstances, or failure to disclose assets.

BACKGROUND

House Joint Resolution 97 and Senate Joint Resolution 122 of the 2006 Session direct the Department of Medical Assistance Services (DMAS) and the Joint Legislative Audit and Review Commission (JLARC) to monitor recent federal restrictions affecting the sheltering of assets to qualify for Medicaid long-term care (Appendix A). This study is the result of a collaborative effort between DMAS and JLARC staff to respond to these mandates. Research activities and methods undertaken for the study are included in Appendix B.

Medicaid is a public assistance program jointly funded by the federal and state governments. States administer the program within federal guidelines, but have flexibility in program design to some extent. Within the Medicaid program, eligible recipients have access to various healthcare services. These services range from preventive care services to acute care services (such as hospitalizations) to long-term care services (including nursing home care, community-based care through waiver programs, and end-of-life care).

Long-term care (LTC) services is one of the largest categories of expenditures in the Medicaid program. While most of the individuals who receive Medicaid LTC services have very low incomes and few assets, there has been increasing concern that some individuals have successfully sheltered their assets through loopholes in Medicaid laws to qualify for Medicaid LTC services. In so doing, these individuals have passed on their assets to individuals of their choosing while the State and taxpayers bear the cost of their long-term care.

In response to these concerns, the federal Deficit Reduction Act of 2005 (DRA) included provisions intended to limit the methods individuals have used to shelter their assets. Some of these provisions will have a substantial impact on methods that have been used by Virginians to shelter assets (as documented in case file examples provided by the State Department of Social Services). However, the act did not address all methods used to shelter assets, and these remaining methods may be increasingly utilized.

MEDICAID LONG-TERM CARE ELIGIBILITY CRITERIA

To qualify for Medicaid long-term care services, applicants must meet the categorical and non-financial criteria used to evaluate all Medicaid applicants. Long-term care applicants must also meet specific medical and income criteria. In addition, applicants for Medicaid LTC services must meet criteria that apply to their resources and assets. Some individuals may meet most of these cri-

teria but have uncompensated asset transfers that result in a penalty period before they can begin receiving payment of LTC services by Medicaid. These individuals may still be eligible to receive coverage for other medically necessary Medicaid services.

General Categorical and Non-Financial Medicaid Criteria

Eligibility for Medicaid is based on objective criteria, family income and available resources, as well as the following categorical criteria for specified coverage groups:

- aged (age 65 or older),
- blind or disabled (according to Social Security disability standards),
- under the age of 19,
- pregnant, or
- parent/caretaker-relative of a dependent child under the age of 18.

Individuals who meet the definition for a Medicaid categorically covered group must also comply with the following non-financial requirements:

- Virginia state residency,
- have a Social Security number,
- assignment of rights to medical support and other third-party payments,
- cooperation in the pursuit of child support,
- application for all benefits to which the individual may be entitled (such as Social Security and unemployment compensation), and
- proof of alien status or citizenship for individuals who declare to be U.S. citizens on their application (State law also requires documentation of legal presence in this country for individuals age 19 and over who claim to be U.S. citizens).

Medical and Income Criteria for Long-Term Care

In addition to the general categorical and non-financial criteria, individuals who receive Medicaid LTC services must meet certain medical and income criteria. Income requirements differ depending on the individual's Medicaid covered group. Medicaid LTC recipients are generally categorized as aged, blind, or disabled and primarily fall into three Medicaid financial eligibility categories:

- Supplemental Security Income (SSI) recipients—individuals who meet the SSI income requirement (less than $603 per month) and resource requirement ($2,000 for an individual and $3,000 for a couple in 2006) and Virginia's real property requirements (which exclude the home, the minimum lot size, and up to $5,000 of contiguous property);
- individuals with countable income (income from certain sources is excluded) less than or equal to 80 percent of the federal poverty level (in 2006, $817 per month for an individual and $1,100 per month for a couple); and
- individuals with income less than or equal to 300 percent of SSI (in 2006, $603 per month).

Medical Criteria. Eligibility for Medicaid payment of LTC services is based on an individual's medical need to receive the level of care provided in a nursing facility or through one of the home and community-based care waivers. Individuals are screened using a uniform assessment instrument, and a determination is made as to the level of care required. If criteria for LTC services are met, and financial eligibility is established, the individual is determined to be eligible for Medicaid-funded LTC services.

Income Criteria. Beyond the medical criteria, each of the eligibility categories also has a separate income limit which changes annually. The 2006 income limits are shown on Table 1 by Medicaid financial eligibility category. Income is determined on a monthly basis and is counted in the month it is received. Countable income includes, but is not limited to, wages, contract or self-employment income, Social Security and SSI benefits, child support, Veteran's Administration benefits, unemployment compensation, Workers' Compensation, retirements, pensions, and gifts. All income must be verified through data matches or from the issuing source (such as pay stubs, wage forms, and award letters).

Table 1: 2006 Income Limits for Medicaid Long-Term Care Recipients

Medicaid Financial Eligibility Category	Monthly Income Limit
SSI recipients	$603[1]
Income less than or equal to 80% of federal poverty level	$654 individual/ $800 married couple
Income less than or equal to 300% of SSI	$1,809 individual[2]

[1] Maximum SSI payment.
[2] Individuals with monthly income greater than $1,809 may also be eligible for Medicaid payment of their LTC services if monthly income is less than the cost of private nursing facility care.

Source: Department of Medical Assistance Services staff.

Resource/Asset Criteria for Long-Term Care

In addition to income, Medicaid LTC eligibility is also determined based on other available financial resources. For all aged, blind, or disabled individuals who have been determined to meet the medical criteria for receipt of LTC services, the resource limit is $2,000.

This limit applies to single as well as married individuals who are institutionalized. Individuals who have countable resources that exceed the $2,000 limit must reduce their resources prior to achieving eligibility. Resources include, but are not limited to, cash, bank accounts, the cash value of investments such as stocks, bonds, trust funds, vehicles, life insurance policies, and the cash value of non-exempt real property. Resources also include assets owned by the individual, his or her spouse, and those in which the individual has an ownership interest.

All resources must be verified, but not all resources are countable. Household goods, personal effects, and the individual's home (if living there) are not countable resources. (An individual's home is only exempt for the first six months after admission to a nursing facility unless other exemptions apply, which are discussed later.) Unique to the eligibility determination for Medicaid payment of LTC services is the requirement to evaluate the value of the resource retained as well as the value of any resource transferred and the compensation received.

Resources held jointly (with a spouse or any other individuals), those in the institutionalized spouse's name, and those in the community spouse's (the spouse not requiring admission to a LTC nursing facility) name must all be evaluated to determine financial eligibility. Section 1924 of the Social Security Act contains special eligibility rules that apply to married couples when only one spouse requires LTC services. These rules were designed to protect the community spouse (who does not need LTC services) from becoming impoverished as they eventually could if they were required to spend all resources on the institutionalized spouse's care. This is accomplished through protecting at least one-half of the couple's resources for use by the community spouse. Depending on the total amount of the couple's resources, a married couple can protect from $19,908 to $99,540. For example, if a couple has countable resources of $180,000, then $90,000 would be protected for the community spouse who does not need LTC services. Medicaid resource eligibility could be established when the couple's countable resources are reduced to $90,000 for the community spouse and $2,000 for the spouse who needs LTC services, or $92,000 in total. The resources in excess of $92,000 must be reduced or spent before Medicaid eligibility for LTC services can be established.

CHANGES IN FEDERAL LAW AFFECTING METHODS VIRGINIANS HAVE USED TO SHELTER THEIR ASSETS

Although most recipients of Medicaid LTC benefits have low incomes and very few assets, some applicants have taken advantage of loopholes in the federal Medicaid law and gained access to Medicaid LTC benefits while sheltering substantial amounts of their assets. In many cases, these assets are passed on to other people, such as a Medicaid recipient's adult children. This is problematic from the State's perspective because the State assumes the burden of paying for an individual's long-term care even though that individual has assets that could be used to pay for that care. In some cases, the amount of assets sheltered is substantial.

To reduce an individual's ability to shelter assets and qualify for Medicaid LTC, changes in the federal law affecting the resource eligibility criteria for Medicaid LTC were included in the federal Deficit Reduction Act of 2005 (DRA). The DRA was signed into law on February 8, 2006, and contains a number of provisions relating to Medicaid LTC, most of which are mandatory and related directly to the eligibility determination for LTC services. (Appendix C provides a summary of the DRA provisions relating to Medicaid LTC.)

Several of the provisions in the act address methods that have been used by Virginians to shelter assets and qualify for Medicaid LTC. These methods include (1) timing transfers to take advantage of how penalty periods are calculated, (2) purchasing annuities, and (3) retaining or purchasing life estates. Each method is discussed below, along with examples from Department of Social Services case files of individuals who qualified for Medicaid LTC by sheltering their assets.

