

Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Chair to Chair

DAVID R. PFALZGRAF •
ALFREIDA B. KENNY •
ANTHONY J. LAMBERTI •
AMY S. O'CONNOR •
LINDA S. ZAHNLEUTER •
ANNE B. RUFFER • DON-
ALD W. MUSTICO • T.
DAVID STAPLETON, JR. •
GAYLE L. EAGAN •
MICHEL HAGGERTY •
RICHARD A. WEINBLATT •
HOWARD F. ANGIONE •
LORRAINE COYLE •
ROSE MARY K. BAILLY •
BRUCE L. BIRNBAUM • VALERIE J. BOGART •
WALTER T. BURKE • CHARLES F. DEVLIN •
RONALD A. FATOULLAH • RITA K. GILBERT •
DAVID GOLDFARB • SHARON KOVACS GRUER •



Daniel G. Fish
Outgoing Chair

(Continued on page 2)

I am honored that you have chosen me to serve as Chair of the Elder Law Section. I follow in the footsteps of some pretty terrific Chairpersons and I feel privileged that you have chosen me to succeed them. My immediate predecessor, Daniel G. Fish, has done an outstanding job in turbulent times. Dan will continue to serve as an officer of the Elder Law Section in his role as Immediate Past Chair. I will also be aided by Ami S. Longstreet, Chair-Elect; Timothy E. Casserly, Vice-Chair; Stephen J. Silverberg, Secretary; Michael J. Amoruso, Treasurer; and the entire Executive Committee.



Ellen G. Makofsky
Incoming Chair

(Continued on page 3)

Inside this Issue

Editor's Message 4

THE DRA: THE NUTS, BOLTS AND IMPACT

Throw Mama From the Train
The Deficit Reduction Act of 2005 Abandons
Our Nation's Elders 5
(Michael Gilfix and Bernard A. Krooks)

Deficit Reduction Act of 2005: Changes to the Medicaid
Look Back and Commencement of the Penalty Period . . 11
(Michael J. Amoruso)

DRA Update 21
(David Goldfarb and Ira Salzman)

Governor and DOH Taking Steps to Immediately
Implement Changes to Medicaid Homecare
Spousal Refusal and Transfer of Asset Rules 25
(David Goldfarb and Ira Salzman)

Long-Term Care Insurance 26
(Carrianna C. Eurillo-Travinski)

Medicaid Planning: The Purchase of Life Estates 32
(Vincent J. Russo)

ELDER LAW NEWS

NEW YORK CASE NEWS 34
(Judith B. Raskin)

MEDIATION NEWS 36
(Robert A. Grey)

SNOWBIRD NEWS: Florida Legislature Proposes Bill
to Implement Provisions of the Deficit Reduction
Act of 2005 37
(Howard S. Krooks and Scott M. Solkoff)

FAIR HEARING NEWS 39
(Ellice Fatoullah and René Reixach)

THE GOLDEN STATE NEWS: Not Happy with the DRA?
Consider Moving to California 45
(Steven M. Ratner)

Outgoing Chair's Message *(Continued from page 1)*

HON. EDWIN KASSOFF • ELLYN S. KRAVITZ • MARTIN B. PETROFF • LOUIS W. PIERRO • MARGARET Z. REED • RENÉ H. REIXACH, JR. • NEIL RIMSKY • JOAN L. ROBERT • STEVEN T. RONDOS • STEVEN H. STERN • HON. JOEL K. ASARCH • GARY E. BASHIAN • MARCIA J. BOYD • DEAN S. BRESS • ANN CARROZZA • JOHN R. DIETZ • ANTHONY ENEA • LISA K. FRIEDMAN • JUDITH D. GRIMALDI • ROBERT KRUGER • ROBERT J. KURRE • ANTONIA J. MARTINEZ • CLIFORD A. MEIROWITZ • LAURIE L. MENZIES • FRANCES PANTALEO • MARIA ELENA ROSARIA PUMA • JOSEPH A. ROSENBERG • ELLEN P. ROSENZWEIG • IRA SALZMAN • EDWARD V. WILCENSKI • JAMES A. CAHILL, JR. • IRA K. MILLER • ANTHONY H. SZCZYGIEL • CORA A. ALSANTE • SHAWN T. NASH • ALLAN E. SILVER • CRISTINE CIOFFI.

These are the names of the members of the Executive Committee of the Elder Law Section of the NYSBA and they are the ones who deserve the credit and the recognition for the accomplishments of this past year. It has been a distinct honor to work with these individuals and I want to thank each of them for their efforts. They are the individuals who participated in the Executive Committee meetings; put the annual, spring, summer and fall meetings together; have written articles for the *Elder Law Attorney*; contacted their elected representatives on senior issues; tracked case developments; mentored others through the listserv; effected living will legislation; effected burial remains legislation; and most importantly they

have furthered the goals of the Section with every client they have assisted.

This year began on a positive note, with the first on-time state budget in twenty years. It gave no indication of the high anxiety that was to follow with Medicare Part D, the Deficit Reduction Act and the Medicaid eligibility provisions of the Governor's budget vetoes. The challenge can be compared with the test of OBRA 1993 or "Granny Goes to Jail" or "Granny's Lawyer Goes to Jail." The response of the Elder Law Section members to these events is inspiring. But, the challenge is not resolved. There are lawsuits alleging that the DRA is unconstitutional because the President signed a bill that was not passed by both houses of the legislature. There will be issues regarding the implementation of the DRA that may not be certain until regulations are issued. There are issues regarding the meaning of sections of the DRA, particularly the language defining the date when the penalty period is to commence.

The seniors of New York State and the members of the Elder Law Section face extraordinary challenges but they are in good hands with the new Chair, Ellen Makofsky. She has an exceptional blend of insight, preparation and courage to meet the difficult issues that we are presented with. There are also exceptional officers and an exceptional Executive Committee to assist her.

Daniel G. Fish

Catch Us on the Web at
WWW.NYSBA.ORG/ELDERLAW



Incoming Chair's Message *(Continued from page 1)*

I come to the position of Chair of the Elder Law Section with both a sense of purpose and trepidation. These are difficult and changing times for the Elder Law attorney. As I write this column, I can only reflect on what has happened in the past several months. The Deficit Reduction Act of 2005 became law on February 8, 2006 and with it, the imposition of much harsher eligibility criteria for those of our clients who need to access Medicaid benefits. As we were trying to explore how to cope with these new changes, Governor Pataki in mid-April made it more difficult for the frail, elderly and disabled to receive Medicaid benefits by vetoing the New York State budget. As things stand today, late in April 2006, Elder Law attorneys not only have to deal with the provisions of DRA 2005, but they also have to live with the elimination of spousal refusal and the imposition of a penalty period for community Medicaid. Hopefully, between today and publication of this issue of the *Elder Law Attorney*, Governor Pataki and the New York State Legislature will have reached a compromise and the issues regarding spousal refusal and community Medicaid will be resolved.

While DRA 2005 and the budget cuts have impacted so negatively on our clients there has been a bright spot this Spring. Both the New York State Senate and Assembly have introduced the Compact for Long Term Care (S.03530 and A.10634). The Compact, if enacted, will provide another option to those who require long term care. It will not affect current Medicaid eligibility rules or access to the Medicaid program, but rather will provide another way to pay for long term care costs. The Compact, as it is currently proposed, provides that the person in need of long term care will pledge to pay from his or her own funds a defined amount for long term care costs for a period of time. At the end of that time the government will pick up most of the long term care costs without requiring a further spend down of assets. Participants will have to contribute a portion of their income to defray costs and co-payments for services rendered may be required. The expectation is that the Compact option will reduce federal, state and county Medicaid costs and simplify the process of qualifying for government payment for long term care.

