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Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery

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Summary

Medicaid is a means-tested entitlement program, covering the elderly with chronic conditions or illnesses such as Alzheimer's disease or severe cardiovascular disease; children born with disabling conditions such as mental retardation or cerebral palsy; and working-age adults with inherited or acquired disabling conditions, among others. Spending on LTC pays for services in both institutional settings — for example, nursing homes and intermediate care facilities for individuals with mental retardation (ICFs/MR) — and a wide range of home- and community-based services such as home health care services, personal care services, and adult day care.

Eligibility for Medicaid's long-term care services is limited to persons who meet a state's functional level-of-care standards and certain financial standards (i.e., income and asset level tests). Persons qualify for Medicaid in one of the three ways: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus "spending down"; or (3) they divest of their assets to meet these income and asset standards sooner then they otherwise might if they first had to spend their income and assets on the cost of their care.

Since the enactment of the Omnibus Budget Reconciliation Act of 1993, Medicaid's rules concerning eligibility, asset transfers, and estate recovery have been designed to restrict access to Medicaid's long-term care services to those individuals who are poor or have very high medical or long-term care expenses, and who apply their income and assets toward the cost of their care. In an attempt to discourage Medicaid estate planning, (a means by which some individuals divest of their income and assets to qualify for Medicaid sooner than they would if they first had to spend their income and assets on the cost of their care), the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) contained a number of provisions designed to strengthen these rules. Some Members of the 110th Congress have expressed interest in both monitoring the implementation of DRA's changes and in considering whether to repeal or modify some of the provisions.

This report provides an explanation of Medicaid's current eligibility, asset transfer, and estate recovery rules. A policy discussion of the potential implications of these rules follows. The report will be updated as necessary.

Appendix 1 provides a summary of DRA's provisions concerning asset transfers, eligibility, and estate recovery. Appendix 2 summarizes the Supplemental Security Income (SSI) rules concerning countable and non-countable assets, often used by states for Medicaid eligibility purposes.

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Introduction

Medicaid is a means-tested entitlement program that covers about 57 million people across the nation, including children and families, persons with disabilities, pregnant women, and the elderly. The program has become the largest single source of financing for long-term care (LTC).[1]

Eligibility for Medicaid's long-term care services is limited to persons who meet a state-designed assessment for functional need and certain financial standards. The assessment for functional need examines physical and/or cognitive functioning that evaluates whether applicants would require the level of care provided in an institution (i.e. a nursing facility, intermediate care facility for the mentally retarded, or a hospital).[2] To meet a state's financial standards, applicants' income and assets must be within specified limits.

People meet Medicaid's income and asset eligibility criteria in one of three ways: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus "spending down"; or (3) they divest of their assets to meet these income and asset standards sooner than they otherwise might if they first had to spend their income and assets on the cost of their care. Recent public policy concerns have centered around the third group. In particular, the Medicaid estate planning issue applies primarily to a subset of Medicaid applicants who are age 65 and over, need long-term care services (such as nursing home or home and community-based services), have income greater than 74% of the federal poverty level (about $637 per month for an individual), and have assets above $2,000.

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[1] Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness, cognitive disorders, or a physically disabling condition. It differs from other types of care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain or maintain an optimal level of functioning.

[2] State tests for measuring level-of-care requirements vary across the nation. In general, the need for long-term care services is measured by a person's ability to perform basic types of daily activities, referred to as activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs generally include bathing, dressing, toileting, transferring from a bed or a chair, eating, and getting around inside the home. IADLs generally include shopping, light housework, telephoning, money management, and meal preparation.

Medicaid estate planning is a means by which elderly people divest of their income and assets to qualify for Medicaid's coverage sooner than they would if they first had to spend their income and assets on the cost of their care. It is also a means by which persons may protect their assets from estate recovery.

Motivation for estate planning is, in part, a result of the high costs of long-term care services and the fear that these costs could quickly deplete savings. A MetLife survey of a select group of nursing homes across the country, for example, found that for these facilities the average daily rate of a semi private room was $189 daily, or $68,985 per year in 2007. MetLife's survey of home health agencies also found that the average per hour private pay rate of a home health aide was $19.[3]

Since the enactment of the Omnibus Budget Reconciliation Act of 1993, Medicaid's rules concerning eligibility, asset transfers, and estate recovery have been designed to restrict access to Medicaid's long-term care services to those individuals who are poor or who have very high medical or long-term care expenses, and apply their income and assets toward the cost of their care. However, the 1993 law did not eliminate all ways for applicants to shield assets and income. In recent years, some people, with the help of attorneys, have used a variety of methods to protect assets so as to enable them to obtain Medicaid coverage while using personal resources for other purposes.[4] The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) was the most recent attempt by Congress to limit this activity.

There are insufficient data available to accurately estimate the prevalence of asset transfers today, and no data that can reasonably predict whether or how much this practice might grow in the future. A significant amount of anecdotal evidence exists about people engaging in Medicaid estate planning. In addition, an industry of lawyers specializing in Medicaid estate planning has developed across the nation. Court cases at federal and state levels also point toward the prevalence of transfers. Furthermore, states have expressed a strong interest in curbing Medicaid estate planning, and have taken a number of steps to do so.

Critics of Medicaid estate planning often explain that asset sheltering places a financial strain on the Medicaid program and directs scarce resources away from people who are most in need of assistance to pay for care for people who are less in need. Some critics also object to this practice by asserting that people should assume financial responsibility for their own long-term care services before relying on tax dollars to pay for care they could otherwise afford.

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[3] *MetLife Market Survey of Nursing Home and Assisted Living Costs*, Metlife Mature Market Institute, Westport, CT, October, 2007. And *Metlife Market Survey of Adult Day Services and Home Care Costs*, Metlife Mature Market Institute, Westport, CT, September, 2007

[4] For a description of some of these methods, see "Medicaid Asset Transfer and Estate Planning: Testimony Before the Senate Committee on Finance," June 29, 2005, at [http://finance.senate.gov/sitepages/hearing062905.htm]; and "Medicaid Estate Planning and Legislative Options: Testimony Before the Senate Special Committee on Aging," June 20, 2005, at [http://aging.senate.gov/public/_files/hr146ja.pdf], both by Julie Stone.

Others believe that people who engage in Medicaid estate planning do so because they feel they should be able to leave their estates to their loved ones. In addition, they explain that Medicaid's generally low allowable asset limit (often $2,000 excluding a home and certain other assets listed below) often leaves persons with long-term care needs without the resources they need to remain at home and requires them to become virtually destitute before they can receive assistance in paying for their care. Medicaid estate planning, they argue, can preserve extra income and/or assets of an individual or couple to be used toward living costs while obtaining Medicaid coverage for long-term care services.

Concern about Medicaid estate planning resurfaced in the 109th Congress as part of the larger policy debate about the financial strains Medicaid places on federal and state budgets in general, and the increasing costs of Medicaid's long-term care coverage in particular. Some are concerned that as the population ages, Medicaid's payments for long-term care services will become unsustainable without changes to the law governing the program. Concern also grew from an interest by some policymakers in assuring that Medicaid play the role of a safety net program for persons who are poor and not as a defacto long-term care insurance program for persons who could otherwise afford to pay for their care. By tightening eligibility, transfer of assets, and estate recovery laws, the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) attempted to further discourage persons from protecting assets to qualify for Medicaid sooner than they otherwise would.[5]

Members of the 110th Congress may choose to revisit some of these issues, particularly as they concern the difficulty that some Medicaid long-term care beneficiaries have in meeting Medicaid's financial eligibility standards while affording the expenses of living in a home or community-based setting, an often-preferred setting to nursing home care. Members may also wish to evaluate and monitor how the changes made by DRA affect access to needed long-term care services among persons with disabilities of all ages.

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[5] In the first session of the 109th Congress, the Senate Committee on Finance, overseeing the Medicaid and Medicare programs, was instructed to meet a budget reconciliation target of $10 billion in direct spending savings over a five-year period, FY2006-FY2010. The Finance Committee met its reconciliation instruction by making changes in Medicaid, Medicare, and the State Children's Health Insurance Program (SCHIP). In the House, the Committee on Energy and Commerce, overseeing Medicaid and part of the Medicare programs, had budget reconciliation instructions that specified a mandatory savings target of $14.734 billion between FY2006 and FY2010. The Energy and Commerce Committee mark-up took place on October 27, 2005. In the health care area, its recommendations resulted in changes in Medicaid. The final conference agreement included a number of changes to Medicaid's asset transfer rules. (A summary of these changes is included in **Appendix 1** of this paper.) Provisions in the DRA amended Medicaid law and further modified the asset transfer rules established by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). See CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*; and CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*.

This report provides an explanation of Medicaid's current eligibility, asset transfer, and estate recovery rules. A policy discussion of the potential implications of these rules follows. **Appendix 1** provides a summary of DRA's provisions concerning asset transfers, eligibility, and estate recovery. **Appendix 2** summarizes the Supplemental Security Income (SSI) rules concerning countable and non-countable assets, often used by states for Medicaid eligibility purposes (explained in the following section).

Financial Eligibility Criteria for Medicaid Coverage of Long-Term Care Services for the Aged

To qualify for Medicaid, an individual must meet both categorical *and* financial eligibility requirements. Categorical eligibility requirements relate to the age or other characteristics of an individual. People aged 65 and over, certain persons with disabilities, children and their parents, and pregnant women are among the categories of individuals who may qualify. For the most part, persons who apply to Medicaid for coverage of long-term care services fall into the category of aged or persons with disabilities. Financial requirements place limits on the amount of income and assets[6] individuals may possess to become eligible for Medicaid (often referred to as standards or thresholds). Additional guidelines specify how states should calculate these amounts (i.e., counting methodologies).

The specific income and asset limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, these standards vary considerably among states, and different standards apply to different population groups within a state.

Major Income Pathways

Below is a description of the eligibility criteria for the major income groups through which people with long-term care needs may qualify. The groups include people who either are receiving cash assistance from the Supplemental Security Income program or have income that does not exceed 100% of the federal poverty level (FPL). Medicaid law also allows states to cover people with higher income if they require the level of care offered in an institution, such as a nursing home, or if they have medical expenses that deplete their income to specified levels. Note that low-income elderly persons without long-term care needs and younger persons with disabilities who do not need long-term care services also qualify for Medicaid through many of these pathways.