Timing of Transfers and Avoidance of Penalties

Individuals who have been able to plan their LTC needs in advance have often timed their transfers of assets to minimize the impact of the transfers on their Medicaid eligibility. Individuals or their spouses who transfer assets for less than fair market value (in other words, without receiving adequate compensation) may be ineligible for Medicaid payment of their LTC services for a specific period of time called the "penalty period." (Transfers to certain individuals such as those between spouses or those to a disabled child are not subject to a penalty period.) Some individuals have planned the timing of transfers of assets to avoid penalty periods altogether or to take advantage of how penalty periods are calculated to minimize their impact. Such techniques are among the least sophisticated methods used to shelter assets, but are also

likely the most frequently used methods. However, they may not involve the largest asset transfers.

Sheltering of Assets Using Methods Involving Timing Mechanisms and Avoidance of Penalties. Individuals have timed their asset transfers and/or taken advantage of the calculation of penalty periods to minimize or avoid incurring a penalty. One way individuals did this was by transferring assets before the look-back period. The look-back period represents the window in which asset transfers are examined for Medicaid LTC eligibility to determine whether they were properly compensated transfers. Until recently, the look-back period for asset transfers that did not involve trusts was 36 months prior to the first day that an individual was both institutionalized and a Medicaid applicant. Therefore, if individuals transferred their assets prior to the look-back period, the transfer was not considered in determining eligibility for Medicaid payment of LTC services.

Another technique individuals used was to wait out the penalty period. The penalty period is calculated by dividing the amount of the asset transferred by the average cost of private nursing home care in an individual's area. For example, if an individual transfers $40,000 without receiving adequate compensation and the average cost of nursing home care in the area is $5,000 per month, this would result in an eight-month penalty period in which the individual would be ineligible to receive Medicaid payment of LTC services. Previously, penalty periods began from the date of the uncompensated transfer. Therefore, for some individuals the penalty period may have expired before they needed to access LTC services. For instance, if the uncompensated transfer in the example above was made two years before an individual became institutionalized, the penalty period would already have expired by the time the individual became a Medicaid LTC applicant.

A third technique individuals used to avoid penalties was to transfer assets in a series of small transfers rather than one large transfer. Because the penalty period is determined by dividing the uncompensated value of an asset transferred by the average monthly cost of private pay nursing facility services, transfers that were equal to or less in value than the monthly cost of a private pay nursing facility did not incur a penalty. Therefore, rather than making one large transfer of $40,000, an individual could make ten transfers of $4,000 each (which would be less than the monthly cost of a private pay nursing facility) in separate months and avoid incurring a penalty.

Restrictions on Timing of Transfers and Avoidance of Penalties Prior to the DRA. As mentioned previously, prior to the DRA the look-back period for asset transfers that did not involve trusts was

36 months prior to the first day that an individual was both institutionalized and a Medicaid applicant. (For transfers involving a trust, the look-back period was 60 months.) Penalty periods began on the date the asset was transferred, and the penalty period for an uncompensated transfer was rounded down to the nearest whole month. For example, a penalty period of three months and 12 days was rounded down to three months. Also, if multiple uncompensated transfers occurred in different months, federal policy required that each individual transfer be calculated separately to determine whether there was a penalty period and, if so, the length of it. When multiple asset transfers occurred such that the penalty periods overlapped, the values of all assets transferred were added together and divided by the average monthly private nursing facility cost. This would produce a single penalty period which would begin on the date the first asset was transferred. However, if penalty periods from multiple transfers did not overlap, each transfer was treated as a separate event with its own penalty period.

DRA Effect on the Timing of Transfers and the Avoidance of Penalties. The DRA mandated several changes that affect individuals' ability to time their asset transfers and take advantage of the calculation of penalty periods. These include lengthening the look-back period for uncompensated asset transfers, changing the beginning date for penalty periods, and imposing partial months of ineligibility.

With regard to the look-back period, the DRA extended the look-back period from the existing three-year period to five years for all transfers made on or after February 8, 2006. This provision will not be fully implemented until 2011. However, under the fully implemented new law, any transfer made within five years of application for Medicaid will be evaluated to determine if it is an uncompensated transfer.

The DRA also changed the start date for penalty periods. When a transfer of assets made on or after February 8, 2006, triggers the imposition of a penalty, the penalty period for Medicaid payment for LTC services begins the date the institutionalized individual would otherwise be eligible for Medicaid payment of LTC services rather than the date the asset was transferred. This new provision eliminates the ability of the individual who transferred assets during the look-back period to wait out the penalty period prior to applying for Medicaid payment of LTC services.

The final mandatory change requires states to impose partial penalty periods. For example, if the calculated penalty period is three months and 12 days, individuals are required to pay for 12 days of their own care in the fourth month. Prior to the DRA, states could

have imposed a penalty of only three months. Similarly, individuals can now be subject to a penalty period of less than a month whereas prior to the DRA, an uncompensated amount less than one month's cost of nursing care would not trigger a penalty in Virginia.

In addition to the mandatory changes required by the DRA that affect the timing of transfers, the DRA gives states the option of counting multiple asset transfers as one for purposes of determining Medicaid LTC eligibility. This prevents individuals from making multiple small transfers to avoid a penalty that would have been incurred for one large asset transfer.

Exhibit 1 (p. 10) is an example of a father who used several techniques involving the timing of transfers to transfer nearly $150,000 to his daughter and son-in-law between 2001 and 2005. Because of the methods used by the father to transfer his assets, he was eligible for Medicaid. The DRA would not allow individuals to use most of the techniques in Exhibit 1 after February 8, 2006.

Purchase of Annuities

Annuities have been used to shelter assets because they can be used to convert countable assets into income, which may then allow an individual to become Medicaid eligible. For example, a single person who has $10,000 of countable assets would not qualify for Medicaid, but a single person who has $500 of monthly income from an annuity but no assets would qualify. In its simplest form, an annuity is an annual payment that occurs throughout a person's lifetime. In the typical case, a person will purchase an annuity contract from an insurance company, and the contract will provide for guaranteed, often monthly, payments over the rest of the person's life. Payments are based on the annuitant's life expectancy.

Use of Annuities to Shelter Assets. For purposes of sheltering assets to qualify for Medicaid, individuals have more frequently made use of "term certain" annuities. Term certain annuities provide payments for a specified term, such as nine years. If an annuitant dies before the specified term, the remaining payments in the term are paid to the annuitant's beneficiary. If the annuitant lives beyond the term, payments will continue until the annuitant's death. For Medicaid eligibility purposes, the federal government has required that all annuities be actuarially sound, meaning that the annuity must pay out its full principal and interest during the annuitant's statistical life expectancy.

Exhibit 1: Case File Example on Timing of Transfers

In February 2006, a father applied for Medicaid long-term care services and was determined eligible. However, in the five years leading up to his Medicaid eligibility determination, he successfully transferred over $148,743 to his daughter and son-in-law.

In 2001, the father made monthly gifts to his daughter and son-in-law ranging from $1,666 to $2,452, and he gave them $25,000 on December 30, 2001. The father's gifts in 2001 totaled $48,947. In 2002, the father made monthly gifts ranging from $1,666 to $6,998 between February and December, for a total gift amount of $22,122 in that year. Because the 2001 and 2002 gifts occurred before the 36-month Medicaid look-back period that was in effect at that time, the $71,069 in gifts over this two-year period was not considered in the father's Medicaid eligibility determination.

In 2003, the father transferred monthly amounts ranging from $1,666 to $5,502 to his daughter and son-in-law for a total of $23,674. With the exception of the $5,502 transfer, the other 2003 transfers were less than the average private monthly cost of nursing home care (which was $3,517 in 2003) and thus were not counted for Medicaid eligibility purposes. The one $5,502 transfer created a one-month penalty period that had expired by the time the father applied for Medicaid.

In 2004, the father made monthly gifts of $5,500 to his daughter and son-in-law between September and December for a total of $22,000 in that year. Each of these transfers resulted in a one-month penalty period, which expired prior to the father's application for Medicaid.

In 2005, the father made monthly gifts of $4,000 to his daughter and son-in-law between April and November totaling $32,000 for that year. Because these transfers were less than the average monthly cost of private nursing home care (which was $4,060 in 2005), they were not counted for Medicaid eligibility purposes.

DRA Impact (Look-Back Period; Penalty Periods; Multiple Transfers)

Under the fully implemented DRA regulations, the transfers made by the father in this example would have resulted in a significant period of ineligibility from the time he applied for Medicaid. For example, if the father utilized the same transfer schedule after February 8, 2006, the various transfers would have resulted in 36 months and 18 days of ineligibility. (The DRA only affects transactions after February 8, 2006. Therefore, the new DRA provisions, in particular the five-year look-back period, will not be fully applicable until 2011.) Due to the new 60-month look-back period for all transfers, the $71,069 in gifts transferred in the first two years would have been counted when determining the father's Medicaid eligibility. Also, the DRA allows states to accumulate multiple transfers into one for purposes of determining the penalty period. Therefore, all of the transfers that were below the average monthly cost of private nursing home care could be accumulated into one large transfer, which would result in a penalty. The DRA also changes the start date of penalty periods from when the asset was transferred to when the individual would otherwise be eligible for Medicaid payment of LTC services (after being approved for the Medicaid program). Therefore, the father would not be able to wait out the penalty periods prior to applying for Medicaid. Finally, the DRA requires states to impose partial month penalty periods rather than disregarding them, as was the case previously.