The idea of the Compact came directly from the Elder Law Section which sought to provide legislators with an alternative to Medicaid. The hardworking Compact Committee includes Howard S. Krooks, Vincent J. Russo, Louis W. Pierro, Michael J. Amoruso, Howard F. Angione, Marc Leavitt and Gail Holubinka. I also serve on the Committee. We hope that the Compact will be enacted and the Committee is providing whatever assistance is required to get the

legislation in place. As Chair I will be seeking other opportunities for the Section to promote legislation which will help seniors and disabled persons.

Planning interesting and informative meetings for the Elder Law Section is another one of my goals. To this end, I have made a good start. The Summer 2006 meeting will take place in beautiful and historic Portsmouth, New Hampshire. Michael J. Amoruso, the Program Chair, has concentrated on providing interactive opportunities for Section members to learn about and explore DRA 2005 and the New York State budget. The Fall 2006 meeting, chaired by Beth Polner Abrahams, will take place in White Plains, New York and will be immediately followed by the Elder Law Advance Institute in the same location. The Advance Institute will have a new format this year and will provide participants up-to-the-minute information on current Elder Law issues and include interactive dialogues with panels of experts. The Program Co-Chairs for the Advance Institute are Margaret Z. Reed and Judith B. Raskin. The Annual 2007 Meeting once again will take place in New York City and will be chaired by Fran Pantaleo. In the Spring, I am looking forward to bringing to the Section a new concept, the Un-Program. I have asked Stephen J. Silverberg and Howard S. Krooks to serve as Co-Chairs. This will be a program without speakers or formal agenda. Substantive and practice-related topics will be suggested by the registrants. During the Un-Program, facilitators will be provided for each topic and attendees will be able to pick and choose those discussion groups which interest them. This will be the Elder Law Section at its best: member helping member and all learning from one another.

As Chair of the Elder Law Section, I am also very focused on making certain that the Section provides its members with the most current information in regard to Elder Law issues. I want to continue the Section's lobbying efforts in regard to matters which affect Elder Law attorneys and the frail, elderly and disabled. As the upcoming year unfolds, I think it will be important to oversee the effort to test the legal boundaries of DRA 2005 and the New York State budget. I also believe that the Elder Law Section needs to think about public relations. We need to put a face on the problems of our clients and make the public at large understand the world of our clients.

We have much to do as a Section and I look forward to a busy year. I thank all those Chairpersons who preceded me and hope that I will be able to lay a strong foundation for those who follow.

Ellen G. Makofsky

Editor's Message

The last few months have certainly provided both the public and the Elder Law Bar with significant challenges and periods of angst and uncertainty. Having survived the flurry of planning undertaken in anticipation of the enactment of the Deficit Reduction Act of 2005 ("DRA"), we were then faced with all of the issues that surround the interpretation of a complex federal statute. As if this was not enough to make you want to cry "uncle," the State of New York was in the midst of enacting its own Budget which had two "Budget Bills" proposed by Governor Pataki, both of which dealt with significant changes to Medicaid and the implementation of the DRA's provisions in New York. The final result as of the date of this writing in late April 2006, appears to be the implementation of the DRA's provisions in New York effective as of February 8, 2006, as well as potentially the implementation, for at least the upcoming fiscal year, of some significant changes to homecare Medicaid in New York, unless the legislature and Governor are able to achieve a compromise. The jury appears still to be out.

As a result of the aforesaid, and as previously promised, we are devoting a significant part of this edition of the *Elder Law Attorney* to an analysis of the DRA and its impact. We are most fortunate to have



been provided with excellent articles prepared by Michael Gilfix and Bernard A. Krooks, as well as Michael J. Amoruso, analyzing the provisions of the DRA. In order to bring you up to date on what has happened in New York, we have included two memoranda prepared by David Goldfarb and Ira Salzman.

I would like to note that the political opinions expressed in the DRA analysis, or any other articles contained herein, reflect only the opinions of the author(s), and not of our Section or the State Bar Association. It is perhaps inevitable that when writing about legislative changes to programs such as Medicaid that the political opinions of the author(s) will be expressed.

In addition, we have included excellent articles by Vincent J. Russo and Carianna C. Eurillo-Travinski dealing with specific aspects of the DRA. As always we have also included articles by our regular contributing authors.

Finally, I am confident that this edition of the *Elder Law Attorney* will be one that you will keep for years to come or at least until the DRA is declared unconstitutional. I wish to thank our editors, Vincent Mancino, Joan L. Robert, Brian Andrew Tully and Andrea Lowenthal, for their continuing efforts and hard work.

Anthony J. Enea
Editor-in-Chief

REQUEST FOR ARTICLES

If you have written an article, or have an idea for one, please contact the new *Elder Law Attorney* Editor

Anthony J. Enea
Enea, Scanlan & Sirignano LLP
245 Main Street, 3rd Floor
White Plains, NY 10601
E-mail: aenea@aol.com

Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.

Throw Mama From the Train

The Deficit Reduction Act of 2005 Abandons Our Nation's Elders

By Michael Gilfix and Bernard A. Krooks

It just got harder to be old and anything short of wealthy. Chapter 2 of the new Deficit Reduction Act of 2005 (DRA) focuses exclusively on "long-term care under Medicaid" and seeks to make it much harder for elders to protect any assets if they are to receive assistance from the federal Medicaid program while in skilled nursing facilities.

Adopted in the U.S. Senate by a margin of 51-50 (because Vice President Dick Cheney cast a deciding vote), and adopted in the House by the minuscule margin of 216 to 214, the legislation is fiercely partisan: Not a single member of the Democratic Party voted for it in the House. President Bush signed the DRA into law on Feb. 8.

One transparent purpose of the DRA's "long-term care under Medicaid" chapter is to trim Medicaid rolls. The legislation is designed to make it more difficult for elders who need long-term care to qualify for the program. Given the harsh and perhaps draconian nature of some provisions, this objective will no doubt be achieved.

Another purpose of the legislation is to increase the sales of long-term care insurance products. We expect this goal will be achieved as well. Government will pay less, private industry will sell more—but what will happen to the elderly? Many will be abandoned. And we're not just talking about the poorest of the poor. Many more middle-class elderly who exhaust their assets will be denied Medicaid because, for example, they inadvertently gifted in previous years, for purposes that had nothing whatsoever to do with asset preservation or Medicaid eligibility. Also, many skilled nursing facilities will be put in an untenable position. They either will have to provide care to individuals who cannot pay and are not Medicaid-eligible, or they'll be forced to discharge such residents. And when these elderly are put out of nursing homes, then what?

This is not just an issue for the middle class and the poor. It's an issue for all Americans with a conscience.

Dramatic Changes

Perhaps one of the most dramatic changes is what's been done to the penalty period. Since passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), the "look-back period" has been 36 months or, in the case of transfers to or from certain trusts, 60 months.¹ The look-back period is important because it may identify asset transfers that, if made for less than fair market value, create a period of Medicaid ineligibility.