Supplemental Security Income (SSI). In general, many Medicaid enrollees who are aged qualify because they meet the financial eligibility requirements of the Supplemental Security Income (SSI) program. SSI provides cash

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[6] For purposes of Medicaid eligibility, assets are often referred to as resources and the terms may be used interchangeably. Resources include cash and other liquid assets or personal property that individuals (or their spouses) own and could convert to cash.

benefits to disabled, blind, or aged individuals who have income that does not exceed $637 per month in 2008, or about 74% of the federal poverty level (FPL),[7] for an individual, and $956 for a couple. Although most states allow persons who meet SSI's eligibility criteria to qualify for Medicaid, 11 apply more restrictive criteria to either the income, assets or disability tests.[8] These states are often referred to as 209(b) states. As of 2003, these states were Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.[9]

100% of FPL. States also have an option to cover persons whose income exceeds SSI levels but is *no greater than* 100% of FPL. As of 2003, 20 states and the District of Columbia used this option.[10]

Special Income Rule. Alternatively, states may extend Medicaid to certain individuals with incomes too high to qualify for SSI or the 100% option (if available), and who need the level of care that would be provided in a nursing facility or certain other institutions.[11] States may also use this higher income standard for those needing institutional care as well as those who qualify for home and community-based long-term care services under Section 1915(c) of the Social Security Act. Under the special income rule, also referred to as "the 300% rule," such persons may have income that does not exceed a specified level established by the state, but *no greater than* 300% of the maximum SSI payment applicable to a person living at home. For 2008, this limit is $1,911 per month (three times the monthly SSI payment of $637), or about 221% FPL.

A number of states also allow persons to place income in excess of the special income level in a trust, called a Miller Trust, and receive Medicaid coverage for their

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[7] In 2008, 100% of the federal poverty level in the 48 contiguous United States and the District of Columbia is $10,400 per year or $867 per month for an individual; and $14,000 per year or $1,167 per month for a couple. In Alaska, this level is $13,000 per year or $1,083 per month for an individual. In Hawaii, it is $11,960, or $997 per month. See [http://aspe.hhs.gov/poverty/08poverty.shtml].

[8] Each of these states has at least one eligibility standard that is more restrictive than current SSI standards, and some also have standards that are more liberal.

[9] A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with the Congressional Research Service.

[10] A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with Congressional Research Service. The District of Columbia allowed people to qualify up to 100% of FPL. Other states using this option included Arkansas (up to 80%), California (100%), Florida (88%), Georgia (100%), Hawaii (100%), Illinois (100%), Maine (100%), Massachusetts (100%), Michigan (100%), Minnesota (95%), Mississippi (100%), Nebraska (100%), New Jersey (100%), North Carolina (100%), Oklahoma (100%), Pennsylvania (100%), Rhode Island (100%), South Carolina (100%), Utah (100%), and Virginia (80%).

[11] Care must be needed for no fewer than 30 consecutive days.

care.[12] Following the individual's death, the state becomes the beneficiary of amounts in this trust.

Spend-Down Groups. Federal law also gives states the option of allowing aged persons with high medical expenses to qualify for Medicaid through so-called "spend-down" groups. Under these groups, people qualify only if their medical expenses (on such things as nursing home care, prescription drugs, etc.) deplete, or spend down, their income and assets to specified Medicaid thresholds.[13] For example, if an individual has monthly income of $1,000 and the state's income standard is $480, then the applicant would be required to incur $520 in out-of-pocket medical expenses before he or she would be eligible for Medicaid. States use a specific time period for calculating a person's medical expenses, generally ranging from one month to six months.[14]

The most common spend down group is referred to as "medically needy." Under this option, states may set their medically needy monthly income limits for a family of a given size at any level up to 133 % of the maximum payment for a similar family under the state's former Aid to Families with Dependent Children (AFDC) cash assistance program in place on July 16, 1996.[15] The monthly income limits are often lower than the income standard for elderly SSI recipients (i.e., less than $637 monthly in 2008). Once eligible for Medicaid, beneficiaries who qualify under these rules must continue to apply their income above medically needy thresholds toward the cost of their care. As a result, elderly recipients living in the community who must spend down to qualify for Medicaid generally are allowed to retain less money

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[12] Since 1993 (OBRA 1993), states that use only the special income rule for institutional eligibility, and do not use the medically needy option, must allow for income-only trusts.

[13] States may use spend down groups to extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, resources requirements for other eligibility pathways.

[14] The calculation becomes the basis for determining the amount of a person's spend-down requirement. Generally a shorter time period is more beneficial to the applicant. For example, if the state has a one month spend-down calculation period, the individual would be required to incur $520 in medical expenses in a month, after which services would be covered by Medicaid. On the other hand, if the state had a six month calculation period, the individual would have to incur a projected amount of $3,120 ($520 times six) in medical expenses before Medicaid would begin coverage. The length of the spend-down period does not significantly affect total out-of-pocket expenditures for persons with predictable and recurring medical expenses, such as persons with chronic illnesses or disabling conditions. However, individuals faced with acute nonrecurring problems generally benefit more from a shorter calculation period.

[15] For families of one, the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons. AFDC was replaced with the Temporary Assistance for Needy Families (TANF) program in 1996.

for their living expenses than Medicaid beneficiaries who qualify through SSI. In 2003, 33 states had medically needy programs for persons age 65 and older.[16]

The second spend down group is available in all 209(b) states. Federal law requires those states that apply more restrictive criteria to the SSI population (see above) to allow these individuals to deduct medical expenses from their income when determining eligibility for Medicaid.

Post-Eligibility Treatment of Income. Once eligible for Medicaid, persons qualifying through certain eligibility groups are required to apply their income above specified amounts toward the cost of their care. The amounts they may retain vary by setting. For example, Medicaid beneficiaries in a nursing home may retain a personal needs allowance (these amounts ranged from $30 to $70 per month in 2003). Persons receiving services in home and community-based settings may retain a maintenance needs allowance. These amounts vary by states and ranged from $500 to $2,267 per month in 2003. All income amounts above these levels, including what may be available in a Miller Trust, must be applied toward the cost of their care.

General Rules Regarding Assets

Under the Medicaid program, states also set asset standards, within federal parameters, that applicants must meet to qualify for coverage. These standards specify the maximum amount of countable assets a person may have to qualify; assets above these amounts make an individual ineligible for coverage. For the treatment of most types of assets, states generally follow SSI program rules. Under SSI (and thus often under the Medicaid program), countable assets, such as funds in a savings account, stocks, or other equities, cannot exceed $2,000 for an individual and $3,000 for a couple. For purposes of eligibility determinations, assets are either: (1) counted for their entire value; (2) excluded for their entire value (e.g., one automobile, household goods and personal effects,[17] certain property essential to income-producing activity); or (3) excluded for part of their value and counted for part of their value (e.g., up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500).

However, state practices for counting assets vary significantly. Under Section 1902(r)(2) of the Social Security Act, states are granted flexibility to modify these rules. This provision grants states permission to use more liberal standards for computing resources (and income) than are specified under SSI. Most states use Section 1902(r)(2) to ignore or disregard certain types or amounts of assets (and

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[16] These include Alaska, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

[17] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, February 7, 2005.

income), thereby extending Medicaid to individuals with assets too high to otherwise qualify under the specified rules for that eligibility pathway.

Special rules apply to the treatment of an applicant's primary place of residence. For most beneficiaries, the entire value of an applicant's primary place of residence (i.e., his or her home) is not counted. The enactment of DRA amended Medicaid law (section 1917 of the Social Security Act) to restrict eligibility for certain individuals who apply for Medicaid coverage for nursing facility or other long-term care services if the applicant's equity interest in his or her home is greater than $500,000.[18] A state may elect to substitute an amount that exceeds $500,000 but does not exceed $750,000.[19] This restriction applies only to applicants who do not have a spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614(a)(3) of the Social Security Act for the 50 states and the District of Columbia) lawfully residing in the home.[20] For purposes of qualifying for Medicaid, people who have home equity above the state-specified amount could use a reverse mortgage or home equity loan to reduce their total equity interest in the home. The income earned from this transaction is subject to repayment and is thus not countable income for Medicaid eligibility purposes in the month it is received. Any amounts retained into the following month are counted as resources and would need to be depleted to the state's asset thresholds before the individual could qualify for Medicaid.[21] (DRA directs the Secretary of DHHS to establish a process for waiving the application of the home equity limit in the case of demonstrated hardship.)

DRA added new rules about annuities that applicants for Medicaid-covered long-term care services (i.e. persons applying for nursing facility care; a level of care in any institution equivalent to that of nursing facility services; and home and community-based services furnished section 1915(c) or (d) waivers) must meet to obtain Medicaid eligibility. The law requires individuals, spouses, or their representatives to provide a disclosure and description of any interest the applicant or the community spouse may have in an annuity, regardless of whether the annuity is irrevocable or is treated as an asset (see section entitled Treatment of Certain Types of Assets later in this report).

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[18] Applies when applicants seek Medicaid coverage for the following services: nursing facility care; a level of care in any institution equivalent to nursing facility services; home and community-based services furnished under a waiver under sections 1915(c) or (d) of the act; and services provided to a noninstitutionalized individual that are described in paragraph (7), (22), or (24) of section 1905(a) of the act, and, if a state has elected to apply section 1917(c) to other long-term care services for which medical assistance is otherwise under the state plan to individuals requiring long-term care services.

[19] Beginning in 2011, these dollar amounts are increased from year to year based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000.

[20] And who are determined eligible for certain long-term care services based on an application filed on or after January 1, 2006.

[21] SSR 92-8p: Policy Interpretation Ruling Title XVI: SSI Loan Policy, Including its Applicability to Advances of Food and/or Shelter.

For any beneficiary (and spouse, if any) who 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. 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.

Appendix 2 provides a more detailed description of SSI's program rules regarding countable and non-countable assets. Under certain conditions (discussed later in this report), these non-countable assets may be considered part of a beneficiary's estate and may be available for recovery by the state Medicaid programs after the beneficiary's death.