Source: Department of Social Services case file, and DMAS and JLARC staff analysis.

Annuities have provided opportunities to shelter assets in two ways. As mentioned previously, if the annuitant died before the end of the term, the beneficiary and not the State received the remainder of payments in the term. This amount can be substantial, particularly if the annuity contains a balloon payment upon maturity. In the case of spouses, annuities allow the healthy spouse to convert assets which would have been pooled for purposes of determining the Medicaid applicant's eligibility into income for the

spouse who remains in the community, which will not be counted in determining eligibility for the individual needing LTC.

A private annuity is an alternative to the traditional annuity and has also provided opportunities to shelter assets. A private annuity is typically a contract between family members (rather than with an insurance company or pension plan) and may involve an asset other than cash. For example, a father can transfer stock to his daughter in exchange for a monthly payment from the daughter for the remainder of his lifetime. If the father dies before his life expectancy, the daughter retains the remainder of the value of the asset.

Limitations on the Use of Annuities Prior to the DRA. Federal Medicaid policy prior to the DRA required Medicaid applicants to disclose all sources of income and resources, including annuities. In addition, federal policy required that annuities owned by an applicant or recipient be actuarially sound. There was no requirement regarding the remainder beneficiary or rule against balloon payments.

DRA Effect on the Purchase of Annuities. The DRA still allows individuals to shelter their assets through annuities to some extent. However, institutionalized individuals and their spouses who apply for Medicaid are now required to disclose ownership interests in annuities purchased on or after February 8, 2006, and must name the Commonwealth as the remainder beneficiary. Non-employment related annuities owned by an institutionalized individual and purchased on or after February 8, 2006, are considered an uncompensated transfer unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity (no deferral and no balloon payments).

Exhibit 2 is an example of a wife of a 2005 Medicaid applicant who successfully sheltered $640,000 of the couple's resources through the purchase of an annuity. In so doing, the wife effectively converted countable resources held jointly by the couple into non-countable income received in her name. No uncompensated transfer amount was calculated, no penalty period was assessed, and the husband successfully qualified for Medicaid. The DRA would still allow a spouse to purchase annuities, as in Exhibit 2. However, if the wife in Exhibit 2 were to die before the end of the annuity term, the State could recover some funds through the requirement that the Commonwealth be named the remainder beneficiary.

Exhibit 2: Case File Example on Purchase of Annuities

A man was admitted to a nursing home in March of 2005. A Medicaid resource assessment was completed at the time of his admission, and his spouse was informed that the couple had resources exceeding the spousal resource allowance by $570,000. The wife subsequently purchased a $640,000 annuity with the couple's resources. Her age at the time of the purchase was 83 and her life expectancy was 7.56 years. The term of the annuity was eight years with a monthly payment of approximately $7,000. The annuity was determined to be actuarially sound and qualified as a non-countable resource.

Because the wife was not a Medicaid recipient, the State may never recover any Medicaid funds related to the annuity. If the wife lives for the full term of the contract, she will receive all of the payments and will be able to spend the income or pass it on to her designated beneficiary. If she dies before the term of the contract, the payments will continue to her designated beneficiary.

DRA Impact (State as Remainder Beneficiary)
The DRA will allow the State to recover funds for annuities in situations similar to the example above if the annuitant dies before the end of the annuity's term. This is because the State must be named the remainder beneficiary on annuities, even when the annuity is held by the community spouse. However, if an annuitant lives beyond the term of the annuity, he or she will successfully shelter the assets.

Source: Department of Social Services case file, and DMAS and JLARC staff analysis.

The DRA requirement that the State be named the remainder beneficiary on annuities will apply to annuities purchased both before and after February 8, 2006. However, for those annuities purchased before February 8, 2006, the requirement will only exist if the annuitant makes an elective transaction after this date. An elective transaction would include a change to the amount of income or principal withdrawn from the annuity. One concern is how the State will know that such a change has been made. To address this concern, the DRA includes an option that allows states to require that the issuer of an annuity inform the State when an annuitant makes an elective change. Virginia may, therefore, want to consider implementing this option to ensure that the State is aware of all circumstances in which it should be named the remainder beneficiary. DMAS and the State Corporation Commission are currently determining which agency would appropriately receive information on elective changes, should Virginia decide to pursue this option.

Recommendation (1). The General Assembly may wish to consider requiring issuers of annuities to inform the State when annuitants make an elective change to their annuity pursuant to Section 3012(b) of the 2005 federal Deficit Reduction Act.

Use of Life Estates

Life estates have been used by individuals to partially shelter their home and property, which are often their largest assets, by transferring them to persons of their choice. A life estate is the right to occupy and use property during a person's lifetime. The value of

life estates is calculated based on a number of factors, including a person's age, life expectancy, and value of the property in which he or she will have a life estate. For purposes of Virginia Medicaid eligibility, life estates have not been considered a countable resource.

Use of Life Estates to Shelter Assets. Life estates have been used to shelter assets for Medicaid LTC eligibility in two ways. Individuals have used life estates to transfer or give property to others. For instance, a parent can make a gift of her home and property to her children and retain a life estate. The donees (in this case, the children) would become the legal owners of their mother's home and property but would not have the right to use, sell, or occupy it until after her death. For Virginia Medicaid eligibility purposes, only a portion of the value of the home (the remainder value, which is discussed below) would be evaluated as an asset transfer.

Individuals planning to apply for Medicaid may have also purchased life estates in other property to shelter their assets. For instance, a father could purchase a life estate in his son's home or property. Because the father receives a life estate on which a value can be established in exchange for cash of equal value, the purchase would be considered a compensated transfer. In this case, the father would have successfully sheltered the cash value of the life estate for his son.

To maximize the sheltering of assets, individuals have frequently both retained and purchased life estates simultaneously. Using both of these techniques has allowed individuals to avoid the potential consequences of the "remainder value" of the property. As mentioned previously, the value of a life estate is based on a number of objective factors. Therefore, a life estate's value may frequently be less than the value of the property in which the life estate is held. This leaves a remainder value in the home and property. The remainder value can be problematic for Medicaid eligibility purposes because, if an individual receives compensation for the remainder value, he would likely have assets in excess of the $2,000 limit. However, if an individual does not receive compensation for the remainder value, the transfer of the portion of his home equal to the remainder value would be considered an uncompensated transfer. (If the property was transferred before the look-back period, the remainder value would be irrelevant, as would any asset transfer occurring before the look-back period.)

To deal with this issue, individuals have often received a life estate in another property as compensation for the remainder value in their own home, or have purchased a life estate in another property with the payment they received for the remainder value. Because Virginia has not considered life estates a countable resource,

this has allowed individuals to increase the amount in assets that they are able to shelter. The following example illustrates how an individual could retain a life estate in his home and receive compensation for the remainder value in the form of a life estate in another property:

> A father owns a home valued at $60,000. He transfers his home to his daughter and retains a life estate. The life estate is valued at $15,000 based on his age, life expectancy, and the value of his home. This leaves a remainder value in the home of $45,000. If the father receives cash compensation for the remainder value of the home, he will be ineligible for Medicaid LTC services. However, if he does not receive compensation, the remainder value in the home will be considered an uncompensated transfer. Therefore, the daughter gives her father a life estate in her home in exchange for the remainder value. The daughter's home is valued at $250,000, so the father's life estate in her home is valued at $48,000 (which is greater than the remainder value in his home). Because Virginia has not counted life estates for Medicaid eligibility, there is no asset that is considered as a countable resource. In addition, because the father received a life estate in exchange for the remainder value, there is no uncompensated transfer.

Limitations on the Use of Life Estates Prior to the DRA. Prior to the DRA, life estates were not evaluated for Medicaid eligibility in Virginia. States had the option of requesting authority to count life estates for this purpose, but Virginia has not pursued this authority.

DRA Effect on Life Estates. The DRA requires that resources used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resided in the home for at least 12 consecutive months prior to the purchase of the life estate. If the purchaser resided in the home for less than 12 consecutive months, the entire purchase amount will be considered an uncompensated transfer for less than fair market value. The act did not affect life estates that are retained.

Exhibit 3 is an example of a couple who transferred their home and an additional property to their daughter in 2002 and retained a life estate in both the home and additional property. The husband and wife also each received a life estate interest in their daughter's home as compensation for the remainder value in their own home and property. The husband and wife successfully qualified for Medicaid, and the daughter received the value of the home

Exhibit 3: Case File Example on Purchase of Life Estates

In 2001, a husband entered a nursing facility and was approved for Medicaid. His wife stayed in the couple's home and began receiving home and community-based services through Medicaid. In October 2002, the wife entered a nursing facility. After six months, she transferred her home (valued at $37,900) to her daughter and retained a life estate for herself and her husband. The couple also transferred a parcel of property valued at $2,500 to their daughter and both retained a life estate in the property, even though it was an undeveloped piece of property. Instead of receiving cash compensation for the remainder value of the home and property, the husband and wife each received a life estate interest in their daughter's home. Because the husband and wife received life estates in their daughter's home as compensation for the remainder value in their own home, there were no uncompensated transfers and the parents were able to maintain eligibility for Medicaid.