If an individual is in a nursing home and applies for Medicaid under pre-DRA law, and assuming that he made a gift within the preceding 36-month period, he'll be ineligible for Medicaid for the number of months the gifted money would have paid for care had he retained the funds. A \$10,000 gift made one year ago, for example, would create about a two-month period of ineligibility in most states. Very importantly, that period of ineligibility started on the date that the gift was made. In other words, this person would be ineligible for Medicaid for the two-month period following the date of the gift, which was 12 months ago. His period of ineligibility would have expired 10 months ago; thus the gift would not affect his current application for Medicaid.

The DRA changes this. The extension of the look-back period from 36 months to 60 months would not be so bad if, as under pre-DRA law, the ineligibility period began on the date of the transfer. Instead, the DRA takes a punitive approach that will severely impact the ability of seniors to access government financed health care.

Under the DRA, the period of ineligibility starts on the date when the individual is in the skilled nursing facility, applies for Medicaid, and proves that he would have been eligible but for the application of the penalty period.²

Fortunately, the DRA is crystal clear in stating that pre-DRA law applies to all transfers made before the date of enactment of the DRA.³

THE DRA: THE NUTS, BOLTS AND IMPACT

Applications made in June 2007, for example, will be unaffected by transfers made in April 2004 because such transfers, (1) were made before DRA's enactment, and (2) were effected more than 36 months before the date of application.

These new provisions will be a formidable trap for the innocent and the unwary. Consider the grandmother who, four years before her stroke and placement in a nursing home, made a \$40,000 gift to her granddaughter to help her granddaughter purchase a first home. Under pre-DRA law, that gift might have generated an eight-month period of ineligibility. That period would have started on the first day of the month in which the transfer was made.⁴ Her period of ineligibility would have expired about eight months after making the gift. Medicaid eligibility for this now-destitute octogenarian for Medicaid would be granted.

But if this gift is made after the DRA's implementation date, it would result in a denial of eligibility. She'd apply for Medicaid and it would be determined that, but for the gift made four years ago, she would be eligible. Now, though, the eight-month period of ineligibility starts the month when she would otherwise have been eligible and is receiving skilled nursing care. She is already in a nursing home, destitute, and facing an eight-month period of ineligibility. She has no funds and Medicaid is denied. The nursing home will be stuck caring for a resident with no source of payment. Perhaps the DRA of 2005 should be renamed the "Nursing Home Bankruptcy Act of 2005."

Realistically, of course, nursing homes cannot be compelled to provide care without compensation. It's also an inescapable conclusion that safe, alternative placement options will simply not exist in most cases. States may therefore have no choice but to pay for long-term care out of other budgetary sources. So perhaps the DRA should be renamed the "State Budget Busting Act of 2005."

Also consider the individual who makes a \$15,000 donation to his local charity in April 2006. In February 2011, that same individual is suffering from Parkinson's disease and requires long-term care in a nursing home. All of his assets have been spent on his care at home and thus he would otherwise be eligible for Medicaid coverage in a nursing home. But the \$15,000 gift to charity almost five years earlier triggers a three-month penalty period starting when he goes into the nursing home. Unfortunately, he has no assets to pay for the cost of his care during this three-month period and he will either be denied admission to the nursing home or the nursing home will not be reimbursed for

his care during that period. It is anticipated that the DRA will have a chilling effect on charitable giving by seniors for fear that they may need long-term care at some future date. So perhaps the DRA should be renamed "The Charity-Chilling Act of 2005."

There may be some solace in that Section 6011(d) of the DRA requires states to include a "hardship waiver process" in accordance with preexisting federal law.⁵ An "undue hardship" would be established when the application of the new transfer of assets provisions would deprive the individual "of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life."

States are required to give notice to recipients of the undue hardship exception, provide a timely process for determining when hardship waivers will be allowed, and establish a process for appeal.⁶

But don't be fooled by this escape hatch. Experienced advocates know that "undue hardship" waivers, which have been encoded in federal legislation for years, traditionally have been elusive, at best. It's not uncommon for such waiver requests to be routinely denied without even the pretense of a hearing. Still, such hardship waivers inevitably are going to have to play a major role in coming years. Given the extensive five-year look-back period, there will be many elders who transfer funds to children, grandchildren, and charities for reasons that have nothing to do with Medicaid eligibility. Indeed, there is even a new provision that permits nursing homes to file for undue hardship waivers on behalf of a resident with the consent of the individual or the personal representative of the individual. When a waiver request has been appropriately filed, states may provide payment for up to 30 days to hold the bed for the elder.

Effective Date?

When will this new look-back period and these penalty period computations go into effect? The answer to this critically important question is unclear. The new look-back period applies to transfers made on or after the date of enactment.⁷ Presumably, that's when the president signed the DRA into law on Feb. 8.

But Section 6016(e) of the DRA has a somewhat different effective date provision. Section 6016 deals with additional reforms of Medicaid asset transfer rules, such as partial months of ineligibility, the aggregation of multiple gifts, limitations on certain notes and loans, and the treatment of life estate purchases. It

THE DRA: THE NUTS, BOLTS AND IMPACT

leaves open the possibility that state legislative action may be required before its provisions go into effect. These aspects of asset transfers may continue to be analyzed under pre-DRA law until the earlier of state legislative action or the first day of the first calendar quarter that begins after the close of the first regular session of the appropriate state legislature that begins after the date of enactment. Section 6016(e) effectively imposes a one-year limit, stating that states with a two-year legislative session shall nevertheless be deemed as having one year to act for purposes of these provisions.

Perhaps unfortunately, this determination will not be up to state Medicaid programs. Rather, this potential and necessary delay in implementation will occur only in states where the U.S. Secretary of Health and Human Services determines that a particular state plan, as the DRA puts it, “requires State legislation in order for the plan to meet the additional requirements” imposed by Section 6016.

Annuities

The DRA also changes the rules for annuities. Under the DRA, the purchase of an annuity is presumptively deemed a “disposal of assets” that is subject to the imposition of a period of ineligibility, unless the state is named as a remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or the state is named as a remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such individual disposes of such remainder interest for less than fair market value.⁸

In addition, the annuity must be irrevocable and non-assignable, actuarially sound, and provide for equal payments during the term of the annuity with, the DRA states, “no deferral and no balloon payments made.” Thus, a balloon annuity or an annuity providing for deferred payments will be treated as an uncompensated transfer of assets and be subject to the penalty period provisions of the DRA even if the state is named as a remainder beneficiary in the first position.

Exceptions apply for annuities described in subsection (b) or (q) of Internal Revenue Code Section 408, or for those annuities purchased with proceeds from an account or trust described in sub-sections (a), (c), or (p) of IRC Section 408, a simplified employee pension (under IRC Section 408 (k) or a Roth IRA described in IRC Section 408(A)).

The DRA requires the applicant for Medicaid to disclose “any interest (or that of a spouse) in an annuity (or similar financial instrument that may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset.”⁹ In addition, the state then is required to notify the issuer of the annuity of the state’s preferred status. The state also may require issuers of annuities to notify the state if there is any change in the amount of income or principal being withdrawn after the date of the most recent disclosure.

These provisions apply to transactions (including the purchase of an annuity) occurring on or after the date of enactment of the DRA.

Forcing Home Sales

Before the DRA, a residence of any value was an “exempt resource.” This means that its value was simply ignored in determining eligibility. So long as an individual, spouse, or siblings or children in limited circumstances were still residing in the residence, or an institutionalized homeowner maintained the “intent to return home,” the house retained its exempt status and was not a barrier to Medicaid eligibility. The lack of a cap on the value of a residence was realistic, given the enormous variety in average home prices in different parts of the country.