Spousal Impoverishment Rules

Medicaid law also 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 to Medicaid law by the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360) to address the situation that would otherwise leave the spouse not receiving Medicaid (i.e., "community spouse," defined as the spouse of an institutionalized Medicaid beneficiary who lives in the community and is not eligible for Medicaid) with little or no income or assets when the other spouse is institutionalized (or, at state option, is receiving Medicaid's home and community-based services — also referred to as the "institutionalized spouse").

Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage, available to be used toward the cost of care for the Medicaid-covered spouse. These rules created hardships for the community spouse who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the institutionalized spouse could qualify for coverage.

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 assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. It specifies that this limit may not exceed $104,400 and may be no less than $20,880 in total countable assets in 2008. For purposes of determining how many assets the community spouse may retain, all assets of the couple are combined, counted, and split in half, regardless of which of the two spouses possesses ownership. If the community spouse's assets are less than the state standard, 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 standard. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

Regarding income, federal law exempts all of a community spouse's income (e.g., pension or Social Security) in his or her name from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with limited income, federal law allows institutionalized spouses to transfer income to the community spouse up to a state-determined maximum level. Federal law specifies that this limit may be no greater than $2,610 per month, and no less than $1,712 per month in 2008. (See the sections on "**Policy Discussion of Selected Issues"** and **Appendix 1** for more information about spousal impoverishment rules.)

Medicaid's Asset Transfer Rules

In an attempt to ensure that Medicaid applicants apply their assets toward the cost of their care and do not give them away to gain Medicaid eligibility sooner than they otherwise would, Congress established stricter asset transfer rules under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993, P.L. 103-66) than had existed in prior law. These rules include penalties for applicants seeking institutional and certain home and community-based long-term care services who have disposed of assets for less than fair market value on or after a look-back date. Under current law, the look-back date is five years prior to application for Medicaid for all income and assets disposed of by the individual.[22] Transfers made for less than fair market value during the look-back period may be, but are not always, subject to penalties. Penalties are defined as months of ineligibility for certain Medicaid long-term care services. The length of the ineligibility period varies by the amount of assets improperly transferred and the average private pay rate for nursing home care in the state.[23] The ineligibility period, or penalty period, begins on 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 of care, whichever is later.[24]

Ineligibility for Medicaid coverage is limited to certain long-term care services — individuals would still be eligible for other Medicaid-covered services (e.g., for dual eligibles, acute care services not covered by Medicare). The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility;

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[22] Prior to DRA's enactment, the look-back date was 36 months prior to application for Medicaid for all income and assets and 60 months in the case of certain trusts treated as assets disposed of by the individual.

[23] The number of months is determined by dividing the total cumulative uncompensated value of all assets transferred 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. 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.

[24] Prior to DRA, the ineligibility period began with the first month during which the assets were transferred or, at state option, in the month following the transfer.

Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations.[25] States may choose to apply the asset transfer rules to other state plan long-term care services and to the services offered under the new home and community-based services option for the elderly and disabled (established under the DRA). In general, states do not extend the penalty to Medicaid's acute care services.

Allowable Transfers

Under the law, not all asset transfers are subject to penalties. For example, asset transfers for fair market value, transfers to spouses of any value, and certain transfers to specified other persons, such as children with disabilities, for less than fair market value, are not subject to penalties. Specifically, a home may be transferred, without penalty, from an applicant to a: (1) spouse; (2) child under age 21; (3) child who is blind or permanently and totally disabled (or is blind or disabled as defined Section 1614 of the Social Security Act); (4) sibling who has an equity interest in the home and who was residing in the applicant's home for at least one year immediately before the date the individual becomes institutionalized; or (5) son or daughter residing in an individual's home for at least two years immediately prior to the institutionalization of the applicant and who provided care that permitted the individual to reside at home rather than in an institution or facility.[26] These rules were established to ensure that certain family members would not be without shelter or lose their homes so that one member of the family could obtain Medicaid coverage.

As mentioned above, all transfers of any value between spouses are permitted. In part, this is because all assets of the couple, regardless of ownership, are combined and counted for purposes of determining Medicaid eligibility for either one or both spouses. (See the spousal protection discussion in the eligibility section above.)

Additional exceptions are made for other types of transfers for less than fair market value. They include certain transfers to a third party by the applicant's spouse for the sole benefit of the spouse or transfers to a disabled or blind child for the sole benefit of the disabled or blind child. These transfers may include the establishment of a trust, such as a special needs trust or a pooled trust, for a disabled or blind child.[27,28] These exceptions allow one spouse to retain a source of financial support

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[25] They also apply to home and community care for functionally disabled elderly individuals (under Section 1929 of the Social Security Act). This is an optional coverage group which operates only in Texas.

[26] Section 1917(c)(2) of the Social Security Act.

[27] Section 1917(c)(2)(B) of the Social Security Act.

[28] Allowable transfers also include a transfer for the establishment of a Miller trust, or income-only trust, that is applied to the cost of the beneficiary's Medicaid care and for which the state is the beneficiary.

for another spouse and for parents of disabled children to secure a source of financial support for their disabled children.[29]

Treatment of Certain Types of Assets

For the purposes of asset transfer rules, all resources (and income) of an individual or couple are evaluated to determine whether the establishment, purchase, sale, or transfer of an asset has occurred for less than fair market value. Most states follow SSI program rules concerning the treatment of most types of assets that people possess at the time of application to Medicaid. Although Medicaid law does not contain provisions specifying how *all* assets should be treated, it does include special rules about how states must treat *some* types of assets: these include trusts, annuities, life estates, promissory notes, loans, and mortgages.[30] The Secretary of the Department of Health and Human Services (DHHS) also has the authority to provide guidance to states on other categories of transactions that may be treated as transfers of assets for less than fair market value.[31]

Trusts. Medicaid defines two types of trusts: revocable and irrevocable. In the case of a revocable trust, any payments from the trust shall be considered assets disposed of by the individual. In the case of an irrevocable trust, payments that could be made, under any circumstances, to or for the benefit of the individual — and any portion of the trust or income from which no payment under any circumstances could be made to the individual — shall be considered to be assets improperly disposed of by the individual.[32] For purposes of the look-back period, a trust is considered an improper transfer of assets if it is established within the five-year look-back period. Trusts established prior to the five-year look-back period may be treated as improper transfers when the trust's payments to the individual are foreclosed during this time.

Annuities. DRA also codified (under section 1917(e)(1) and (2) of the Social Security Act) when annuities should be treated as allowable transfers and when they should not.[33] DRA specifies that the purchase of an annuity be treated as an improper

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[29] Section 1917(c) of the Social Security Act.

[30] Requirements concerning annuities, life estates, promissory notes, loans, and mortgages were added to Medicaid law by DRA.

[31] Also added to Medicaid law by DRA.

[32] Section 1917(c) of the Social Security Act.

[33] OBRA 1993 addressed annuities only tangentially by providing that the term "trust" includes an annuity only to such extent and in such manner as the Secretary of HHS specifies. Transmittal 64, or §3258.9(B) of the State Medicaid Manual, HCFA, No. 45-3, (November 1994), provides the official Centers for Medicare and Medicaid Services (CMS) guidance on annuities. The guidance requires that annuities be actuarially sound (i.e., that the annuity pay back to the annuitant all of the funds used to purchase the annuity within that person's expected lifetime); otherwise, the annuity will be considered a transfer of assets for less than fair market value and thus penalized. The CMS guidance attempted to "avoid penalizing annuities validly purchased as part of a retirement plan but to capture

(continued...)

transfer unless the state is named as a beneficiary of the annuity for at least amounts paid by Medicaid for certain long-term care services (or in the second position after the community spouse or minor or disabled child and such spouse or a representative of such child does not dispose of any such remainder for less than fair market value). In addition, all annuities are penalized as transfers for less than fair market value if applicants do not submit the necessary disclosure documentation from the financial institution, employer, or employer association that issued the annuity.[34] Annuities may be excluded from penalties if they are (1) irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments;[35] or (2) fall into certain categories specified in Section 408 of the Internal Revenue Code of 1986 (IRC).[36] [37] DRA also allows states to deny Medicaid eligibility to individuals based on the income or resources they receive from annuities.

Life Estates. The DRA amended section 1917(c)(1) fo the Social Security Act and redefined the term "assets,"with respect to the Medicaid asset transfer rules, to include the establishment 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. CMS specifies that a life estate is at issue 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.[38]

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[33] (...continued)
those annuities which abusively shelter assets." However, the CMS guidance did not state whether the payments must be monthly or equal in size, or whether the remainder of the annuity can be paid to another person if the annuitant dies before the annuity is paid back.

[34] State Medicaid Directors Letter SMDL #06-018, Centers for Medicaid and State Operations, Department of Health and Human Services, July 27, 2006.

[35] The prohibition on deferral or balloon payments in an annuity was a response by Congress to try to prevent the practice of converting one's countable assets into non-countable assets so as to avoid applying them toward the cost of an individual's care and, instead, saving them for use by the applicant's beneficiary's after he or she passes away.

[36] DRA excludes from the definition of an asset, those that are described in subsection (b) and (q) of Section 408 of the IRC, or purchased with proceeds from: (1) an account or trust describe 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.

[37] DRA also requires individuals applying and getting recertified for Medicaid-covered long-term care services to disclose to the state a similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such an 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 beneficiary about Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest.

[38] Prior to DRA, Medicaid law did not specify whether life estates should be treated as (continued...)

Promissory Notes, Loans, and Mortgages. The DRA makes funds used to purchase a promissory note, loan or mortgage subject to the look-back period, and thus a penalty period 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 or 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, the outstanding balance is due as of the date of the individual's application for certain Medicaid long-term care services and could be subject to asset transfer penalties.

Exceptions to the Application of Penalties

To protect beneficiaries from facing unintended consequences as a result of asset transfer penalties, Medicaid law includes provisions that allow states to waive penalties for persons who, according to criteria established by the Secretary, can show that penalties would impose an undue hardship.[39] The DRA added requirements that states approve undue hardship requests when the asset transfer penalty would deprive the individual of: (a) medical care such that the individual's health or life would be endangered; or (b) food, clothing, shelter, or other necessities of life. Under DRA, states are also subject to new requirements that would increase applicant awareness of the availability of undue hardship exceptions as well guarantee that when applications for such exceptions are submitted, states are responsive. Specifically, states are required to provide (1) notice to recipients about the availability of hardship waivers; (2) timely processing for determining whether the waivers will be granted; and, (3) an appeals process for applicants to challenge adverse state determinations. The law also allows institutions, such as nursing homes to file hardship applications on behalf of residents (with their consent or that of their personal representative). In addition, states may pay nursing facilities to hold beds of residents (for no longer than 30 days) while applications are pending.