DRA Impact (Purchase of Life Estates as a Countable Resource)
The DRA only affects purchased life estates, not those retained. However, the DRA would consider the life estate interest received by each parent in the daughter's home as a purchase of a life estate and, therefore, would require the State to count their value in determining Medicaid LTC eligibility.

Source: Department of Social Services case file, and DMAS and JLARC staff analysis.

and property. The DRA would not affect the life estate retained in this example. However, the life estate each parent received in the daughter's home would now be considered a purchase and would therefore be evaluated as an uncompensated transfer.

As mentioned previously, the DRA only requires states to evaluate as asset transfers life estates that are purchased, not those retained. However, states have the option (and 45 states have exercised this option) to request authority from the federal Centers for Medicare and Medicaid Services (CMS) to consider all life estates in determining Medicaid eligibility. Virginia may want to consider requesting this authority. As illustrated in Exhibit 3, some individuals retain life estates in multiple pieces of property, including undeveloped property. It is unclear why individuals would do this other than to shelter their assets. Also, including life estates in an individual's principal residence as a countable resource subjects the residence to the same stipulations that would occur if the individual had retained ownership of the residence. This would remove the incentive to create a life estate in principal residences for the sole purpose of sheltering assets. Authority to count all life estates would affect Medicaid eligibility determinations in general, not just eligibility for Medicaid LTC services.

Recommendation (2). The General Assembly may wish to direct the Department of Medical Assistance Services to request authority from the Centers for Medicare and Medicaid Services to consider all life estates as a countable resource for determining Medicaid eligibility.

ADDITIONAL CHANGES IN FEDERAL LAW AFFECTING THE SHELTERING OF ASSETS

In addition to the changes affecting annuities, life estates, and the timing of transfers, the DRA addressed other issues related to the transferring of assets to qualify for Medicaid LTC. These provisions will likely not have as large an impact on Virginians as those mentioned above, in part because Virginia had already implemented several of them at the State level prior to the act.

Limit on Home Equity

The DRA imposed a requirement that prohibits Medicaid payment for LTC services for individuals with home equity in excess of $500,000. This provision does not apply if the home is occupied by the individual's spouse, dependent child under age 21, or blind or disabled child of any age. This provision applies to individuals who met the requirements for Medicaid payment for LTC services on or after January 1, 2006, but does not apply to recipients approved for LTC prior to January 1, 2006, who maintain continuous eligibility. The home equity provision does not impact Medicaid coverage for other medically necessary services. Prior to this provision, home equity was not an issue until the home became a countable resource (six months following admission to a nursing facility, if not exempt for another reason). This provision is not expected to have a large impact in Virginia because it is unlikely that many Medicaid LTC applicants have home equity in excess of $500,000.

Treatment of Promissory Notes, Loans, and Mortgages

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless there is a repayment plan that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and prohibits the cancellation of the balance upon the death of the lender. If the promissory note, loan, or mortgage does not meet these criteria, the uncompensated amount for transfer of assets purposes is the outstanding balance as of the date of the individual's application for Medicaid. The countable value as a resource is the outstanding principal balance as of the month in which the Medicaid eligibility determination is being made. Prior to this provision, it was not required that these items be considered for asset transfer purposes. However, in Virginia these items were already considered as resources, so this provision is not expected to have a large impact.

Treatment of Life Care/Continuing Care Retirement Community (CCRC) Admission Contracts

According to the DRA, an individual's payment of an entrance fee to a life care or a continuing care retirement community is considered an available resource when

- the individual has the ability to use the entrance fee to pay for care if needed,
- the individual is eligible for a refund if leaving the community, and
- the fee does not confer an ownership interest in the community.

The countable amount is the amount that could be refunded. The payment of this fee is not subject to the transfer of assets provisions. Prior to this provision, Virginia considered the entrance fee to a CCRC as a countable resource if the individual was able to receive a refund of the payment. The countable portion was the amount that could be refunded. The DRA codifies policy that was already in place in Virginia.

Availability of Hardship Waivers

Undue hardship exists when the application of the transfer of asset provisions would deprive individuals of medical care such that their health or life would be endangered. Undue hardship also exists when the application of the transfer of assets provisions would deprive individuals of food, clothing, shelter, or other necessities. The DRA mandates that the State must provide for an undue hardship exception for individuals who have transferred assets without adequate compensation. Virginia had an undue hardship policy in effect prior to the implementation of the act; however, this provision expands the reasons an undue hardship can be granted while ensuring that avenues for recovery of the transferred asset are explored.

Prior to the DRA, Virginia had a policy that required eligibility workers in local departments of social services to determine if a transfer of assets for less than fair market value resulting in a period of ineligibility for Medicaid payment of LTC services would cause an undue hardship on the individual. The act expanded Virginia's undue hardship provision by mandating that the State evaluate, in addition to the loss of medical care, the loss of food, clothing, shelter, or other necessities of life in determining if an undue hardship exists.

In order to promote consistency in the determination of undue hardship, waiver requests are evaluated centrally by the Department of Medical Assistance Services (DMAS) using the following criteria:

- what was transferred;
- date of transfer;
- value at time of transfer and what was received;
- reason the asset was transferred;
- individual's other assets at the time of transfer;
- whether legal action was taken to recover the asset and if not, why not;
- whether the asset can be recovered and if not, why not; and
- impact if the individual is not eligible for LTC services.

Case Study 1: Undue Hardship Request for Sale of Home

A Medicaid applicant sold her former home for $32,068. The home was sold several months before the applicant entered a nursing facility. The tax-assessed value at the time of the sale was $113,502. The uncompensated amount of $81,434 would have resulted in a penalty period of 15 months and two days. An undue hardship waiver was requested. The documentation provided with the undue hardship request showed that the house, which was built in 1917, was uninhabitable. The family did not have the money to repair the home. The home was sold "as is" and the family accepted the higher of the two offers received. The proceeds from the sale of the house were used to pay outstanding hospital bills and set up a pre-need burial trust.

The undue hardship request reported the applicant had no other resources and had no ability or financial means to recover the property. The applicant, who had been diagnosed with Alzheimer's disease, required constant supervision. Her daughter with whom she was living prior to entering the nursing facility was employed and unable to provide 24-hour care in the home.

The request for an undue hardship was approved because there were no other resources, no opportunity for recovery, and the denial of Medicaid payment for LTC services would have placed the applicant at risk for loss of medical care that could have endangered her life or led to the loss of food, shelter, clothing, or other necessities.

Income First Rule for Community Spouse

The DRA requires that all available income from the institutionalized spouse be considered before additional resources can be protected for the community spouse. As part of the Medicaid application process, a determination is made regarding a minimum monthly income allowance for the community spouse. In some circumstances, couples assert that the community spouse does not receive sufficient income on his or her own to maintain his or her standard of living and that more resources are needed to generate additional income. In this situation, couples will petition for greater amounts of their resources to be protected for the community spouse. (Typically, couples can protect all resources up to a minimum level or one-half of the total resources up to a maximum level for the community spouse.)

Prior to the DRA, there was no federal rule specifying that all available income from the institutionalized spouse be counted and made available for the community spouse before additional resources were protected. This often resulted in resources being protected unnecessarily for the community spouse when income was available from the institutionalized spouse. In some cases, the additional protected resources could have been used to pay for the institutionalized spouse's care.

While this mandatory provision will change practice in many states, Virginia was already utilizing an income first rule; therefore, this provision is not expected to have a large impact on the Virginia Medicaid program.

CHANGES IN STATE REGULATION NEEDED TO IMPLEMENT RECENT FEDERAL CHANGES

Virginia needs to make a number of regulatory changes to implement provisions in the federal DRA. Some of these changes are mandatory while others are optional. DMAS is currently pursuing regulatory changes to implement two of the three state options. The mandatory and optional changes do not require action on the part of the General Assembly.

Mandatory Changes to State Plan and Regulations

Because the Medicaid program is jointly funded by Virginia and the federal government (currently at 50 percent for each entity), and the program must work within guidelines specified by the federal government through the Centers for Medicare and Medicaid Services (CMS), all program changes require both amendments to the State Plan for Medical Assistance (which is based on the federal guidelines) and changes in the Virginia Administrative Code

(State regulations). These long-term care provisions of the DRA were mandatory and in many cases, already in effect under federal law. Therefore, DMAS has already implemented the necessary regulatory and State Plan changes to address these LTC provisions. (DMAS is awaiting formal CMS approval of the State Plan, but given the mandatory nature of the changes, DMAS does not anticipate any issues with that approval.)

State Options

In addition to the mandatory LTC provisions required by the DRA, states have the option to adopt certain other changes for their Medicaid programs. Among these options are

- increasing the home equity value,
- accumulating multiple transfers into one penalty period, and
- LTC Partnerships.