As a matter of public policy, the average \$200,000 residence in Michigan was given the same level of protection as an \$800,000 house in Connecticut or California. Public policy was clear: Elders should not be disrupted and compelled to sell their residence as a condition of eligibility. This treatment was consistent with our nation’s tax policy, which encourages home ownership and protects substantial gain from capital gains tax exposure.

The DRA imposes a \$500,000 cap on the value of an exempt residence when the owner is institutionalized in a nursing home.¹⁰ States are given the option of increasing the level of protection to no more than \$750,000. These values will increase annually with the Consumer Price Index commencing in 2011.

Fortunately, there are exceptions. When an individual’s spouse or his minor, blind or disabled child is living in the residence, this cap will not apply. It will, however, apply to single elders, most of whom will be women with no living spouse. The home equity cap provisions apply to individuals who are determined eligible for medical assistance with respect to nursing

THE DRA: THE NUTS, BOLTS AND IMPACT

facility services or other long-term care services based on an application filed on or after Jan. 1.¹¹

This provision of the DRA specifically references a “reverse mortgage or home equity loan” to reduce the equity interest in the home. The use of a reverse mortgage could be catastrophic and may result in the forced sale of the residence. Virtually every reverse mortgage contract calls for acceleration and complete payment of total indebtedness when an individual has ceased to reside permanently in her home. This is typically a maximum of one year after an individual moves out of the home for any reason.

Satisfaction of the loan will compel a sale that, in turn, results in cash proceeds then being in the name of the institutionalized individual. Deprived of any exempt asset (the residence), the individual will have countable or includible assets well in excess of the allowable limit (typically \$2,000) and be denied Medicaid coverage. Her entire estate may then be dissipated.

A home equity loan will have the same result, given the immediate repayment responsibility and the inevitable inability of net rental income (assuming viability of renting) to service any home equity loan. Again, forced sale will be inevitable and the entire value of the residence will be lost.

This provision is aimed at the individual who resided in a “million dollar house” and who somehow, therefore, ought not to receive any protection or support from the Medicaid program. But state Medicaid programs have long been protected in such circumstances by their right to assert estate claims on the estates of deceased Medicaid recipients or to impose liens on Medicaid-exempt residences. In other words, state Medicaid programs have been able to recover benefits paid and have collected hundreds of millions of dollars in this way. But at least they waited until the individual was deceased and clearly had no further use for their home.

The plight of a 68-year-old widow, a resident of San Jose, Calif., painfully makes the point. Afflicted with both diabetes and polio, she is extremely limited in mobility. She receives assistance from a state program that provides limited in home care and receives help from family members. Her eventual placement in a skilled nursing facility is a virtual certainty.

Her only asset is her residence, worth perhaps \$700,000. Even in her lower-middle-class community, this is the average home value. As she’ll be entering a skilled nursing facility after Jan. 1, the value of her res-

idence will preclude Medicaid eligibility. Either a reverse mortgage or a home equity loan will, inevitably, cause the loss of her only asset, an asset she acquired after a lifetime’s labor. This loss should be considered in the context of the Bush administration’s overall tax, entitlement and fiscal policies. The administration relentlessly advocates the elimination of the estate tax because it doesn’t want to force the sale of a parent’s business to pay taxes. But the President doesn’t hesitate to force middle- and lower-middle-class families to sell their primary asset, the parent’s home, before allowing any degree of assistance from the Medicaid program.

It also should be noted that reverse mortgages are unavailable to individuals who are no longer living in their homes. Individuals who enter nursing homes and have equity in excess of \$500,000, therefore, will have absolutely no opportunity to obtain reverse mortgages, notwithstanding the explicit suggestion in the DRA that they do so.

We also wonder what types of home equity loans will be available to isolated elders who are denied Medicaid because of the value of their homes. They have no income that can be used to repay such loans. Far too many will have no loved ones to protect their interests. Historically, the secondary market of lenders has taken advantage of vulnerable elders, loaning money with excessive closing costs and at high rates, knowing that the elderly homeowner will be unable to make payments. This ultimately results in the loss of the elder’s home. Foreclosure will be inevitable.

Insurance

The Republicans are privatizing elder care not only by forcing home sales but also by forcing a move to long-term care insurance. But “private” does not necessarily mean “better.”

Subchapter B of the “Long-Term Care Under Medicaid” chapter of the DRA is extensive. It reflects the DRA’s rather explicit elevation of long-term care insurance as it seeks to diminish the role of Medicaid in paying the cost of long-term care for older Americans.

The State Long-Term Care Partnership Program was initiated many years ago with assistance from a grant from the Robert Wood Johnson Foundation. It was designed to encourage individuals to purchase long-term care (LTC) insurance by providing such purchasers with an elevated level of asset protection. The program was curtailed with the enactment of OBRA-93. But four states—California, New York, Connecticut

THE DRA: THE NUTS, BOLTS AND IMPACT

and Indiana—have partnership programs that were grandfathered at that time.

Generally, these policies provide that purchasers of partnership long-term care insurance policies can shelter, dollar for dollar, funds received or utilized through the LTC policy.¹² For example, if a policy provides an individual with \$100,000 worth of coverage and the individual exhausts the policy limits, he will be allowed to qualify for Medicaid while retaining \$100,000, rather than the presumptive level of \$2,000. Such protected assets also are shielded from Medicaid estate claims at the time of the Medicaid recipient's death.

The policies have not enjoyed consistent levels of success, in large part because other long-term insurance policies seemed more attractive and competitive to consumers. In a clear victory for the long-term care insurance industry, the DRA seeks to shift greater responsibility to the private sector and concomitantly, dollar for dollar, diminish the role played by Medicaid.

The protection of assets we've just described is allowed only if seven requirements are satisfied:

- (1) The partnership policy must cover an insured who is a resident of the state when coverage first became effective.
- (2) The policy must be a "qualified long-term care insurance policy" as defined in IRC Section 7702B(b). The policy must not be issued earlier than the effective date of the state plan amendment allowing for partnership LTC policies.
- (3) The policy must satisfy or comport with sections of the Long-Term Care Insurance Model Act that are identified in the DRA and the 19 identified provisions in the Model Regulation of the National Association of Insurance Commissioners (NAIC). Certification of satisfaction is to be the responsibility of each state's Insurance Commissioner.
- (4) A policy must provide for "compound annual inflation protection" if an individual is under age 61 when the policy is purchased, "some level of inflation protection" for individuals age 61 through 75, and the optional provision of inflation protection for individuals age 76 and over at the time the policy is purchased.
- (5) Each state Medicaid agency is to provide information and technical assistance to state insurance departments regarding its role in assuring

that individual sellers (licensed agents) who sell long-term care insurance under the partnership receive appropriate training about the policies and how they relate to other sources of coverage for long-term care, presumably including other long-term care insurance policies and Medicaid.

- (6) The insurance company must provide reports to the U.S. Secretary of the Department of Health and Human Services (DHHS), including the dates, amounts, and termination of any benefits.
- (7) The state must not impose requirements on partnership policies that are not imposed on non-partnership policies.

Beyond this, there are extensive reporting requirements for the individual and DHHS ultimately must report on partnership programs and their impact on the cost of care (and specifically Medicare and Medicaid expenditures). DHHS also must establish a "National Clearinghouse for Long-Term Care Information" to provide consumer information.