As prior to DRA, Medicaid statute continues to allow waivers of penalties for persons who can demonstrate to the state (according to the rules established by the Secretary) that they either: (1) intended to dispose of the assets at fair market value, or for other valuable consideration; (2) transferred the assets exclusively for a purpose other than to qualify for medical assistance; or (3) recovered the assets that were transferred for less than fair market value.[40] Medicaid law does not include instructions for states about how they should interpret or apply these exceptions, thus allowing states some discretion in the ways in which this provision is applied. As a result, state practices vary across the country. In general, states consider the

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[38] (...continued)
countable or non-countable assets for purposes of Medicaid asset transfer rules. In CMS guidance, however, the Secretary specified that the establishment of a life estate constituted a transfer of assets and 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.

[39] Section 1917(c)(2) of the Social Security Act.

[40] Sections 1917(c)(2)(C) and (D) of the Social Security Act.

circumstances under which transfers were made (e.g., whether an applicant was healthy and living independently at the time of making a charitable gift or whether the applicant was already frail and in great need of medical assistance). In general, the burden of proving to the state that a transfer for less than market value was made for a purpose other than to qualify for Medicaid falls on the applicant.

Additional State Rules Regarding Asset Transfers

States have also established additional rules that go beyond federal law to further discourage people from protecting assets to qualify for Medicaid sooner than they might otherwise. Such state rules have been permitted under regulation and program guidance from the Secretary of HHS.[41] In addition, the Secretary has advised states that they may add criteria to the determination of actuarially sound annuities or promissory notes, such as prohibiting balloon payments, or states may interpret gray areas of the law or areas where the law is silent.[42]

Medicaid Estate Recovery

As discussed above, beneficiaries are allowed to retain certain assets and still qualify for Medicaid. The Medicaid estate recovery program is intended to enable states to recoup these private assets (e.g., countable and non-countable assets held by recipients) upon a beneficiary's death to recover Medicaid's expenditures on behalf of these individuals. Since 1993, Medicaid law has required states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care, related services and other services at state option.[43]

General Statutory Requirements

There are two instances in which states are *required* to seek recovery of payments for Medicaid assistance:

- when an individual of any age is an inpatient in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) and is not reasonably expected to be discharged from the institution and return home; and

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[41] CMS issued opinion letters to individuals requesting information on how federal law applies to particular state Medicaid rules on transfers of assets. In such letters (see, e.g., CMS letter to Michael J. Millonig, April 26, 2004), CMS asserted that states have considerable flexibility in administering their Medicaid programs and may validly make reasonable interpretations of federal law in areas that have not been specifically addressed in federal law, regulation or policy.

[42] CMS letter to Michael J. Millonig, April 26, 2004.

[43] Michigan is the only state in the nation that has not yet adopted an estate recovery program. Georgia began implementation of its program on May 1, 2006. Arkansas and Texas began their programs within the last four years. No state has ever been sanctioned by HHS for failing to implement an estate recovery program.

- when an individual age 55 years and older receives Medicaid assistance for nursing facility services, home and community-based services and related hospital and prescription drug services.[44]

Included in these groups are dual eligibles who are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits.

For non dual eligibles age 55 and over, states are given the *option* of recovering the amount of funds spent on *any other* items or services covered under the state Medicaid plan.[45]

Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21, or no surviving child who is blind or has a disability.[46] Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery. (As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.) For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state *probate* law. At the option of the state, recoverable assets also may include any other real and personal property, annuities,[47] and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.[48] Thus, assets (i.e., living trusts, life insurance policies, and certain annuities), which may pass to heirs outside of probate, would only be subject to Medicaid recovery if a state expanded its definition of "estate."

Exemptions From Recovery

Medicaid law, regulations and guidelines allow states to exempt certain Medicaid long-term care beneficiaries from estate recovery. These beneficiaries are:

- persons for whom the state has determined that recovery would impose an undue hardship (in accordance with standards specified by the Secretary of the Department of Health and Human Services, (DHHS);

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[44] Section 1917(b) of the Social Security Act.

[45] Ibid.

[46] Section 1917(b)(2) of the Social Security Act.

[47] DRA amended Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity is issued by a financial institution or other business that sells annuities in the state as part of its regular business.

[48] Section1917(b)(4) of the Social Security Act.

- persons for whom the state has determined that recovery would not be cost- effective (subject to a methodology approved by the Secretary and written into the state plan); and
- persons who have received benefits under a state-approved long-term care insurance partnership policy.[49] (Prior to DRA, four states had active LTC insurance partnership programs, while other states, except Iowa, were prohibited from implementing such programs.[50] DRA allowed all states to implement partnership programs as long as their programs meet certain requirements specified in the law). Amounts that are excluded from recovery equal the amounts paid by the LTC insurance policy (except for New York and Indiana which allow for full asset protection for certain LTC insurance purchasers.) States may recover amounts not protected under this program if they choose to do so.

States also make exemptions from estate recovery for certain assets and resources for American Indians and Alaska Natives.[51] When considering whether to exempt a person's assets from estate recovery, Medicaid guidance requires states to provide for special consideration of cases in which the estate is the sole income-producing asset of survivors, such as a family farm or other family business; or a homestead of modest value.

Use of Liens

To assist states in carrying out estate recovery and deter individuals from transferring or selling their property before repaying the state for payments made on their behalf, Medicaid law allows states to place liens on the property of certain beneficiaries before or after their death. The law limits the placement of liens on the property of only certain individuals residing in nursing facilities, ICF/MRs, or other medical institutions who the state determines, after notice and opportunity for a hearing, cannot reasonably be expected to be discharged from the medical institution to return home. Liens may also be placed on property when, based on the judgment

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[49] For more information about the Medicaid LTC Insurance Partnership Program, see CRS Report RL32610, *Medicaid's Long-Term Care Insurance Partnership Program*, by Julie Stone. For a summary of the changes made to this program, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz et al.

[50] The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) limited approval of Medicaid exemptions for estate recovery to only those states with approved state plan amendments as of May 14, 1993. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, implemented partnership programs. These four states received assistance from the Robert Wood Johnson (RWJ) Foundation to help design, market, and operate what became known as the LTC Insurance Partnership Programs.

[51] Specifications for exempt and non-exempt resources are found in Medicaid state guidance. Source: State Medicaid Manual.

of a court, Medicaid payments have been made incorrectly on behalf of an individual.[52]

Liens may not be placed on homes in which the following persons are lawfully residing in the home, including the beneficiary's: (1) spouse; (2) child under age 21; (3) child who is blind or permanently and totally disabled (or blind or disabled as defined under Section 1614 of the Social Security Act); or (4) sibling who has an equity interest in the home and who has resided in the home for at least one year immediately before the date the individual becomes institutionalized. (In addition, states cannot recover against a beneficiary's home on which the state has placed a lien, unless additional protections for siblings and adult children are satisfied.)[53]

Collection Amounts for FY2004 and FY2003

The amount of funds collected through states' estate recovery programs has been relatively small. In FY2004, for example, the amount recovered from all states was approximately $361.8 million.[54] As a comparison, this amount represents about .8% of Medicaid's total nursing home expenditures in that year, which totaled about $45.8 billion. The recovery ratio was identical with FY2003, at 0.8% of Medicaid's FY2003 nursing home expenditures. Although nursing home expenditures represent the largest service for which recovery is attempted, states may attempt to recover payments made for other LTC services (as described above). In fact, total benefits paid for LTC services for which states may recover is far greater.

Despite the relatively low recovery ratio overall, ratios vary significantly across states. Arizona had the highest recovery ratio in the nation, at 10.4%, followed by Oregon with the second highest recovery ratio in the nation of 5.8%. Idaho had the third highest recovery ratio (4.5%). All other states had recovery ratios of under 3% (**Table 1**).

Differences in estate recovery across states reflect variation in their political and economic environments. For example, states with more rigorous programs have tended to view estate recovery as a cost-containment strategy. States with lower recovery ratios, often face barriers to estate recovery as a result of political debate about the appropriateness of recovering an individual's home after a beneficiary's death. In still others, particularly those with relatively low per capita income, a belief that recovery is not cost-effective in that state (i.e. administrative costs exceed recovery amounts) may contribute to weaker efforts to recover assets than might otherwise exist.

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[52] Section 1917(a) of the Social Security Act and Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), State Medicaid Manual Part 3 — Eligibility, Section 3810. Medicaid Estate Recoveries. (Transmittal 75), January 11, 2001 (State Medicaid Manual).

[53] Ibid.

[54] Estate Recovery Amounts: state-reported data from CMS Third Party Liability data, Probate amounts, 2004TPLCollections.xls, available online at [http://www.cms.hhs.gov/ThirdPartyLiability/].