Increasing the Home Equity Value

As discussed previously, the DRA sets the substantial home equity value threshold at $500,000; if home equity exceeds this threshold, the recipient/applicant is not eligible for long-term care services through Medicaid. Under the DRA, states have the option to increase this equity threshold amount up to $750,000. Given that the provision would be applied statewide and in some regions of Virginia this would result in an unreasonably high threshold, DMAS does not currently intend to increase the threshold amount.

Accumulating Multiple Transfers into One Penalty Period

As mentioned previously, prior to the DRA a separate penalty period calculation occurred for each uncompensated transfer. When penalty periods for multiple transfers did not overlap, each transfer was treated as a separate event with its own penalty period. The act now allows states the option to consider multiple asset transfers in the determination of one cumulative penalty period. DMAS is currently drafting proposed regulations to adopt this optional provision.

LTC Partnerships

Pursuant to an optional provision in the DRA, Virginia is currently developing a Long-Term Care Partnership in order to make the purchase of LTC insurance more attractive to consumers. The General Assembly has been encouraging the development of a LTC Partnership in Virginia for many years. In 2004, House Bill 266 amended the *Code of Virginia* for this purpose. In 2006, House Bill 759 further addressed the *Code* changes needed to implement a partnership. However, in both cases, changes in federal law were

necessary to allow the creation of a LTC Partnership in Virginia. The DRA accomplished that federal law change.

Nationally, 60 percent of LTC costs are paid by state and federal funds though the Medicaid program. By encouraging the purchase of LTC insurance, LTC Partnerships attempt to delay or eliminate the need for individuals to access Medicaid for LTC services. LTC insurance helps pay for services an individual may need as the result of a chronic disease, serious accident, sudden illness, or cognitive impairment such as Alzheimer's disease. Contrary to common understanding, Medicare and other types of health insurance generally do not cover LTC. LTC may be provided by a health care professional such as a nurse, a home health aide, or other personal care providers such as family members and personal care attendants. Varying amounts of care can take place in a variety of locations (including home or institutional settings). LTC insurance policies vary greatly in the amount and scope of services covered and the settings in which services are delivered.

LTC Partnerships are public-private ventures. These partnerships are designed to encourage individuals with moderate incomes to purchase a limited, and therefore more affordable amount of LTC insurance coverage, with the assurance that they could receive additional LTC services through Medicaid without having to reduce their resources to the $2,000 Medicaid resource limit (which is required in order to meet Medicaid eligibility) after their insurance coverage is exhausted.

The DRA allows states to establish new LTC Partnerships to increase the role of private LTC insurance in financing long-term care services. The act establishes the following key provisions for LTC Partnerships:

- Expanded Authority: Every state may establish a LTC Partnership program.
- National Association of Insurance Commissioners (NAIC) Model Regulations: Establishes model standards for LTC Partnerships.
- Portability of Partnership Policies: Requires Secretary of Health and Human Services to establish uniform reciprocal recognition standards for all states.
- Clearinghouse for LTC Information: Appropriates $3 million per year to educate consumers about LTC insurance.

The DRA requires that states use the “dollar-for-dollar model” for all new LTC Partnerships. These programs provide dollar-for-dollar asset protection: for every dollar that a LTC Partnership insurance policy pays out in benefits, a dollar of assets can be pro-

tected during the Medicaid eligibility determination. The amount protected is not equal to the amount of the premiums paid and not necessarily equal to the maximum benefit—the amount protected is equal to the amount of benefits paid by the LTC insurance company on the policyholder's behalf.

To implement a LTC Partnership in Virginia, DMAS is seeking approval for a State Plan Amendment (SPA) from CMS. The SPA must include that the state insurance commissioner certifies that LTC Partnership policies meet the specified consumer protection requirements of the National Association of Insurance Commissioners (NAIC) LTC Insurance Model Act and Regulation. In addition, DMAS is promulgating regulations for the LTC Partnership and developing a process to collect policy and policyholder information for estate recovery purposes so that DMAS does not attempt to recover legally protected assets at a recipient's death.

The Bureau of Insurance (BOI), in accordance with NAIC model guidelines and regulations, is promulgating regulations and establishing requirements for Virginia LTC Partnership policies. BOI is also developing agent training programs to ensure that agents and consumers in Virginia fully understand the benefits, and importantly, the limitations of these policies.

In addition, the Virginia Department for the Aging (VDA) and the Department of Social Services (DSS) are also involved in Virginia's LTC Partnership development. The DRA requires that the federal government establish a clearinghouse for LTC information and appropriates $3 million per year to educate consumers about LTC insurance. VDA may look to coordinate a statewide marketing campaign in conjunction with this effort. VDA is also considering including information about the LTC Partnership in its "Own Your Future" LTC awareness campaign—a campaign that seeks to heighten the public's awareness regarding the importance of planning for future LTC needs. In addition, DMAS will develop a protocol for DSS to identify LTC Partnership policyholders during the eligibility determination process, and training on the LTC Partnership will be provided for all eligibility workers who determine Medicaid eligibility.

Virginia is awaiting information from CMS regarding the establishment of standards for the uniform reciprocal recognition of policies between states with qualified partnership programs (expected around January 1, 2007). In addition, CMS is considering establishing a uniform reporting standard for LTC Partnership policies.

Many states are currently exploring the DRA-allowed LTC Partnerships and several have obtained approved state plan amend-

ments; however, it does not appear as if any states have finalized an implementation strategy for their new programs. Virginia is planning a LTC Partnership kick-off during the spring of 2007.

ASSET SHELTERING METHODS NOT AFFECTED BY RECENT FEDERAL CHANGES

Although the DRA affects some of the major methods that Virginians have used to shelter their assets and qualify for Medicaid LTC, several other methods were not addressed. These methods include (1) purchasing savings bonds, (2) paying family members for care provided, (3) transferring homes to family members in certain circumstances, and (4) failing to disclose assets. While the exact extent to which individuals have sheltered assets using these methods is unknown, use of these methods has been documented by DMAS staff, in a 2005 report by the Joint Commission on Health Care on asset transfers, and in a 1992 JLARC report *Medicaid Asset Transfers and Estate Recovery*.

Purchase of U.S. Savings Bonds

Individuals have used U.S. Savings Bonds as a vehicle to transform countable resources into non-countable resources to shelter assets. Regulations of the U.S. Department of the Treasury restrict the holders of some commonly issued bonds from redeeming the bonds for certain time periods following issuance. This minimum retention period is 12 months for Series EE bonds, Series I bonds, and Series HH bonds. Based on the U.S. Treasury regulations, the Social Security Administration issued guidance for the SSI program that U.S. Savings Bonds are not countable resources during the retention period. Virginia follows the SSI policy when considering the value of savings bonds for Medicaid purposes, which means that these bonds are not counted as a resource during the retention period. Therefore, some individuals may have transferred large amounts of assets into bonds to qualify for Medicaid during this period.

Two related factors have further allowed individuals to maintain the non-countable status of their assets through savings bonds. First, if a co-owner of a bond has physical possession of the bond and will not relinquish it, the bond cannot be counted as a resource for the co-owner seeking Medicaid. Also, bond owners have the ability to roll funds over into other bonds once the retention period is complete, thereby maintaining the non-countable status of their assets.

Case Study 2: Sheltering Assets Through the Purchase of U.S. Savings Bonds

In August 2005, a man purchased $68,000 in Series I and Series EE U.S. Savings Bonds. In September 2005, his wife applied for Medicaid long-term care services. U.S. Savings Bonds are not counted as a resource for Medicaid purposes during the required retention period, which is 12 months for Series I and EE bonds. Therefore, the husband successfully sheltered $68,000 of his assets (which would have been pooled with his wife's assets for Medicaid eligibility purposes) and allowed his wife to qualify for Medicaid long-term care services.

Under the DRA, individuals are still able to shelter their assets through the purchase of U.S. Savings Bonds. However, DMAS is currently seeking guidance from CMS on existing federal policy that may allow the Commonwealth to count bonds as available resources in some circumstances. The Commissioner of the Public Debt is able to waive the retention period on U.S. Savings Bonds to relieve individuals of unnecessary hardship. (The Commissioner of Public Debt determination of hardship is separate from Medicaid's LTC hardship waiver.) Waiver of the minimum retention period by the commissioner is determined on a case-by-case basis. If waiver of the retention period is granted by the commissioner, it may be possible for the State to treat the redemption value of the bond as an available resource in determining Medicaid eligibility.

DMAS is currently pursuing whether it is possible for Virginia to require Medicaid applicants to request a hardship waiver from the Commissioner of the Public Debt for the retention period on U.S. Savings Bonds. If the waiver were granted, the value of the bonds could be considered as a resource for determining Medicaid eligibility. If the hardship were denied, the value of the bonds would continue to be exempt from the resource calculation. This approach could minimize the effectiveness of U.S. Savings Bonds as a means to shelter assets during the Medicaid eligibility determination.