Historically, long-term care insurance policies have not enjoyed a consumer-friendly reputation. The November 2003 issue of *Consumer Reports* published an extensive analysis of long-term care insurance policies then available. That article was extremely critical on balance. Policy options are proliferating and products are improving in response to such market pressures as the *Consumer Reports* piece, as well as in response to expected restrictions on access to Medicaid (as evidenced by the DRA). Consumers increasingly will be attracted to policies that, for example, combine LTC insurance benefit options with annuity features.

To the extent that invested dollars are not used to pay for the cost of long-term care, such dollars ultimately are recovered by identified residual beneficiaries in the form of annuity distributions. Life insurance policies are increasingly expected to allow the insured to utilize cash value or borrow against death benefits to pay the cost of long-term care.

But long-term care insurance cannot be expected to address the needs of individuals who cannot afford the cost of their premiums or who apply for insurance only after experiencing a health problem that enhances the likelihood of their long-term care needs. For such individuals, Medicaid will remain the payer of last resort. And the punishing provisions of the DRA are expected to impose difficult burdens on these individuals.

THE DRA: THE NUTS, BOLTS AND IMPACT

CCRC

Increasing numbers of America's elders are entering life care or continuing care retirement communities (CCRCs) across the nation.¹³

Some CCRC contracts allow a resident to access funds that are deposited with the CCRC to pay for the cost of living and the cost of care if their other assets are somehow depleted. Still other CCRC contracts provide that, upon the death of the resident, all or some portion of deposited funds are returned to the decedent's estate.

In determining Medicaid eligibility under the DRA, assets deposited or paid as an entrance fee shall be deemed available if the individual can use those funds to pay for care if other resources are exhausted, if the individual can obtain a refund upon death or termination of care, and if the payment of the entrance fee does not confer an ownership interest in the community.¹⁴

This provision is not expected to impact many individuals, as few CCRCs, and virtually no new life care communities accept Medicaid coverage for the skilled nursing component of their care continuum. Older communities, and particularly those that are religiously based and managed, often do accept Medicaid for qualifying individuals.

The DRA further provides that a CCRC admissions agreement may require residents to exhaust any resources they had at the time of admission before applying for medical assistance. Although most CCRCs are not Medicaid-certified, admissions agreements typically contain an anti-alienation provision designed to prevent a resident from transferring assets. Some provide for exceptions if prior approval of the facility is obtained. Maryland's highest court had previously held such provisions to be unenforceable.¹⁵ The DRA, in effect, overrules that decision.

Stop the Madness

These are just a few of the significant changes the DRA makes to the Medicaid rules. Through the imposition of increasingly restrictive rules and interpretations, the DRA seeks to restrict access to the Medicaid program as a means of paying all or a portion of the cost of nursing home care for our nation's elders. It remains to be seen how many states will implement some of the more draconian provisions. Importantly,

many other planning approaches that have been legal are not addressed in the DRA. They continue to be legal and will be available to elders in need.

Increased utilization of long-term care insurance is a potential outcome, confirming that the DRA is perhaps more a victory for the long-term care insurance industry than for the actual cause of deficit reduction. Indeed, the impact on the federal budget will be minuscule—while the impact on our most vulnerable elders will be as formidable as it is unfortunate.

As advisors to our clients, we have an affirmative responsibility to monitor implementation of the DRA at the state level and to document its inevitable abuses. Repeal of its onerous, irresponsible provisions must follow.

Endnotes

1. Some states, such as California, have not yet fully implemented OBRA-93 and are still utilizing the pre-OBRA-93 30-month look-back.
2. DRA Section 6011(b)(2).
3. DRA Section 6011(b)(1).
4. At the state option, the penalty period may commence in the month following the asset transfer.
5. 42 United States Code Section 1396(p)(c)(2)(D) of the Social Security Act.
6. DRA Section 6011(d)(2).
7. DRA Section 6011(c).
8. DRA Section 6012(b).
9. DRA Section 6012(a).
10. DRA Section 6014(a).
11. DRA Section 6014(b).
12. New York has a variation of the dollar-for-dollar partnership policy which provides for unlimited asset protection under applicable circumstances.
13. See Michael Gilfix, "Elder Housing," *Trusts & Estates*, April 2003, pp. 50-53.
14. DRA Section 6015.
15. *Oak Crest Village Inc. v. Murphy*, 379 Md. 229 (2004).

Michael Gilfix is principal at Gilfix & La Poll Associates LLP in Palo Alto, Calif.

Bernard A. Krooks is a partner at Littman Krooks LLP in New York City.

Reprinted with permission from *Trusts & Estates*, March 2006, trustsandestates.com.

Deficit Reduction Act of 2005: Changes to the Medicaid Look Back and Commencement of the Penalty Period

By Michael J. Amoruso

Introduction

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005¹ ("DRA") into law. Portions of the DRA provide for the first monumental changes to Medicaid eligibility rules since OBRA 1993. Of the many changes wrought by the DRA, perhaps the most significant include the changes to the look-back period and the commencement of the penalty period due to an uncompensated transfer of assets. Given these changes, consumers and providers alike will need the guidance of an elder law attorney schooled in the sophisticated Medicaid eligibility rules to navigate the minefield created by the DRA. This article will explore the changes to both the Medicaid look-back period and the commencement of the penalty period caused by the DRA and by the recently proposed New York State enabling legislation, as it existed in the Budget Bill on April 1, 2006. At the time this article is published, however, New York State is in the middle of an unresolved budget debate which may substantially affect the conclusions contained in this article.

The author would like to thank Daniel Fish, Esq., René Reixach, Esq., Howard Krooks, Esq., Louis Piero, Esq., Stephen Silverberg, Esq., Vincent Russo, Esq. and Bernard Krooks, Esq. for their insight and analysis regarding the DRA during the preparation of this article.

It is important to note, however, that we are in uncharted waters regarding how the DRA provisions for look-back and commencement of the penalty period will be interpreted and implemented. At this early date, we do not have the benefit of an ADM, GIS, fair hearing decision or court decision interpreting these provisions. In fact, issues regarding the constitutionality of the DRA itself remain unresolved. Thus, the discussion in this article will be refined by precedent as we elder law attorneys test these new rules.

The Medicaid Look-Back Period

I. Pre-DRA

Prior to February 8, 2006, there were two separate look-back periods to determine whether an individual disposed of assets for less than fair market value,

namely, (1) thirty-six months (or three years) for direct transfers of assets and (2) sixty months (or five years) for transfers made to or from a trust. In particular, the federal Medicaid law provided:

The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual . . . 60 months).²

The trigger date for the look-back, unaffected by the DRA, for an institutionalized individual is the first date the individual is receiving institutional services (at home or in a facility) and applies for Medicaid under a State plan.³ For an individual requiring community Medicaid, the trigger date is the date on which the individual applies for Medicaid or the date on which the individual disposes of assets for less than fair market value, if later.⁴

Given the disparity in the look-back period for direct transfers (3 years) and transfers involving trusts (5 years), some elder law attorneys leveraged these look-back periods to maximize asset preservation.