Table 1. Medicaid Estate Recovery Amounts as a Percentage of Nursing Facility (NF) Expenditures in FY2003 and FY2004

	FY2003			FY2004		
State	**NF expenditures**	**Estate recovery**	**Amount recovered as % of Medicaid NF expenditures**	**NF Expenditures**	**Estate Recovery**	**Amount recovered as % of Medicaid NF expenditures**
Alabama	$768,429,449	$4,222,784	0.5%	$766,521,275	$6,204,836	0.8%
Alaska	$99,307,550	$0	0%	$107,091,559	$0	0%
Arizona	$22,317,755	$2,200,444	9.9%	$23,172,901	$2,403,306	10.4%
Arkansas	$540,164,919	$1,730,100	0.3%	$540,193,697	$2,104,052	0.4%
California	$2,931,814,408	$44,024,077	1.5%	$3,033,946,724	$44,668,847	1.5%
Colorado	$415,217,012	$4,649,920	1.1%	$423,944,387	$6,241,993	1.5%
Connecticut	$997,830,090	$10,884,820	1.1%	$1,015,579,338	$8,204 ,283	0.8%
Delaware	$152,539,852	$1,108,545	0.7%	$158,840,995	$436,370	0.3%
Florida	$2,126,718,331	$11,474,485	0.5%	$2,250,455,672	$13,478,207	0.6%
Georgia	$900,262,135	$0	0%	$1,466,092,237	$0	0%
Hawaii	$177,179,348	$2,255,074	1.3%	$182,705,650	$1,684,280	0.9%
Idaho	$125,414,776	$5,357,412	4.3%	$126,613,061	$5,695,851	4.5%
Illinois	$1,431,124,039	$16,993,946	1.2%	$1,608,092,952	$21,254,742	1.3%
Indiana	$762,160,704	$7,366,747	1%	$948,116,230	$7,649,409	0.8%
Iowa	$487,480,360	$10,977,823	2.3%	$426,181,610	$12,194,616	2.9%
Kansas	$35,1051,074	$6,193,161	1.8%	$344,645,407	$4,866,505	1.4%
Kentucky	$619,759,104	$2,961,800	0.5%	$627,317,272	$5,391,045	0.9%
Louisiana	$594,880,647	$104,755	0%	$593,234,878	$103,853	0%

	FY2003			FY2004		
State	**NF expenditures**	**Estate recovery**	**Amount recovered as % of Medicaid NF expenditures**	**NF Expenditures**	**Estate Recovery**	**Amount recovered as % of Medicaid NF expenditures**
Maine	$237,859,692	$5,934,701	2.5%	$248,697,265	$6,178,845	2.5%
Maryland	$801,725,424	$6,919,915	0.9%	$867,262,512	$5,456,547	0.6%
Massachusetts	$1,511,869,307	$28,524,313	1.9%	$1,617,497,416	$32,577,301	2%
Michigan	$999,090,959	$0	0%	$1,704,056,909	$0	0%
Minnesota	$930,440,562	$18,300,218	2%	$904,205,889	$ 24,998,595	2.8%
Mississippi	$503,630,708	$168,735	0%	$563,151,164	$391,933	0.1%
Missouri	$733,310,219	$7,480,548	1%	$789,726,442	$8,597,322	1.1%
Montana	$143,950,197	$1,982,288	1.4%	$164,145,366	$2,363,322	1.4%
Nebraska	$345,932,257	$12,361,598	3.6%	$359,714,726	$1,125,970	0.3%
Nevada	$111,198,439	not available	not available	$141,377,842	$420,429	0.3%
New Hampshire	$138,368,754	not available	not available	$276,085,727	$4,362,641	1.6%
New Jersey	$2,092,780,914	not available	not available	$1,479,889,851	$8,329,882	0.6%
New Mexico	$165,599,566	$0	0%	$179,818,250	$1,681,931	0.9%
New York	$7,121,191,662	$27,244,711	0.4%	$6,486,722,331	$29,953,334	0.5%
North Carolina	$892,644,843	$4,053,121	0.5%	$1,096,619,059	$5,529,652	0.5%
North Dakota	$171,627,898	$1,684,666	1%	$166,456,173	$2,000,766	1.2%
Ohio	$2,647,297,226	$12,382,674	0.5%	$2,722,643,741	$13,987,964	0.5%
Oklahoma	$438,007,880	$1,873,304	0.4%	$462,935,035	$1,573,913	0.3%
Oregon	$270,751,263	$13,996,362	5.2%	$238,642,419	$13,843,592	5.8%
Pennsylvania	$3,732,029,413	$23,149,026	0.6%	$4,069,955,523	$5,888,558	0.1%
Rhode Island	$265,937,326	$3,559,076	1.3%	$292,744,235	$2,792,488	1%
South Carolina	$418,286,025	$5,150,428	1.2%	$461,865,198	$6,206,820	1.3%

	FY2003			FY2004		
State	**NF expenditures**	**Estate recovery**	**Amount recovered as % of Medicaid NF expenditures**	**NF Expenditures**	**Estate Recovery**	**Amount recovered as % of Medicaid NF expenditures**
South Dakota	$130,053,431	$1,293,813	1%	$118,375,810	$1,222,693	1.0%
Tennessee	$918,785,385	$4,156,333	0.5%	$1,006,485,725	$8,895,934	0.9%
Texas	$1,835,713,376	$0	0%	$1,781,030,713	$0	0%
Utah	$104,652,074	$459,400	0.4%	$105,854,730	$47,443	0%
Vermont	$96,293,595	$487,029	0.5%	$104,364,396	$402,156	0.4%
Virginia	$615,543,238	$953,406	0.2%	$656,180,320	$776,866	0.1%
Washington	$623,752,430	$5,816,188	0.9%	$593,061,233	$10,770,875	1.8%
Washington DC	$192,937,448	$1,658,606	0%	$188,211,034	$1,789,570	1%
West Virginia	$330,832,100	$1,183,754	0.4%	$367,149,385	$214,656	0.1%
Wisconsin	$1,526,259,152	$12,812,864	0.8%	$917,421,595	$16,772,729	1.8%
Wyoming	$56,803,388	$1,097,240	1%	$60,552,927	$1,632,368	2.7%
United States	**$44,610,032,180**	**$337,190,210**	**0.8%**	**$45,835,646,786**	**$361,765,396**	**0.8%**

Sources: Congressional Research Service (CRS) Analysis of CMS, Form 64 data published by B. Burwell. Estate Recovery Amounts: state-reported data from CMS Third Party Liability data, Probate amounts, 2004TPLCollections.xls [http://www.cms.hhs.gov/ThirdPartyLiability/].

Policy Discussion of Selected Issues

Medicaid's strain on federal and state budgets combined with projected increases in the program's long-term care spending sparked interest among some Members in the 109th Congress in containing program expenditures so as to free up federal dollars for other purposes.

Supporters of DRA, passed by both houses at the beginning of the first session of the 109th Congress, argued that when faced with a range of undesirable options for containing Medicaid spending, such as cutting benefit packages, eligibility, or reimbursement amounts to providers, the better choice would be to restrict eligibility for persons who are better off so as to maintain spending for persons who are worse off. Provisions in the DRA concerning asset transfers are intended to do just this. The law made changes to Medicaid's eligibility, asset transfers, and estate recovery requirements in an attempt to further discourage people from sheltering or depleting their assets so as to qualify for Medicaid sooner than they otherwise might.

Many Members opposed to DRA argued that cuts to the Medicaid program were misguided, in part because Medicaid estate planning was not a large contributor toward Medicaid's financial strain on state and federal budgets. They also asserted that Medicaid's covprotected and even expanded to cover additional groups of low-income persons for whom the often catastrophic costs of long-term care could quickly lead a family into impoverishment.

During the 109th Congress, debate arose among policymakers about whether DRA would actually discourage and/or make it more difficult for persons to protect or deplete their assets to qualify for Medicaid or whether such persons would simply find other methods to do so that are not prohibited by law. It is likely that both outcomes will come true. It is clear that new restrictions on the use of annuities, promissory notes and life estates, for example, will reduce the types of financial vehicles available for protecting assets. In addition, tighter penalties (i.e., change in penalty start date) for transferring assets for less than fair market value will likely deter some people from making transfers. Together, these tougher requirements will likely discourage some people from engaging in Medicaid estate planning, although it is not yet known how many. The Congressional Budget Office estimated that the savings generated by these asset transfer provisions would total $2.4 billion over 2006-2010.[55]

On the other hand, the legislative language in DRA does not penalize *all* methods of transferring assets. Certain methods for protecting or depleting assets for the purpose of qualifying for Medicaid will still be available to some. Consequently, it is also likely that some people will engage in Medicaid estate planning despite the changes made by DRA.

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[55] Congressional Budget Office Cost Estimate, S. 1932 Deficit Reduction Act of 2005 Conference agreement, as amended and passed by the Senate on December 21, 2005, January 27, 2006, at [http://cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf].

Policymakers also raised concerns about the potential impacts of DRA that are less clear. For example, concern has been raised about the extent to which stronger penalties for people who make asset transfers to qualify for Medicaid would negatively impact other groups of eligibles as well, particularly those who may have transferred assets without any intention of ever needing Medicaid's assistance. In particular, concern has been raised that persons who make charitable donations, transfers to adult children in need, or other transfers of small amounts, would be penalized even when, at the time of the transfers, the individuals had no intention of needing Medicaid coverage for long-term care services.

Other concerns have been raised about the possibility that the change in the penalty start date would result in some people not having access to adequate care during the penalty period (i.e., period of non-coverage), leaving the health of frail elders to decline more rapidly than it otherwise would. This, people assert, would significantly impact the health and safety of some of the frailest among us.

Finally, DRA's requirement that states apply the income-first rule when allocating income and assets among certain couples (in which one spouse qualifies for Medicaid long-term care coverage and the other does not) has raised concerns about potentially undoing the spousal impoverishment protections established by Congress in the Medicare Catastrophic Coverage Act (MCCA) of 1988. Specifically, these concerns are about how this new requirement might impact the long-term financial security of community spouses.

Although the actual impacts of DRA will not be known for some time, the following discussion provides additional insight into these questions. Note that this analysis is limited to information available as of a point in time, and thus does not reflect the future choices of states about how they will implement the act's new requirements. The 110th Congress may choose to monitor the implementation of DRA, as well as evaluate how Medicaid rules pertaining to eligibility, asset transfers, and estate recovery, in general, determine who obtains and who is excluded from Medicaid's coverage of long-term care services and support.

Will penalties be imposed on individuals who make transfers for purposes other than to qualify for Medicaid? The law includes provisions intended to prevent the application of penalties on persons who made transfers without having ever intended to increase the speed with which they qualified for Medicaid. However, these provisions are not easily applied and implemented and states have thus far been inconsistent in their implementation of this provision. As a result, whether penalties will be applied to such persons will depend on whether the Secretary publishes additional guidance; whether those states that are not actively examining intent begin to apply it; and whether the Secretary increases its oversight of this law.