Payment For Care Provided

Another way individuals have transferred assets to individuals of their choice is to pay them for care provided. Typical services may include activities such as shopping or cleaning. Payments for care provided by family members are permissible under Medicaid eligibility rules, provided that the payment reflects the fair value for the services rendered. (Payments are not allowed to legally responsible persons, who generally include spouses and parents of minor children.) However, to reduce potential fraud, there must be

strong evidence which supports that there was an agreement to pay for the care prior to the rendering of the services.

Transfer of Homes to Family Members

Under certain circumstances, individuals have also transferred their home to family members as a means of sheltering assets. As mentioned previously, the primary residence of Medicaid LTC recipients is an exempt resource for six months after an individual enters a nursing home but becomes a countable resource after that time, unless additional exemptions apply. (These exemptions are when the community spouse, a minor child, or a disabled child is living in the home.) However, Medicaid policy allows individuals to transfer their homes without penalty to siblings and adult children when certain criteria are met. Individuals can transfer homes to siblings if the sibling lived in the home for at least one year prior to the date the individual became institutionalized and has an equity interest in the home. Homes can also be transferred to adult children as compensation for care provided as long as the child lived in the home for at least two years prior to the individual becoming institutionalized, and the adult child provided care during this period, which permitted the individual to reside in the home and avoid or delay nursing facility placement.

> ***Case Study 3: Transfer of a Home to a Sibling to Shelter Assets***
>
> *In December 2004, a woman applied for Medicaid long-term care services and indicated she owned a home worth $352,500. According to Medicaid eligibility rules, her home was exempt for six months, until May 31, 2005.*
>
> *In February 2005, the woman transferred a one percent interest in the home (valued at $427,000 in 2005) to her brother who had lived in the home with her for the past five years. The one percent interest was an uncompensated transfer. However, the value of the transfer was $4,270, which was less than the average cost of private nursing care of $5,403 so did not result in a penalty. Once the brother had an equity interest in the home, she transferred the remaining 99 percent of the home to him in May 2005. Because her brother had an equity interest in the home (the one percent transferred in February) and had lived in the home for at least one year, the transfer did not affect her Medicaid eligibility. The brother sold the home in October 2005 for $475,000.*

The DRA generally will largely not affect individuals' ability to transfer homes to family members in the manner illustrated in Case Study 3. Medicaid applicants will still be able to transfer

homes to siblings and adult children without penalty when specified criteria are met. The DRA would require states to impose a partial penalty period in Case Study 3 for the one percent interest (valued at $4,270) that the woman transferred to her brother in February. In this example, the penalty period would last less than a month.

Although the DRA does not change individuals' ability to transfer homes to family members when certain criteria are met, there are estate recovery tools available that may allow the Commonwealth to increase the recovery of the value of homes in general. One option is to pursue authority to place liens on the property of institutionalized Medicaid recipients. Virginia currently has the authority to make claims on the estates of recipients of Medicaid LTC services, but it does not make use of liens for estate recovery. The 1992 JLARC report *Medicaid Asset Transfers and Estate Recovery* recommended that the General Assembly provide lien authority to the State for this purpose, and as of 2005, 19 other states had made use of pre-death liens on the property of permanently institutionalized individuals for Medicaid estate recovery purposes. It is unknown whether lien authority would be a significant enhancement in the State's estate recovery ability over its existing claim authority. Therefore, the General Assembly may wish to direct DMAS to investigate this issue.

Recommendation (3). The General Assembly may wish to direct the Department of Medical Assistance Services to investigate the differences between lien authority and claim authority and whether lien authority could enhance the State's estate recovery program for Medicaid long-term care recipients.

Failure to Disclose Assets

Another asset sheltering method individuals have used is failure to disclose assets when applying for Medicaid. The extent to which individuals currently fail to disclose assets is unknown. However, the 1992 JLARC report estimated that eight percent of Medicaid applicants seeking nursing home benefits did not report their full assets. If individuals are found to have withheld assets, they may be required to reimburse the Medicaid program for funds expended on their behalf. In addition, criminal charges may be brought in some cases.

SUMMARY

The DRA limited many of the methods individuals have used to shelter their assets and qualify for Medicaid LTC services. The act's provisions that are expected to have the most impact in Vir-

ginia are the lengthening of the look-back period, a change in the method of calculating the penalty period, a requirement that the Commonwealth be named a remainder beneficiary on annuities, and the evaluation of purchases of life estates as uncompensated transfers. The General Assembly may want to provide additional direction to complement several of these provisions. Numerous other provisions were also included in the DRA to limit the sheltering of assets for LTC, but in many cases, Virginia had already implemented these provisions at the State level prior to the act.

Although the DRA increased restrictions on the sheltering of assets to qualify for Medicaid LTC, methods for sheltering assets remain available. Individuals are still able to use some of the methods addressed by the DRA, such as purchasing annuities, but to a more limited extent. Also, the act did not address several other methods for sheltering assets. These include purchasing U.S. Savings Bonds (although DMAS is pursuing whether the State can obtain authority to consider U.S. Savings Bonds as a countable resource in some circumstances), paying family members for care provided, transferring homes to family members when certain conditions are met, and failing to disclose assets. Because of the limits the DRA placed on some of the methods used to shelter assets, it is anticipated that there may be an increase in the use of those methods not addressed by the act.

Appendix A

Study Mandates

HOUSE JOINT RESOLUTION NO. 97

Requesting the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Report.

Agreed to by the House of Delegates, February 10, 2006
Agreed to by the Senate, February 28, 2006

WHEREAS, House Bill No. 2601 (2005) was introduced to allow the Department of Medical Assistance Services to seek a waiver of the Social Security Act, 42 U.S.C. 1315, § 1115, to create more restrictive asset transfer limits than those currently allowed under federal law or regulations; and

WHEREAS, the introduction of HB No. 2601 raised a variety of issues related to individuals disposing of assets to gain access to Medicaid long-term care services; and

WHEREAS, the Joint Legislative Audit and Review Commission completed a study over a decade ago entitled *Medicaid Asset Transfers and Estate Recovery* Senate Document 10 (1993) that addressed the impact of Medicaid asset transfers in Virginia; and

WHEREAS, the federal Omnibus Budget Reconciliation Act of 1993 imposed additional restrictions on Medicaid asset transfers after the conclusion of the Joint Legislative Audit and Review Commission study; and

WHEREAS, the Joint Commission on Health Care, in response to Commission member requests, conducted a review of Medicaid asset transfer issues and found that other than anecdotal evidence, current data is not available on the extent of Medicaid asset transfer abuses in Virginia; and

WHEREAS, federal legislation has been proposed to reform Medicaid asset transfer rules; and

WHEREAS, states have primary responsibility for enforcement of Medicaid asset transfer limitations; and

WHEREAS, the Department of Medical Assistance Services is the state agency charged with the administration of Medicaid funds and determining eligibility; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission be requested to

monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services.

For the purpose of advising the General Assembly and the Governor, the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission shall monitor pending federal legislation concerning Medicaid asset transfers to (i) evaluate the potential impact of proposed changes in federal law and their correlation to Virginia law; (ii) ascertain reports and analyses prepared in connection with the proposed federal legislation; (iii) review the practice by which persons transfer, convert, give away, or otherwise shelter assets to become eligible for Medicaid long-term care services; (iv) recommend options available to limit the financial impact of sheltering assets for Medicaid qualification on the Commonwealth upon the passage of any such federal legislation; and (v) apprise the General Assembly concerning any changes in state law regarding asset sheltering that may be necessary.

Technical assistance shall be provided to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, to accomplish the objectives of this resolution, by the Departments of Social Services and Taxation. All agencies of the Commonwealth shall provide assistance to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, upon request.

The Director of the Department of Medical Assistance Services and the Chairman of the Joint Legislative Audit and Review Commission shall jointly submit to the Division of Legislative Automated Systems an executive summary and report of their progress in meeting the requests of this resolution no later than the first day of 2007 Regular Session of the General Assembly. The executive summary and report shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

SENATE JOINT RESOLUTION NO. 122

Requesting the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Report.

Agreed to by the Senate, March 8, 2006
Agreed to by the House of Delegates, March 6, 2006

WHEREAS, House Bill No. 2601 (2005) was introduced to allow the Department of Medical Assistance Services to seek a waiver of § 1115 of the Social Security Act, 42 U.S.C. 1315, to create more restrictive asset transfer limits than those currently allowed under federal law or regulations; and

WHEREAS, the introduction of House Bill No. 2601 raised a variety of issues related to individuals disposing of assets to gain access to Medicaid long-term care services; and

WHEREAS, the Joint Legislative Audit and Review Commission completed a study over a decade ago entitled *Medicaid Asset Transfers and Estate Recovery*, Senate Document 10 (1993), that addressed the impact of Medicaid asset transfers in Virginia; and

WHEREAS, the federal Omnibus Budget Reconciliation Act of 1993 imposed additional restrictions on Medicaid asset transfers after the conclusion of the Joint Legislative Audit and Review Commission study; and

WHEREAS, the Joint Commission on Health Care, in response to Commission member requests, conducted a review of Medicaid asset transfer issues and found that, other than anecdotal evidence, current data is not available on the extent of Medicaid asset transfer abuses in Virginia; and

WHEREAS, federal legislation has been proposed to reform Medicaid asset transfer rules; and

WHEREAS, states have primary responsibility for enforcement of Medicaid asset transfer limitations; and

WHEREAS, the Virginia Department of Medical Assistance Services is the state agency charged with the administration of Medicaid funds and determining eligibility; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission be requested to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services.