Example 1: Assume a regional rate for three years of nursing home assistance is \$314,064 and a client has \$630,000 in available resources. Prior to the DRA, if the client did not require nursing home care for 3 years, the elder law attorney may have suggested a direct gift of \$314,000 to the client's children and a \$314,000 transfer into an irrevocable income only trust. This strategy may have preserved \$628,000 if the client did not apply for Medicaid until the expiration of 3 years. The direct transfer to the children would be outside the look-back period. While the transfer into the trust would be within the 5 year look-back, the penalty caused by the transfer would have expired in three years ($\$314,000 / \$8724 = 35.99$ months).

THE DRA: THE NUTS, BOLTS AND IMPACT

Under the DRA, however, this leveraging of the look-back period is no longer a viable strategy for the client.

II. Post-DRA

The DRA amended the Federal look-back statute to include the following:

The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual . . . , or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005, 60 months).⁵

While the author would agree that the drafting of this new provision in conjunction with the existing 42 U.S.C.A. § 1396p(c)(1)(B)(i) is poor, at best, such language clearly expresses Congress's intent to change the look-back period for any post February 8, 2006 transfer to five (5) years. Confusion may exist, however, regarding when the five (5) year look-back period will truly be five (5) years. The author respectfully suggests that the look-back period will not be five (5) years until February 8, 2011.

Specifically, 42 U.S.C.A. § 1396p(c)(1)(B)(i) explicitly preserves the three (3) year look-back for any transfer before February 8, 2006. The DRA does not authorize a back door opportunity for the Medicaid administering agency to require the Medicaid applicant to disclose five (5) years of transfers before February 8, 2006 simply because a transfer was made on February 8, 2006. For such post-DRA transfers, the look-back period should remain at three years until February 8, 2009.

Example 2: Ned made a single charitable transfer to the Alzheimer's Association on February 10, 2006 and is applying for institutional Medicaid on August 1, 2006. Although the pre-DRA look-back period would only require a disclosure of all transfers from August 1, 2003, does the DRA allow the local agency to require a disclosure of all transfers from August 1, 2001 to present? NO!

In fact, it is not until February 8, 2011 that the look-back of five (5) years will be applicable—five (5) years from February 8, 2006. The author does not sug-

gest, however, that the look-back will remain three (3) years until February 8, 2011. Instead, the five year look-back should be "phased-in" with February 8, 2009 as the trigger date for the first increase in the traditional three (3) year look-back period.

Example 3: Ned made a single charitable transfer to the Alzheimer's Association on February 10, 2006 and is applying for institutional Medicaid on May 1, 2009. The local Medicaid administering agency should require Ned to disclose all transfers for the past 3 years and 3 months. Remember, May 1, 2009 is not yet 5 years from February 8, 2006 so 5 years of disclosure should not need to be provided.

Essentially, the author suggests that after February 8, 2009, there should be an ascending sliding scale as to the number of years and months for which disclosure will be required until the five (5) year threshold is reached on February 8, 2011.

A. New York State Enabling Legislation

On or about April 1, 2006, the New York State budget bill provided enabling legislation for the DRA changes in New York.⁶ It is important to note, however, that as a result of certain budget vetoes of Governor Pataki on or about April 12, 2006, the state of the budget and the fate of the proposed DRA enabling legislation is uncertain. In the event that the Governor, Senate and Assembly cannot negotiate a compromise to the budget, the Governor's vetoes will make certain provisions of his corresponding appropriations bill law until March 31, 2007, including, (1) imposing a five (5) year look-back for community Medicaid and institutional Medicaid, (2) imposing penalty periods for community Medicaid, (3) changing the start of the penalty period caused by an uncompensated transfer to the date of Medicaid application, and (4) eliminating spousal refusal for community Medicaid. It is also important to note, that by virtue of the Governor's vetoes, New York State may not be in compliance with the Federal Medicaid Program.

Assuming, however, that a compromise is reached to enact the NYS Budget Bill as it existed on April 1, 2006, then such legislation should contain the DRA enabling legislation. As it existed prior to the Governor's vetoes, the NYS Budget Bill adopted the DRA's five (5) year look-back period for all transfers

THE DRA: THE NUTS, BOLTS AND IMPACT

on or after February 8, 2006.⁷ Specifically, S. 6457-C (“Budget Bill”) provides:

§ 50-a. Paragraph (e) of subdivision 5 of section 366 of the social services law . . . is relettered paragraph (f) and a new paragraph (e) is added to read as follows:

(e) For transfers made on or after February eighth, two thousand six:

(vi) “look-back period” means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance.

(vii) “institutionalized individual” means any individual who is an inpatient in a nursing facility, including an intermediate care facility for the mentally retarded, or who is an inpatient in a medical facility and is

receiving a level of care provided in a nursing facility, or who is receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act.⁸

PRACTICE NOTE: Periodically contact your local DSS (HRA for NYC) or log on to the NYSBA Elder Law Section listserve to see if an ADM or GIS is issued to provide guidance on the DOH’s interpretation and implementation of the DRA look-back period.

Starting on February 9, 2009, New York’s seniors and disabled persons will be overburdened by the responsibility of providing over three (3) years of financial statements with their Medicaid applications. Today, in most cases, it is difficult for clients to obtain even three (3) years of statements. In fact, certain financial institutions may not retain a customer’s monthly statements (including deposit slips and cancelled checks) for greater than three (3) years. This is certain to be an issue that the elder law attorney will confront after February 8, 2009, when the look-back period begins the gradual ascent to five (5) years.

Region	Counties	Rate
New York City	Bronx, Kings, New York, Queens and Richmond	\$9,132
Long Island	Nassau and Suffolk	\$9,842
Northern Metropolitan	Westchester, Dutchess, Orange, Putnam, Rockland, Sullivan and Ulster	\$8,724
Western	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming	\$6,540
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington	\$6,872
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates	\$7,375
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga and Tompkins	\$6,232

Commencement of the Penalty Period

I. Pre-DRA

For transfers before February 8, 2006, Medicaid is entitled to look-back three (3) years from the first day of the month of application to identify direct transfers and five (5) years for trust-related transfers. As mentioned above, the purpose of the look-back is to see if the Medicaid applicant (“A/R”) divested himself of otherwise available assets to pay for his care in order to qualify for Medicaid. Generally, whenever an A/R makes an uncompensated transfer of property (a gift or donation), a time period of ineligibility (“Penalty Period”) for Medicaid institutional coverage (i.e., nursing home or Lombardi Program coverage) is created.⁹ Prior to February 8, 2006, such Penalty Period commences on the first day of the month following the month of transfer.¹⁰ There is no Penalty Period for community Medicaid eligibility.

The Penalty Period is calculated by dividing the value of the transferred property by the average monthly costs of nursing home care in the A/R’s geographic region.¹¹ The 2006 rates are listed in the chart at left.¹²

THE DRA: THE NUTS, BOLTS AND IMPACT

Example 4: Ned gifts real property in Albany County to his nephew Bill that has a fair market value of \$150,000. Ned cannot apply for institutional Medicaid for 21.83 months ($\$150,000 / \$6,872 = 21.83$).