Intent of the Transfer. Medicaid provisions established by the Omnibus Budget Reconciliation Act of 1993 contain a safety net requirement designed to protect individuals who make transfers for purposes other than to speed up the process of becoming eligible for Medicaid. The first, Section 1917(c)(2)(C) of the Social Security Act, limits states to applying penalties only on persons who made transfers for less than fair market value with the intention of protecting or depleting

their assets and prohibits states from imposing penalties on individuals who transferred assets exclusively for a purpose other than to qualify for Medicaid, provided that a satisfactory showing is made to the state in accordance with regulations promulgated by the Secretary.[56] In spirit, this provision should protect persons who make transfers that are relatively small in size, give regularly to charitable organizations, provide financial assistance to adult children or grandchildren during crises, among others — and in some circumstances, the provision does.

In other circumstances, however, this provision may be less effective, in part, because the provision can be hard for states to implement. The intent of the transfer is difficult to measure and no guidance has been provided at the national level, either under the law or by the Secretary, to assist states in developing standards for measuring intent. Consequently, states' implementation of this requirement varies across the country. An informal CRS survey of selected states in the fall of 2005 found that some states do not evaluate the intent of a transfer and other states do. Among states that do not evaluate intent, some simply automatically apply penalties to all transfers made for less than fair market value within the look-back period.

Among those that do, the survey also found that states considered the health status and living circumstances of an applicant at the time the transfer was made. For example, a person who was healthy and living independently may be determined by a state to have been less likely to have transferred assets for the purpose of qualifying for Medicaid because he or she may not have suspected ever needing Medicaid. Alternatively, some states determine that gifts made while persons are already frail and dependent are likely to have been made with the intention of protecting or depleting assets to qualify for Medicaid sooner than they otherwise would.

The following are two examples of the way in which this process might work in a state. To show that charitable gifts made during the five-year look-back period were not made to speed up qualification for Medicaid, an individual could provide financial records to the state demonstrating the applicant's long history of annual charitable giving (such as $1,000 a year for the past 10 years). Another method might be to provide medical records around the time of the transfer to demonstrate that, at that time, the applicant was healthy. A person's health record might suggest to the state that the individual had not expected to need Medicaid long-term care coverage at the time the gift was made.

Another important factor that may complicate the application of the intent provision is that applicants, for the most part, shoulder the burden of proving to the state that their transfers were conducted for an alternative purpose. Applicants may use a variety of methods to prove the purpose of their past transfers, but each method

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[56] Section 1917(c)(2)(C) of the Social Security Act provides that penalties are not applied to persons when a satisfactory showing is made to the state (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration; (ii) the assets were transferred exclusively for a purpose other than to qualify for Medicaid; or (iii) all assets transferred for less than fair market value have been returned to the individual.

is personal and particular to the circumstances of the transfer and the state in which the individual resides.

Will the change in the penalty start date result in persons losing access to needed care, affecting the health of applicants who must forgo care? The change in the penalty start date will likely result in more severe penalties for people who make transfers for less than fair market value. However, OBRA 1993 established a provision in Medicaid law intended to protect persons from experiencing significant harm as a result of asset transfer penalties, regardless of the intent for the transfer. Specifically, Section 1917(c)(2)(D) of the Social Security Act (prior to DRA) specifies that if a state determines, under procedures established by the state, that the denial of eligibility would create an undue hardship, the state must not apply asset transfer penalties.

As a result, all states are required to waive penalties when penalties would result in undue hardship. However, an informal survey conducted by CRS in Fall 2005, found that not all states had a process for determining undue hardship and not all made sure to accurately notify people of their rights to undue hardship waivers. DRA attempted to standardize the process states use to evaluate undue hardship as well as the procedures states use for notifying applicants of their rights. (See section, "Medicaid's Asset Transfer Rules: Exceptions to the Application of Penalties"). As a result of DRA, Medicaid law now also requires states to provide: 1) notice to recipients about the hardship waivers; 2) timely processing of the waivers; and, 3) an appeals process for rebutting penalties. It is still unclear at the present time whether and how states will change their practices to comply with these new requirements.

Furthermore, some observers speculate that applicants will take advantage of their rights to such exceptions by making transfers with the intent of speeding up their qualification for Medicaid, and then seeking waivers to the penalty periods so as to obtain care sooner than they otherwise would.

Right to Challenge Penalties through Undue Hardship Exception and Appeals. In the case that an applicant does not receive a favorable determination from the state for an undue hardship exception, other safety net provisions in Medicaid law grant applicants the opportunity to rebut the appropriateness of a penalty. All applicants, regardless of the intent of the transfers leading to penalties, have the right to appeal a penalty through each state's appeal process. States have the option to provide the opportunity for rebuttal during the application or redetermination process (i.e., before a penalty is imposed), or the state's fair hearing process[57] (i.e., after a penalty is imposed).[58]

How will the income-first requirement affect the long-term financial security of community spouses and the savings or expenditures of the Medicaid program? The answer to this question depends on the financial situation of the couple and the amount of income and assets available to the community spouse. For some couples, the income-first requirement will have no

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[57] Described in 42 CFR Part 431, Subpart E.

[58] State Medicaid Guidance, Section 3250.3.

impact on the couple's financial security; for others, it will decrease a couple's financial security in the long run.

The section above (see the section entitled "Financial Eligibility Criteria for Medicaid Coverage of Long-Term Care Services for the Aged" and **Appendix 1** of this report for more information on spousal impoverishment rules) describes Medicaid's provisions to prevent *spousal impoverishment* — a situation that leaves the spouse who lives at home on in another community setting with little or no income or resources when the other spouse requires institutional or home and community-based long-term care. These provisions were intended to allow the community spouses to retain more of the couple's income and assets so as to prevent him or her from becoming destitute while the institutionalized spouse receives Medicaid-covered long-term care.

Spousal impoverishment law provides guidance to states about how to count the income and resources of a couple and how to allocate this income and resources between spouses. This guidance includes instructions about minimum and maximum income and resources levels that community spouses may retain, and guidance about how to calculate how much of the couple's income and resources should be depleted to reach Medicaid eligibility thresholds.

Prior to the passage of DRA (requiring states to apply the income-first rule), Medicaid law granted states flexibility in how they allocated income and resources when addressing the circumstance in which the income of the community spouse falls short of the MMNA. This flexibility resulted in states employing two divergent methods, with the potential to affect the long-term financial security of community spouses differently as well as resulting in different Medicaid savings effects. Under the method used by most states, known as the "income-first" method, states attempt to make up the community spouse's income shortfall by first allocating the income of the institutionalized spouse to the community spouse. Under this method, states consider whether all of the institutionalized spouse's income that could be made available to the community spouse (in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing) has been made available. After this calculation is completed, resources may only be allocated to the community spouse if a shortfall still exists between the community spouse's expected monthly income and the MMNA.[59] If so, states will allocate the institutionalized spouse's assets to the community spouse's income, even if this expected transfer results in the community spouse's total resources exceeding the state-specified resource limit. All other resources of the institutionalized spouse must be depleted to Medicaid eligibility thresholds before the individual can qualify for Medicaid.

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[59] The assets of an institutionalized spouse cannot be transferred to the community spouse (if it would raise the community spouse's total resources level above the maximum resources limit) to generate additional income for the community spouse unless the income that could be transferred would still leave the community spouse with a monthly shortfall.

This method generally requires a couple to deplete a larger share of their assets than the resources-first method, and could reduce the amount of funds available to community spouses to cover their living expenses over their lifetimes. At the same time, this provision could increase the amount of a couple's funds that would be available to pay for a spouse's care, incurring savings to Medicaid.

Under the other method, known as the "resources-first" method (no longer permitted as of DRA's enactment), which is employed by fewer states, the couple's resources can be protected first (even though the transfer of resources would bring the community spouse's total resource level above the state-specified maximum) for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income meets, but does not exceed, the community spouse's monthly maintenance needs allowance. Under this method, states do not consider whether income from the institutionalized spouse could be transferred to the community spouse. Rather, they calculate the size of the allowable income based on the amount of income that would be generated by moving of resources of the institutional spouse to the community spouse first. Only if a shortfall remains after the transfer of all available resources, will the state consider transferring income to the community spouse. This method generally enables the community spouse to retain, at least theoretically,[60] a larger amount of the couple's assets than the income-first method, and can reduce the amount of funds available to pay for the institutionalized spouse's care, thus costing the Medicaid program more.

For example, say a state's maximum income allowance for the community spouse (MMNA) in 2006 is $2,000, and the maximum resource allowance for the community spouse is $60,000. In this example, the community spouse (e.g., wife) retains exactly $60,000 in resources but has only $1,500 in monthly income ($500 less than the MMNA). To raise the community spouse's monthly income level to $2,000, the resources-first method would allow the institutionalized spouse (e.g., husband) to transfer additional assets that would be expected to generate income capable of covering the income shortfall. As a result, in this example, the husband could transfer enough assets to generate $500 of monthly income for the community spouse.[61]

Under the income-first rule, a transfer of assets from the husband to the spouse that would increase the community-spouse's resource allowance above the maximum allowable level could, but would not likely occur. Instead, the law requires that states assume that the husband will transfer his income and not his assets to his wife. As a result, the state would assume that the husband would transfer $500 of his income each month to his wife and require him to meet the state's resources test (e.g., assets

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[60] Whether transfers of resources are ever actually made from the institutionalized spouse to the community spouse is not monitored by states.

[61] The determination of how many assets would be required to generate $500 would depend on the method a state uses to calculate the amount of income that is generated from assets. For example, the state may assume that the husband might place assets into an annuity or it might assume that it places assets into a savings account. The state would then make an assumption about how much income would be generated from this annuity or savings account.

may not exceed $2,000). As a result, any additional assets above the protected $2,000 for the institutionalized spouse and $60,000 for the community spouse would need to be depleted before the husband could be eligible for Medicaid. The use of these funds on the cost of the husband's care would delay Medicaid coverage and generate some savings to the program. However, Medicaid law does not specify how these excess funds must be used. Rather, the law allows for excess funds to be used without asset transfer penalties for care or for other purposes, such as home improvements, debt repayments, and purchases of household items, among other things.

Regarding the community spouse, the husband may continue to transfer $500 of monthly income to his wife as long as he remains living. Concerns can be raised about the community spouse's long-term financial security surrounding the risk that the $500 may not be available to the community spouse in the long term. If the husband were to pass away, for example, what would happen to that income? If, for example, the income were in the form of a pension, a variety of outcomes could occur. It is possible that the pension would be automatically transferred to the surviving spouse. In other instances, the funds could be transferred, but at a reduced amount; and in still other instances, the pension would no longer be available. Under the latter two scenarios, the surviving spouse's income would drop and less would be available to pay for monthly living expenses.