For the purpose of advising the General Assembly and the Governor, the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission shall monitor pending federal legislation concerning Medicaid asset transfers to (i) evaluate the potential impact of proposed changes in federal law and their correlation to Virginia law; (ii) ascertain reports and analyses prepared in connection with the proposed federal legislation; (iii) review the practice by which persons transfer, convert, give away, or otherwise shelter assets to become eligible for Medicaid long-term care services; (iv) recommend options available to limit the financial impact

of sheltering assets for Medicaid qualification on the Commonwealth upon the passage of any such federal legislation; and (v) apprise the General Assembly concerning any changes in state law regarding asset sheltering that may be necessary.

Technical assistance shall be provided to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, to accomplish the objectives of this resolution, by the Departments of Social Services and Taxation. All agencies of the Commonwealth shall provide assistance to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, upon request.

The Commissioner of the Department of Medical Assistance Services and the Chairman of the Joint Legislative Audit and Review Commission shall jointly submit to the Division of Legislative Automated Systems an executive summary and report of their progress in meeting the requests of this resolution no later than the first day of the 2007 Regular Session of the General Assembly. The executive summary and report shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

Research Activities and Methods

Research activities undertaken by Department of Medical Assistance Services (DMAS) staff and Joint Legislative Audit and Review (JLARC) staff included a literature review of the methods individuals have used to shelter assets to qualify for Medicaid long-term care (LTC) services; reviews of both federal and State laws and regulations regarding Medicaid LTC eligibility; and the identification of case examples illustrating how individuals have successfully sheltered assets to qualify for Medicaid LTC.

Literature Reviews

To understand the issues surrounding the sheltering of assets to qualify for Medicaid LTC services, DMAS and JLARC staff reviewed a variety of sources developed both within and outside Virginia State government. Documents prepared by State government entities included the Joint Commission on Health Care's 2005 *Medicaid Asset Transfer Allowances* and JLARC's 1992 *Medicaid Asset Transfers and Estate Recovery*. Outside sources included *The Medicaid Planning Handbook: A Guide to Protecting Your Family's Assets from Catastrophic Nursing Home Costs* by Alexander Bove, Jr. and *Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices*, prepared by the American Association of Retired Persons.

Reviews of Federal and State Laws and Regulations

DMAS and JLARC staff reviewed provisions in the recent Deficit Reduction Act of 2005 (DRA) affecting federal laws governing how assets are considered for determining Medicaid LTC eligibility. Staff also reviewed State law to determine whether changes are needed in the *Code of Virginia* to implement certain provisions of the DRA. In addition, DMAS has begun implementing the regulatory changes required by the DRA.

Illustrative Case Examples

As part of this review, the Department of Social Services (DSS) provided case files of individuals who successfully sheltered their assets using a variety of methods in recent years to qualify for Medicaid LTC services. DMAS and JLARC staff reviewed these case files to find examples that best illustrate the methods discussed in this report.

Appendix C

Summary of Provisions of Deficit Reduction Act of 2005 Affecting Asset Sheltering for Medicaid Long-Term Care

This table includes excerpts from a summary of the 2005 Deficit Reduction Act produced by the National Conference of State Legislatures in February 2006.

LONG-TERM CARE REFORMS/TRANSFER OF ASSETS

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
Lengthen Look Back Period (Sec. 6011)	• Current law requires states to review the assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." • Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed. • Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. • If a state eligibility screener finds a non-allowed transfer, current law requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. • The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.	• Lengthens the look-back date to five years, or 60 months, for all income and assets disposed of by an individual. The look back periods of 36 months for income and assets and 60 months for certain trusts would apply for income and assets disposed of prior to the enactment date. • Effective upon enactment, but applies to asset transfers that occur after the date of enactment. As a result, the impact of the longer look back period will not be felt until 2009.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
Change in "Look Back" Penalty (Sec. 6011(b))	• Under current law, the penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.	• Changes the start date of the ineligibility period for all transfers made on or after the date of enactment to 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 Medicaid 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 period of ineligibility as a result of an asset transfer policy. • Effective upon enactment.
Protection Against Undue Hardship (Sec. 6011(d and e))	• To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship.[1]	• Codifies a modified version of the CMS guidance on hardship waivers. • Provides that approval of a hardship waiver 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. • Requires states to provide for: (A) notice to recipients that an undue hardship exception 18 exists; (B) a timely process for determining whether an undue hardship waiver will be granted; and (C) a process under which an adverse determination can be appealed. • Permits facilities in which institutionalized individuals reside to

[1] CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation. CMS guidance requires that state procedures, at a minimum, provide for and discuss (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		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. These payments cannot be made for longer than 30 days.
Treatment of Annuities (Sec. 6012)	• Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the HHS Secretary defines them as such. • CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. The State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place.[2]	• Requires individuals, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. • Includes 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 subsection (b) and (q) of section 408 of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in subsections (a), (c), and (p) of section 408 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

[2] States and courts interpret this guidance differently. In Mertz v. Houston, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. In a recent case in Ohio, a state court ruled that it was proper to look at the intent of asset transfers, even if the annuity was actuarially sound. (Bateson v. Ohio Dept. of Job and Family (Ohio Ct. Appl., 12th, No. CA2003-09-093, Nov. 22, 2004).

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		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. ***The State as the Remainder Beneficiary (Sec. 6012(b))*** • The application or recertification form includes a statement naming the state as the remainder beneficiary. In the case of disclosure concerning an annuity, the state notifies the annuity's issuer of the state's right as a preferred remainder beneficiary for Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest. • States may require an issuer to notify the state when there is a change in the amount of income or principal withdrawn from the amount withdrawn at the point of Medicaid application or recertification. States take this information into account when determining the amount of the state's financial share of costs or in the individual's eligibility for Medicaid. 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. States may deny eligibility for medical assistance for an individual based on the income or resources derived from an annuity. • Provides that the purchase of an annuity will 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 or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		of any such remainder for less than fair market value. • Provisions apply to transactions, including the purchase of annuity, occurring on or after the date of enactment.
Application of "Income First" Rule in Applying Community Spouses Income Before Assets in Providing Support of Community Spouse (Sec. 6013)	• Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid, the community spouse, with little or no income or assets when the other spouse is institutionalized or, at state option, receives Medicaid's home- and community-based services. • MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules. • Regarding income, current law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance for each community spouse to try to ensure that the community spouse has sufficient income to meet his or her basic monthly needs. (The community spouse's minimum monthly maintenance needs allowance is set at a level that is higher than the official federal poverty level.) • Once income is attributed to each of the spouses according to their ownership interest, the community spouse's monthly income is compared	• Codifies the "income first" methodology. • Effective upon enactment.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	against the minimum monthly maintenance needs allowance. If the community spouse's monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse may choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e. the difference between the community spouse's monthly income and the state-specified minimum monthly maintenance needs allowance). This transfer allows more income to be available to the community spouse, while Medicaid pays a larger share of the institutionalized spouse's care costs. • Within federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no greater than $2,377.50 per month, and no less than $1,561.25 per month in 2005. Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource allowance (CSRA). Federal requirements specify that this amount may be no greater than $95,100 and no less than $19,020 in total countable assets in 2005. • When determining eligibility, all assets of the couple are combined, counted, and split in half, regardless of ownership. If the community spouse's share of the assets is less than the state-specified maximum, then the Medicaid beneficiary must transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid. • States have some flexibility in the way they apply these rules when a person applies through the fair hearing process to raise his or her minimum maintenance needs allowance. At this point, a state may decide to allocate	

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	more income or resources from the institutionalized spouse to the community spouse. In doing so, states have employed two divergent methods. Under the method used by most states, known as the "income-first" method, the state requires that the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet or, if approved by the state, exceed the minimum monthly maintenance needs allowance; the remainder, if any, is applied to the institutionalized spouse's cost of care. Under this method, the assets of an institutionalized spouse (e.g. an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse unless the income transferred by the institutionalized spouse would not enable the community spouse's total monthly income to reach the state-approved monthly maintenance needs allowance. This method generally requires a couple to deplete a larger share of their assets than the resources-first method. • In contrast, under the other method, known as the "resources-first" method, the couple's resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income, including income generated by the CSRA, meets or, if approved by the state, exceeds the community spouse's minimum monthly maintenance needs allowance. Additional income from the institutionalized spouse that may be, but has not been, made available for the community spouse is used toward the cost of care for the institutionalized spouse. This method generally allows the community-spouse to retain a larger amount of assets than the income-first method.	