1. Transfers to Persons Exempt from Penalty Period

Uncompensated transfers of the home (i.e., gifts) to a “qualified individual”¹³ are exempt from the imposition of a Penalty Period. Specifically, a transfer to A/R’s:

- a. spouse;
- b. child under the age of twenty-one (21);
- c. child who is certified blind or certified disabled of any age;
- d. sibling with an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized and continues to lawfully reside in the home;
- e. “caretaker child” who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care, as defined in 18 N.Y.C.R.R. 311.4(a)(1), to the A/R which permitted the A/R to reside at home rather than in the facility and such child continues to lawfully reside in the home.¹⁴

Similarly, uncompensated transfers of other assets are exempt from the Penalty Period if the assets:

- a. were transferred to the individual’s spouse, or to another for the sole benefit of the individual’s spouse;
- b. were transferred from the individual’s spouse to another for the sole benefit of the individual’s spouse;
- c. were transferred to the individual’s child who is blind or disabled, or to a trust established

solely for the benefit of such child; or

- d. were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.¹⁵

In long-term care crisis planning (i.e., immediate institutional Medicaid is required), a transfer to a qualified individual is an attractive proposition in terms of Medicaid eligibility and recovery. A transfer of the home or other asset to any of these individuals or trust, alone, will not cause a Penalty Period for Medicaid eligibility. In addition, a transfer to a qualified individual, *other* than the spouse, will protect the home or asset from Medicaid recovery. Remember, a transfer of the home or asset to a spouse may insure Medicaid eligibility of the A/R (since there is no Penalty Period for the spousal transfer) and it may protect against the imposition of a lien if the spouse continues to reside in the home. However, if the home or other asset remains in the estate of the spouse, then it may be subject to Medicaid recovery at the spouse’s death. Thus, if an exempt transfer to a spouse is utilized, it is imperative that the elder law attorney advise the spouse during post-Medicaid eligibility asset preservation planning to remove the home or other asset from the spouse’s estate. Obviously, an exception to this, however, is if the transfer is made in trust solely for the benefit of the (a) spouse, (b) child or (c) disabled person under age 65, and such person is receiving Medicaid. In such case, the home or other asset may be subject to Medicaid recovery at their death.

These qualified transfers will play an important role in asset preservation planning in a post DRA environment.

II. Post-DRA

Perhaps the most profound and devastating effect of the DRA to seniors and disabled persons (and their families) is the change in the Penalty Period start date. As discussed above, for transfers *prior* to February 8, 2006, the Penalty Period commences on the first day of the month following the month of transfer.¹⁶ This statutory start date authorized clients to make uncompensated transfers (i.e., to children, charities, churches, temples) and qualify for Medicaid as long as the individual privately paid for care (or waited out) the resulting Penalty Period. Such a statutory system was fair and, most times, not harmful to our seniors and disabled clients when properly guided by qualified

THE DRA: THE NUTS, BOLTS AND IMPACT

elder law counsel. The pre-DRA Penalty Period start date required our clients *immediately* to be accountable to the State for any uncompensated transfers of assets.

Under the DRA, however, the Federal government flips this fundamentally fair start date on its head and, instead, penalizes seniors when they are most frail and vulnerable—only when they are receiving institutional level care and have just \$4,150 to their name. Specifically section 6011 of the DRA amends 42 U.S.C. § 1396p(c)(1)(D) as follows:

(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, *or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (c) based on an approved application for such care but for the application of the penalty period, whichever is later*, and which does not occur during any other period of ineligibility under this subsection.¹⁷

While poorly drafted, the DRA appears to mandate that the Penalty Period (for an uncompensated non-exempt transfer) will not commence until the A/R *files* an application for institutional Medicaid and would be eligible for such coverage except for the resulting Penalty Period.¹⁸ This is the point in time that the individual is receiving (a) nursing home services, (b) a level of care in any institution equivalent to nursing home services, or (c) home or community based services under a waiver program (i.e., the Lombardi Program),¹⁹ and, Penalty Period aside, the A/R is otherwise financially eligible for institutional Med-

icaid (i.e., non-exempt assets < \$4,150 and available monthly income < medical expenses).²⁰

PRACTICE NOTE: Prepare the client for the possibility of filing two applications if there was a post-DRA transfer. While we need guidance through an ADM or GIS, presumably the initial application will be denied and the penalty period will be calculated by the DSS/HRA. At the expiration of the Penalty Period, the A/R may be forced to re-apply to obtain coverage.

Such a harsh provision has a profound and detrimental impact on the safety and well-being of an individual requiring immediate nursing home care under the Medicaid program who unwittingly made an uncompensated transfer of assets within the last 5 years. It is important to note, however, that the DRA does *not* impose a Penalty Period for community Medicaid.

Consider the following two examples to illustrate the dramatic difference between the pre-DRA and post-DRA penalty start date:

Example 5 (Pre-DRA Penalty Start Date): Mary Senior is 76 years old and lost her husband to Alzheimer's disease in early 2005. In August 2005, Mary makes a one time donation to the Alzheimer's Association in the amount of \$10,000. In addition, in August 2005, her granddaughter was unable to obtain financial aid for college so Mary gave her \$20,000 to use for tuition. Mary has a stroke in January 2006 and she now requires 24 hour custodial care in a nursing home. Mary resides in Westchester County and has \$2,000 in her name. The gift to the Alzheimer's Association and to her granddaughter would cause a 3.4 month Penalty Period **which commences on September 1, 2005 and ends in December 2005.**

Assuming other factors for eligibility, Mary is eligible for institutional Medicaid in January 2006 when she needs care.

Example 6 (Post-DRA Penalty Start Date): Mary Senior is now 80 years old and lost her husband to Alzheimer's disease in 2005. In

THE DRA: THE NUTS, BOLTS AND IMPACT

August 2006, Mary makes a one time donation to the Alzheimer's Association in the amount of \$10,000. In addition, in August 2006, her granddaughter was unable to obtain financial aid for college so Mary gave her \$20,000 to use for tuition. Mary has a stroke October 1, 2010 and she now requires 24 hour custodial care in a nursing home. Mary resides in Westchester County and has \$2,000 in her name. The gift to the Alzheimer's Association and to her granddaughter would cause a 3.4 month Penalty Period **which does not commence until Mary files an application for Medicaid in October 2010 and would not end until January 2011. Assuming other factors for eligibility, Mary would not be eligible for institutional Medicaid until January 2011** based upon the two transfers made approximately 4½ years earlier. With only \$2,000 in her name how can she pay for her care during the 3.4 month penalty caused at such late date?

PRACTICE NOTE: For transactions such as Mary Senior's in Example 6, consider litigation or fair hearing to demonstrate that such transfers were made exclusively for a purpose other than to qualify for Medicaid.²¹

Surprisingly, it appears during the rush to pass the DRA that certain moderate Republican U.S. Congresspersons were ill advised as to the effect gifts and charitable donations have on the Penalty Period. In a letter dated January 17, 2006, from U.S. Congresswoman Susan Kelly of New York on the impact of gifts and donations on the Penalty Period she explicitly states:

If a person makes an innocent gift or donation, the transferor CANNOT be penalized for making a gift or donation during the look-back period as long as he or she can demonstrate an exclusive purpose for the transfer other than to qualify for Medicaid. In addition, there will be no penalty when the transferor can demonstrate intent to transfer the asset for full

market value or when the transferred assets are subsequently returned.