The income-first rule requires couples to apply more of their assets to the cost of their care and makes fewer assets available to community spouses to use for living expenses than under previous law . As a result, Medicaid savings will accrue. At the same time, the income-first rule may decrease financial security for some spouses residing in the community after the death of a Medicaid-covered spouse.

Appendix A. Provisions Affecting Asset Transfer, Eligibility, and Estate Recovery Requirements in the Deficit Reduction Act of 2005

The DRA made a number of changes to Medicaid rules concerning asset transfers, eligibility for long-term care coverage, and estate recovery. These changes are described below.

Look-Back Period

The DRA lengthens the look-back period from three years to five years for all income and assets disposed of by the individual after enactment. It does not change the look-back period for certain trusts, which was already five years prior to DRA's enactment. Under this change, asset transfers for less than fair market value of all kinds made within five years of application to Medicaid would be subject to review by the state for the purpose of applying asset transfer penalties.

Potential Impact: Lengthens the period of time for which transfers are evaluated for the purpose of Medicaid eligibility.

Ineligibility or Penalty Period

The DRA changes the start date of the ineligibility period, or penalty period, for all transfers made on or after the date of enactment. Rather than beginning the penalty period when a transfer was made, the DRA requires states to begin the penalty period on 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 of care, whichever is later.

Potential Impact: Increases the probability that penalties applied will actually be experienced by applicants.

Requirement to Impose Partial Months of Ineligibility. The DRA requires that a state shall not round down or otherwise disregard any fractional period of ineligibility when determining the penalty period (or ineligibility period) with respect to the disposal of assets.

Potential Impact: When calculating periods of ineligibility for certain applicants, this provision ensures that longer penalty periods would be applied to certain applicants.

Authority for states to accumulate multiple transfers into one penalty period. For an individual or an individual's spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, a state may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the

individual (or individual's spouse) during all months as one transfer. The state would be allowed to begin such penalty periods on the earliest date that would apply to such transfers.

Potential Impact: Gives states the option of imposing stricter penalties on persons who make multiple transfers within a given time period.

Hardship Waivers

The DRA adds requirements that states approve undue hardship requests when the asset transfer penalty would deprive the individual of (a) medical care such that the individual's health or life would be endangered, or (b) food, clothing, shelter, or other necessities of life. States are required to provide notice to recipients about the hardship waivers, timely processing of the waivers, and an appeals process. Institutions may file hardship applications on behalf of residents. States may pay nursing facilities to hold beds of residents while applications are pending.

Potential Impact: Encourages standardization of penalty exceptions for undue hardship across states.

Converts Uncountable Assets into Countable Assets

DRA expands the types of assets that are counted for the purpose of Medicaid eligibility and asset transfer penalties. 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.

Other rules defining countable and non-countable assets apply only in particular states. States' 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 could qualify for Medicaid earlier than they might otherwise. Significant variation exists across states that have such rules.

Annuities. Under current law, states have discretion concerning the way they treat annuities for the purpose of evaluating improper asset transfers. The law specifies that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. The DRA added additional requirements concerning annuities. First, it requires individuals applying and getting recertified for Medicaid-covered long-term care services 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 treated as an asset. Second, it specifies that the purchase of

an annuity is treated as an improper transfer unless the state would be named as a beneficiary to the assets for amounts paid by Medicaid for certain long-term care services. Third, the DRA made certain annuities subject to Medicaid estate recovery.[62]

Potential Impact: May discourage the use of annuities, in certain circumstances, from being used as a financial tool to protect income and resources.

Certain Notes and Loan Assets. The DRA makes funds used to purchase a promissory note, loan or mortgage subject to the look-back period, and thus a penalty period 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 or 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, the value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

Potential Impact: May discourage the use of promissory notes, loans, and mortgages from being used as financial tools to protect income and resources.

Home Equity. For purposes of Medicaid eligibility, current law provides that the value of an item may be totally or partially excluded for eligibility purposes when calculating countable resources. Current Medicaid and SSI asset counting practices exclude the entire value of an applicant's home. However, if an individual (and spouse, if any) moves out of his or her home without intending to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. 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 DRA excludes from Medicaid eligibility for nursing facilities or other long-term care services those individuals with an equity interest in their home of greater than $500,000. A state may elect to substitute an amount that exceeds $500,000 but does not exceed $750,000. Beginning in 2011, these dollar amounts are increased from year to year based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000. Individuals who have a spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) lawfully residing in the individual's home would not be

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[62] Current law requires states to recover the private assets of the estates of deceased beneficiaries who have received certain long-term care services. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual, and includes only certain assets that remain in the estate of the beneficiary upon his or her death. For purposes of recovery, estates are defined as all real and personal property and other assets as defined in state probate law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death. In general, assets such as living trusts, life insurance policies, and certain annuities that may pass to heirs outside of probate would be subject to Medicaid recovery only if a state expanded its definition of "estate."

affected by this provision. Persons could use a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home for the purpose of qualifying for Medicaid.

Potential Impact: Excludes from eligibility certain homeowners applying for Medicaid who would not have been excluded prior to DRA. Could encourage the use of reverse mortgages or home equity loans by these homeowners.

Life Estates. Current law does not specify whether life estates should be treated as countable or non-countable assets for purposes of Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets, and 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 at issue 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. The DRA redefines the term "assets," with respect to the Medicaid asset transfer rules, as including 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.

Potential Impact: Under certain circumstances, this change may discourage the use of life estates as a tool to protect an individual's home for Medicaid purposes.

Continuing Care Retirement Communities (CCRCs). CCRCs offer a range of housing and health care services to older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees and who often reside in such CCRCs throughout their later years. CCRCs are paid primarily with private funds, but a number also accept Medicaid payments for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do. Current law prohibits a Medicaid-certified nursing facility from requiring oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under Medicaid or Medicare.

The DRA allows state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or life care communities to require residents to spend their resources (subject to Medicaid's rules concerning the resources and income allowances for community spouses), declared when applying for admission, on their care before they apply for Medicaid. It would also allow certain entrance fees for CCRCs or life care communities to be considered by states to be countable resources for purposes of the Medicaid eligibility determination.

Potential Impact: Could delay or prevent individuals residing in CCRCs and life care communities from becoming eligible for Medicaid long-term care coverage.

Income-First Rule for Community Spouses

Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services, permitting the community spouse to retain higher amounts of income and assets (on top of non-countable assets) than allowed under general Medicaid rules. The law allows community spouses with more limited income to retain at least a state-specified amount set within federal guidelines. If the community spouse's monthly income amount is less than this amount, 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.

Current law allows states some flexibility in the way they apply these rules. In allocating income and resources between spouses, states have employed two divergent methods. Under the method used by most states, known as the "income-first" method, the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet 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 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, employed by fewer states, 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 meets, but does not exceed, 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 Medicaid-covered care for the institutionalized spouse. This method generally enables the community spouse to retain a larger amount of the couple's assets than the income-first method.

The DRA requires all states to apply the income-first rule. Thus, it requires states to consider whether all of the institutionalized spouse's income that could be made available to the community spouse (in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing) has been made available before allocating the institutionalized spouse's assets to the community spouse's income to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

Potential Impact: Under certain circumstances, this provision could increase the amount of a couple's funds that would be available to pay for a spouse's care,

incurring savings to Medicaid. Consequently, it could reduce the amount of funds available to cover the living expenses over the lifetime of the other non-Medicaid covered spouse in the community.

Appendix B. Asset Rules Under SSI

SSI is a federal program that provides monthly cash payments to people with limited income and resources who are age 65 or older, blind, or disabled. To qualify for SSI benefits, an individual (or a couple) must meet categorical criteria by being age 65 or older, blind, or disabled. They must also meet financial criteria by having *countable* resources below the SSI limit ($2,000 for an individual and $3,000 for a couple; these amounts are not indexed for inflation and have been at current levels since 1989) and *countable* income below the SSI benefit rate ($579 for an individual and $869 for a couple in 2005; these amounts are indexed annually for inflation and may be lower for individuals and couples living in someone else's household or an institution).[63]

Federal regulations specify that for purposes of SSI, resources are cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.[64] Not all resources are counted in determining SSI eligibility. The value of an item may be totally or partially excluded when calculating countable resources. Couples receive the same resource (and income) exclusions as individuals (e.g., one automobile is excluded from countable resources for the couple as a whole, rather than one automobile for each member of the couple).

According to the Social Security Administration's most recent annual report on SSI, principal items that are excluded from countable resources include the following:[65]

- a home serving as the principal place of residence, regardless of value;
- life insurance policies whose total face value is no greater than $1,500;
- burial funds of $1,500 each for an individual and spouse (plus accrued interest);
- all household goods and personal effects;
- one automobile (if used for transportation for the individual or a member of the individual's household);[66]

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[63] In some cases, the income and resources of others are also counted when determining SSI eligibility. This process is called deeming, and it applies when an eligible child lives with an ineligible parent, an eligible individual lives with an ineligible spouse, or an eligible alien has a sponsor.

[64] 20 CFR 416.1201(a).

[65] Social Security Administration, *SSI Annual Statistical Report, 2003*, September 2004, pp. 3-4, available at [http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2003/ssi_asr03.pdf].

[66] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable resources. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. See 70 *Federal Register* 6340, February 7, 2005.

- property essential to self-support (e.g., property used by an individual as an employee for work);
- resources set aside by an individual who has a disability or is blind to fulfill an approved Plan for Achieving Self-Support (PASS); and
- amounts deposited into an individual development account (including matching funds and interest earned on such amounts) under the Temporary Assistance for Needy Families program or the Assets for Independence Act.

Table 2 provides a more comprehensive accounting of items (including those listed above) that are excluded from countable resources for purposes of determining SSI eligibility.