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
Disqualification for Long Term Care Assistance for Individuals with Substantial Home Equity (Sec. 6014)	• Under current law, the value of an individual's home[3] is not included in the determination of Medicaid eligibility.	• Excludes from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. Permits a state to elect an amount that exceeds $500,000, but does not exceed $750,000. • These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), and rounded to the nearest $1,000. • Individuals whose spouse, child under age 21, or child who is blind or disabled, lawfully resides in the individual's home would not be excluded from eligibility. • This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home. • Applies 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.
Enforcement of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Sec. 6015)	• No provision.	• Provides that contracts for admission to a state licensed, registered, certified, or equivalent continuing care retirement community or life care community, including a nursing facility that is part of the community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance. • Provides that for determining

[3] A home is defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's **principal place of residence**. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. However, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		eligibility for Medicaid nursing facility services, an individual's entrance fee in a continuing care community will be considered a resource available to the individual to the extent that: (1) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income be insufficient to pay for care; (2) the individual is eligible for a refund of any remaining entrance fee when the individual dies, terminates the CCRC contract, or leaves the community; and (3) the entrance fee does not confer an ownership interest in the CCRC. • To the extent the entrance fee is determined to be an available resource to an individual applying for medical assistance, and the individual has a community spouse, the entrance fee will be considered in the computation of the spousal share.
Requirement to Impose Partial Months of Ineligibility (Sec. 6016 (a))	• Current law requires states to impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse)[4] for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state	• Amends current law by prohibiting states from rounding down, or otherwise disregarding any fractional period of ineligibility when determining the ineligibility period.

[4] Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets. Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an individual's primary place of residence, one automobile, household goods and personal effects, property essential to income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items. Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	option, certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date."[5] • The length of the delay is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application.[6] The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period. • When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month.[7]	
Authority for States to Accumulate Multiple Transfers into One Penalty (Sec. 6016 (b))	• Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the *same* month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or	• Amends current law by providing 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

[5] The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.
[6] For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services.
[7] For example, in a state with an average private stay in a nursing home of $4,100, an ineligibility period for an improper transfer of $53,000 could be 12.92 months (i.e. $53,000/$4,100=12.92). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31day month), other states may round down the quotient to an ineligibility period of 12 months only.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. • When a number of assets are transferred during *different* months, then the rules vary based upon whether the penalty periods overlap. • If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. • If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.	transferred by the individual (or individual's spouse) during all months as one transfer. • States would be allowed to begin the penalty periods on the earliest date which would apply to the transfers.
Inclusion of Transfer of Certain Notes and Loans Assets (Sec. 6016 (c))	• Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. • The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets. • Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's	• Amends current law to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. • These 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 must be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	medical or nursing facility care, even if the funds or payments are not distributed. • Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.	
Inclusion of Transfers to Purchase Life Estates (Sec. 6016 (d))	• Current law does not specify whether life estates should be treated as countable or noncountable assets for purposes of applying the Medicaid asset transfer rules.[8]	• Amends current law to add a provision that 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.
State Long Term Care Partnerships (Sec. 6021)	• The program is a joint Medicaid/private long-term care insurance venture designed to encourage individuals to purchase long term care insurance and to save both state and federal government's money by substituting private insurance for Medicaid. Under the program, once private insurance benefits are exhausted, special Medicaid eligibility rules are applied if additional coverage is necessary. • The Omnibus Reconciliation Act (OBRA) of 1993 contained language with both indirect and direct impact on the expansion of partnership programs. Indirectly, the Act provides further incentives for persons to purchase private insurance for long-term care by closing several loopholes in the Medicaid eligibility process (transfer of asset provisions). • The Act also makes specific mention	***General Provisions*** . • Amends the Medicaid statute to reinstate the Long Term Care Partnership program to permit new states to enter into the partnership program and imposes additional requirements on those states with approved programs. • For existing state partnership programs, the consumer protection standards for private long-term care policies (including a certificate issued under a group insurance contract) may not be less stringent than the standards that were in effect under the state's plan as of December 31, 2005. . • For state partnership programs approved after May 14, 1993 (essentially all new programs), individuals may be exempt from estate recovery procedures if the state program provides for the disregard of any assets in an amount equal to the

[8] In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
	of Partnership programs. The language indirectly recognized the four initial states now in operation plus a future program in Iowa and a modified program in Massachusetts. These states were allowed to operate their partnerships as planned, because they had a HHS approved state plan amendment before May 14, 1993. • States obtaining a state plan amendment after this date were permitted to proceed with partnership programs, however, they would be required to recover from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the partnership is in effect only while the insured is alive. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets. As a result, only the four grandfathered states (California, Connecticut, Indiana and New York) continued their programs.	private long-term care insurance benefits paid on behalf of the individual. • Under the program, private long-term care policies and partnership programs must meet the following requirements: (1) the covered individual is a resident of the state when private coverage begins; (2) the policy meets IRS requirements; (3) the policy meets NAIC model LTC insurance act and regulations (adopted October 2000)[9]; (4) the policy provides compound inflation protection for purchasers under age 61, some level of inflation protection for purchasers between age 61 and 75, and may provide some inflation protection for purchasers age 76 and older; (5) the state Medicaid agency provides technical assistance related to the training of individuals selling these policies; (6) the issuer of the policy reports to the Secretary the amount of benefits paid, and when the policy terminates; and (7) the state applies any requirements affecting the terms or benefits of these policies to all long-term care policies sold in the state. ***Reporting Requirements*** • Directs the HHS Secretary, in consultation with other appropriate governmental agencies, the NAIC, and consumer representatives, to develop recommendations to Congress to fund a uniform minimum data set to be supplied electronically by all policy issuers qualified for a partnership program and to be maintained in a secure, centralized data bank that is

[9] The NAIC model LTC insurance act provisions that apply include: (a) preexisting conditions; (b) outline of coverage; (c) prior hospitalization; (d) certification under group plans; (e) contingent nonforfeiture benefits; (f) policy summary; (g) right of return; and (h) monthly reports on accelerated death benefits. The NAIC model LTC insurance regulation provisions that apply include: (a) guaranteed renewal/noncancellability; (b) prohibitions on limitations/exclusions; (c) extension of benefits; (d) continuation or conversion of coverage; (e) discontinuation/replacement of policies; (f) unintentional lapse; (g) disclosure; (h)required disclosure of rating practices to consumers; (i) prohibition of post-claims underwriting; (j) minimum standards; (k) application forms and replacement coverage; (l) reporting requirements; (m) filing requirements for marketing; (n) standards for marketing (including inaccurate completion of medical histories); (o) prohibition of preexisting conditions/probationary periods in replacement policies; (p) contingent nonforfeiture for those who decline offer of nonforfeiture protection; (q) appropriateness of recommended purchase; (r) standard format outline of coverage; and (s) delivery of shopper's guide. If the state insurance commissioner certifies that the LTC insurance policies offered in a partnership program meet the above requirements, the policies will be deemed to meet the applicable requirements of the NAIC model act and regulation.

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		accessible to states, HHS, and other federal agencies. ***Changes to the NAIC Model Act or Regulation*** • When the NAIC adopts changes to the model act or regulation, the HHS Secretary is directed to determine whether or not the changes should be incorporated into the requirements for policies available in partnership programs, within one year of any change issued by the NAIC. ***State Plan Amendments*** • A state plan amendment may be made effective in a state no earlier than the first day of the calendar quarter in which the amendment is submitted to the Secretary. ***Portability*** • To ensure portability of LTC insurance policies purchased under a partnership program, the Secretary will develop (in consultation with the NAIC, states, and consumer representatives) standards for uniform reciprocal recognition of such policies in states with qualified partnership programs by January 1, 2007. • States with partnership programs will be subject to meeting these standards unless the state elects to be exempt. ***Reports*** • Requires the Secretary to report to Congress annually on the partnership program and its impact on access to long-term care and on federal and state Medicare and Medicaid expenditures. ***National Clearinghouse for Long-Term Care Information*** • Directs the HHS Secretary to establish a National Clearinghouse for Long-term Care Information by contract or interagency agreement. The Clearinghouse will provide education on Medicaid long-term care benefits and eligibility requirements, objective information regarding the purchase of long-term care insurance, contact information on objective counseling

ISSUE	PRIOR LAW	NEW LAW UNDER THE DRA
		services to assist in planning for long-term care needs, and a list of states with approved partnership programs. • Prohibits the Clearinghouse from recommending a specific long-term care insurance product or provider.

Source: Modified from National Conference of State Legislatures. *Deficit Reduction Act of 2005: Summary of Medicaid/Medicare/Health Provisions*. February 2006. http://www.ncsl.org/print/health/SumS1932Jan3106.pdf.

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339. Evaluation of HB 623: Mandated Coverage for Treatment of Malignant Brain Tumors at NCI Cancer Centers
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341. Evaluation of HB 1405: Mandated Coverage of Intensity Modulated Radiation Therapy (IMRT) for Specified Cancer Sites
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343. Evaluation of Underground Electric Transmission Lines in Virginia
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345. VRS Biennial Status and Semi-Annual Investment Report, December 2006

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346. Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act
347. Virginia Compared to the Other States, January 2007
348. Review of State Spending: 2006 Update
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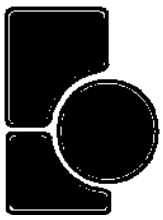

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