Table 2. Supplemental Security Income (SSI) Resource Exclusions

Exclusion	Limit on value or length of time?	Description
Home serving as the principal place of residence	No	A home is 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. The home is not included in countable resources, regardless of its value. 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. 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.
Funds from the sale of a home if reinvested timely in a replacement home	Yes	The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of receipt of the proceeds.
Non-liquid resources above the SSI resource limit if certain conditions are met	Yes	People with excess Non-liquid resources generally cannot receive SSI benefits even if they meet all other eligibility requirements. As a result, they may have little or nothing on which to live while they look for a buyer for excess property. However, SSA has statutory authority to prescribe the period(s) within which and the manner in which to dispose of various kinds of property, and federal SSI regulations describe the conditions under which SSI payments can be made while an individual attempts to dispose of property. Such "conditional benefits" paid during this period are considered overpayments and must be repaid from the proceeds of the sale of excess resources. When the excess resources are in the form of real property which cannot be sold for certain specified reasons (undue hardship or unsuccessful reasonable efforts to sell, exclusions which are described later in this table), the owner can receive regular (not conditional) benefits.

Exclusion	Limit on value or length of time?	Description
		An individual (or couple) who meets all nonresource eligibility requirements, but fails to meet the resources requirement due solely to excess Non-liquid resources, can receive SSI benefits based on a "conditional" exclusion of the excess Non-liquid resources (lasting nine months for real property, and up to six months for personal property) if the individual/couple (or deemor) meets both of the following conditions: Countable liquid resources do not exceed three times the applicable federal SSI benefit rate (e.g., $579/$869 x 3 = $1,737/$2,607 in 2005) for an individual/couple. — The individual/couple agrees in writing to sell excess Non-liquid resources at their current market value within a specified period and use the proceeds of sale to refund the conditional benefits (which are considered overpayments) they received.
Jointly owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)	No	Excess real property which would otherwise be a resource is not a countable resource when it is jointly owned and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources.
Real property for so long as the owner's reasonable efforts to sell it are unsuccessful	No	Real property that an individual has made reasonable but unsuccessful efforts to sell throughout a nine-month period of conditional benefits (see the"Non-liquid resources above the SSI resource limit" exclusion described earlier in this table for an explanation of conditional benefits) will continue to be excluded for as long as: (1) the individual continues to make reasonable efforts to sell it and (2) including the property as a countable resource would result in a determination of excess resources. If the property is later sold, benefits paid during the nine-month conditional benefits period are subject to recovery as overpayments. Benefits paid beyond the nine-month period as a result of this exclusion are not subject to recovery as overpayments.

Exclusion	Limit on value or length of time?	Description
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his/her tribe, or an agency of the federal government	No	In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest of the individual (or spouse, if any) in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government is excluded.
Life insurance, depending on its face value	Yes	In determining the resources of an individual (and spouse, if any), life insurance owned by the individual (and spouse, if any) will be considered to the extent of its cash surrender value. If, however, the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any). In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance will not be taken into account.
Burial funds for an individual and/or his/her spouse	Yes	In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	No	In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.

Exclusion	Limit on value or length of time?	Description
Household goods and personal effects	No	Household goods are not counted as a resource to an individual (and spouse, if any) if they are: (1) items of personal property, found in or near the home, that are used on a regular basis, or (2) items needed by the householder for maintenance, use and occupancy of the premises as a home. Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes. Personal effects are not counted as resources to an individual (and spouse, if any) if they are: (1) items of personal property ordinarily worn or carried by the individual, or (2) articles otherwise having an intimate relation to the individual. Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. Items of cultural or religious significance and items required because of an individual's impairment also are not counted as resources to an individual. However, items that were acquired or are held for their value or as an investment are counted as resources because they are not considered to be personal effects. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles. Such items will be counted as a resource. (Prior to March 9, 2005, there were restrictions placed on the value of household goods and personal effects that could be excluded from countable resources. See 70 *Federal Register* 6340, Feb. 7, 2005.
One automobile	No	One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be Non-liquid resources and are counted as a resource. (Prior to March 9, 2005, there were restrictions placed on the value of the automobile that could be excluded from countable resources. See 70 *Federal Register* 6340, Feb. 7, 2005.

Exclusion	Limit on value or length of time?	Description
Property essential to self-support	Yes	When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property used in a trade or business, nonbusiness income-producing property, and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support. Resources excluded under this provision generally fall into three categories: (1) Property excluded regardless of value or rate of return. This category encompasses: — property used in a trade or business (effective 5/1/90); — property that represents government authority to engage in an income producing activity; — property used by an individual as an employee for work (effective 5/ 1/90); and — property required by an employer for work (before 5/1/90). (2) Property excluded up to $6,000 equity, regardless of rate of return. This category includes nonbusiness property used to produce goods or services essential to daily activities. For example, it covers land used to produce vegetables or livestock solely for consumption by the individual's household. (3) Property excluded up to $6,000 equity if it produces a 6% rate of return. This category encompasses: — property used in a trade or business in the period before 5/1/90; and — nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each.
Resources of a blind or disabled person which are necessary to fulfill an approved Plan for Achieving Self-Support (PASS)	Yes	If the individual is blind or disabled, resources will not be counted that are identified as necessary to fulfill a plan for achieving self-support. A PASS must: (a) be designed especially for the individual; (b) be in writing; (c) be approved by the Social Security Administration (a change of plan must also be approved); (d) be designed for an initial period of not more than 18 months. The period may be extended for up to another

Exclusion	Limit on value or length of time?	Description
		18 months if the individual cannot complete the plan in the first 18-month period. A total of up to 48 months may be allowed to fulfill a plan for a lengthy education or training program designed to make the individual self-supporting; (e) show the individual's specific occupational goal; (f) show what resources the individual has or will receive for purposes of the plan and how he or she will use them to attain his or her occupational goal; and (g) show how the resources the individual set aside under the plan will be kept identifiable from his or her other funds.
Stock held by native Alaskans in Alaska regional or village corporations	No	Shares of stock held by a native of Alaska (and spouse, if any) in a regional or village corporation were not counted as resources during the period of 20 years in which the stock was inalienable (nontransferable). Effective January 1, 1992, the stock became transferable and is treated as an excluded resource.
Federal disaster assistance received on account of a presidentially declared major disaster, including interest accumulated thereon	No	Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a state or local government, or from a disaster assistance organization, is excluded in determining countable resources. Interest earned on the assistance is excluded from resources.
Retained retroactive SSI or Social Security Disability Insurance (SSDI) benefits	Yes	In determining the resources of an individual (and spouse, if any), the unspent portion of any Title II (SSDI) or Title XVI (SSI) retroactive payment received on or after 3/2/04 is excluded from resources for the nine calendar months following the month in which the individual receives the benefits. The unspent portion of retroactive SSI and SSDI benefits received before 3/2/04 is excluded from resources for the six calendar months following the month in which the individual receives the benefits.
Certain housing assistance	No	The value of any assistance paid with respect to a dwelling under: (1) the United States Housing Act of 1937; (2) the National Housing Act; (3) Section 101 of the Housing and Urban Development Act of 1965; (4) Title V of the Housing Act of 1949; or (5) Section 202(h) of the Housing Act of 1959 is excluded from resources.

Exclusion	Limit on value or length of time?	Description
Tax refunds related to the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC)	Yes	In determining the resources of an individual (and spouse, if any), any unspent federal tax refund or payment made by an employer related to an EITC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund or payment made by an employer related to an EITC that is received before 3/2/04 is excluded from resources only for the month following the month refund or payment is received. Any unspent federal tax refund from a CTC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund from a CTC that is received before 3/2/04 is excluded from resources only for the month following the month the refund or payment is received. Interest earned on unspent tax refunds related to an EITC or a CTC is not excluded from resources.
Victims' compensation payments	Yes	In determining the resources of an individual (and spouse, if any), any amount received from a fund established by a state to aid victims of crime is excluded from resources for a period of nine months beginning with the month following the month of receipt. To receive the exclusion, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.
State or local relocation assistance payments	Yes	Relocation assistance is provided to persons displaced by projects which acquire real property. In determining the resources of an individual (or spouse, if any), relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that act is excluded from resources for a period of nine months beginning with the month following the month of receipt. Interest earned on unspent state or local relocation assistance payments is not excluded from resources.

Exclusion	Limit on value or length of time?	Description
Dedicated financial institution accounts required for past-due benefits paid to disabled children	No	In determining the resources of an individual (or spouse, if any), the funds in a dedicated financial institution account that is established and maintained for the payment of past-due benefits to disabled children will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account (specified in federal SSI regulations) and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.
Grants, scholarships, fellowships, and gifts used to pay for educational expenses	Yes	Effective June 1, 2004, there is a nine-month resource exclusion for grants, scholarships, fellowships, and gifts used to pay for tuition, fees, and other necessary educational expenses at any educational institution, including vocational and technical education.
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	Yes	Cash (including any interest earned on the cash) or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource. This exclusion applies if the cash (and the interest) is used to repair or replace the excluded resource within nine months of the date the individual received the cash. Any of the cash (and interest) that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the nine-month period expires. The initial nine-month time period will be extended for a reasonable period up to an additional nine months if the individual is found to have had good cause for not replacing or repairing the resource.
Certain items excluded from both income and resources under a federal statute other than the Social Security Act.	Varies	In order for applicable payments and benefits received under a federal statute other than Title XVI of the Social Security Act (SSI) to be excluded from resources, the funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

Exclusion	Limit on value or length of time?	Description
		Examples of excluded payments include those relating to: Agent Orange; Austrian Social Insurance; Corporation for National and Community Service (CNCS) programs; Individual Development Accounts (IDAs) funded by the Temporary Assistance for Needy Families (TANF) program; demonstration project IDAs; Japanese-American and Aleutian restitution payments; energy assistance for low-income households; victims of Nazi persecution; the Netherlands' WUV program for victims of persecution; a Department of Defense (DOD) program for certain persons captured and interned by North Vietnam; the Radiation Exposure Compensation Trust Fund; the Ricky Ray Hemophilia Relief Fund; and veterans' children with certain birth defects. (For more information on these and other excluded payments and benefits, see 20 CFR 416.1236 and [http://policy.ssa.gov/poms.nsf/lnx/0501130050].)

Source: Congressional Research Service (CRS), based on 20 CFR 416.1201-1266; Social Security Administration (SSA), Program Operations Manual System (POMS), *Excluded Resources*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501110210!opendocument]; SSA, POMS, *Guide to Resources Exclusions*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501130050]; and SSA, *Social Security Handbook*, What are the Resource Exclusions?, available at [http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2156.html].