For a law that narrowly passed the U.S. Senate by a tie-breaking vote cast by the Vice President of the United States and merely passed the U.S. House of Representatives by two (2) votes, it is heartbreaking to read that our leaders may have been misinformed. Nowhere in the DRA is there a definition of an "innocent gift or donation." Most important, however, such a statement misses the mark because the A/R must overcome the presumption in law that a gift was made to qualify for Medicaid. That is the very reason why the law imposes a Penalty Period for non-exempt transfers. While the author does not know what is meant by the phrase an "innocent gift or donation," consider the following example:

Example 7: Ned is diagnosed with Parkinson's disease in 2006. Over the next 4 years, to help deal with the pain of the diagnosis, Ned donates his life savings of \$50,000 to a scientific research association that promises to find a cure and to his local church. In 2010, Ned requires nursing home care and files a Medicaid application which is denied due to the \$50,000 transfer. At a fair hearing, Ned must make a showing to overcome the presumption that he donated the money to qualify for Medicaid even though he was afflicted with Parkinson's at the time the gift was made and knew that without a cure he would need nursing home care. Can Ned prevail? Is this the type of "innocent gift or donation" that CANNOT result in a Penalty Period to Ned?

PRACTICE NOTE: Consider attaching Representative Susan Kelly's letter as an exhibit to a Medicaid application where there appears to be an unintentional gifting of assets (as Ned in Example 7, above) to demonstrate Congress's legislative intent not to impose a penalty for such an "innocent gift or donation."

A. New York Enabling Legislation

Assuming that the NYS budget impasse ends with an adoption of the Budget Bill as it existed on April 1, 2006, the Budget Bill should provide enabling

THE DRA: THE NUTS, BOLTS AND IMPACT

legislation for the DRA which is effective July 1, 2006.²² Specifically, the Budget Bill amends Social Services Law § 366[5](e) as follows:

(e) For transfers made *on or after February eighth, two thousand six:*

* * *

(2) The uncompensated value of an asset is the fair market value of such asset at the time of transfer, minus the amount of the compensation received in exchange for the asset.

(3) In determining the medical assistance eligibility of an institutionalized individual, *any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for nursing facility services for the period of time specified in subparagraph four [sic]²³ of this paragraph.*²⁴

* * *

(5) *Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the office of temporary and disability assistance. The period of ineligibility shall begin the first day of a month during or after which assets have been transferred for less than fair market value, or the first day the individual is receiving services for which medical assistance coverage would be available based on an approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph.*

In addition to adopting the DRA look-back period (discussed above), the Budget Bill adopts the cruel and harsh Penalty Period start date. While at first blush it may appear that the Budget Bill departs from the DRA Penalty Period start date—by commencing on the first day the individual is receiving “medical assistance coverage” (i.e., community Medicaid instead of institutional Medicaid)—a later reference in the same sentence to subdivision (c) dealing with nursing home services may negate the possibility that the Penalty Period can commence on the filing of a community Medicaid application. Clearly, this issue of statutory construction is one that must be addressed by a NYS Department of Health ADM or possibly, the Courts.

PRACTICE NOTE: The most effective outcome of the DRA is that the traditional rule of halves planning is eliminated from the elder law attorney's arsenal. Prior to the DRA, the elder law attorney may have advised a client to transfer up to half of the client's assets either outright or in trust for beneficiaries and retain the remaining half of assets to pay for care during the Penalty Period. Such a strategy was effective because the Penalty Period, prior to the DRA, commenced the month immediately following the month of the transfer. Thus, if the client required care during the Penalty Period, the client could use the retained assets to pay for such care until the Penalty Period expired. Since the Penalty Period under the DRA does not start until the individual is receiving nursing home care and is otherwise eligible for institutional Medicaid (i.e., income and resource requirements), traditional rule of halves planning serves no purpose. Remember, by retaining half of the assets (assuming greater than \$4,150), the individual is not “otherwise eligible” for Medicaid.

Perhaps the most alarming aspect of the Penalty Period is the fact that it exposes an individual who requires nursing home care to the possibility that he will not be admitted into a facility due to a transfer years earlier. If an individual made a transfer three (3) years prior to their immediate need for nursing home care, that causes a multi-month (or multi-year) Penalty Period (beyond any potential Medicare coverage), and the individual has no assets or insurance remaining to pay for care, the practical chances of that indi-

THE DRA: THE NUTS, BOLTS AND IMPACT

vidual being offered admission into a nursing home are likely to decline. This exposure to the stark reality of the business side of a nursing home (filling beds to generate income), will certainly place such an individual in a dire situation. On the flip side, in the event a new resident, out of sheer desperation, fails to dis-close a post-DRA transfer, that will place the nursing home in the precarious position of filling a bed that fails to generate income until the expiration of the Penalty Period. These competing concerns demonstrate the harsh reality of the Penalty Period to both the A/R and the care facility.

It is important to note however, that while the Budget Bill as it existed on April 1, 2006 does *not* impose a Penalty Period for community Medicaid, by virtue of Governor Pataki's vetoes of the Budget Bill on April 12, 2006, a penalty period may now exist for community Medicaid until March 31, 2007 as contained in the Governor's corresponding Appropriations Bill. During the months ahead, the elder law attorney must vigilantly follow and digest the developments of the Budget Bill and inform the client about this fluid situation *prior* to offering advice regarding eligibility for community Medicaid.

1. Transfers Exempt from the Penalty Period

Most important, however, New York State's enabling legislation, as it existed in the Budget Bill on April 1, 2006, preserves the exempt transfers to certain qualified individuals that existed for pre-DRA transfers. In particular, if the asset transferred is the A/R's home, no penalty will be assessed if the home is transferred to the A/R's

- a. spouse;
- b. child under the age of twenty-one (21);
- c. child who is certified blind or certified disabled of any age;
- d. sibling with an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized;
- e. "caretaker child" who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care which permitted the A/R to reside at home rather than in the facility.²⁵

If the A/R transfers assets other than the home, such transfers are exempt from the Penalty Period if the assets

- a. were transferred to the individual's spouse, or to another for the sole benefit of the individual's spouse;
- b. were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;
- c. were transferred to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or
- d. were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.

As with pre-DRA transfers, the elder law attorney should first identify whether an opportunity exists to utilize an exempt transfer before initiating the harsh Penalty Period start date under the DRA. Such transfers have proven effective in the past and will continue to be a strong tool in the elder law attorney's arsenal post-DRA.

In the event that the possibility of an exempt transfer does not exist, there may be hope to escape the harsh Penalty Period if the A/R can demonstrate that any transfers were made exclusively for a purpose other than to qualify for institutional Medicaid.²⁶ It is important to note, however, that since the Penalty Period under the DRA will not commence, in some cases, for many years later, the exclusive purpose for such a transfer, in fact, may have been for a purpose other than to qualify for Medicaid. Further, the Budget Bill provides that if a satisfactory showing is made to demonstrate that the A/R (or spouse) (a) intended to dispose of the assets at fair market value or other valuable consideration or (b) that all assets transferred for less than fair market value have been returned to the A/R, then a Penalty Period may be avoided.²⁷

PRACTICE NOTE: If you identify that a non-exempt transfer was made by the A/R, explore the purpose and circumstances surrounding the transfer. Was the A/R in good health with no expectation of requiring nursing home care at the time of transfer? Was the transfer made as part of the individual's

estate planning (i.e., consistent history of annual exclusion gifting while in good health)? Can the facts rise to a level that the A/R may succeed at a fair hearing or in Court?

2. Undue Hardship Provision

Interestingly, both the DRA and the Budget Bill, as it existed in the Budget Bill on April 1, 2006, contain a provision that may permit the A/R to obtain institutional Medicaid if application of the Penalty Period would deprive the A/R of medical care that would endanger the A/R's life or health or deprive the A/R of food, clothing or shelter.²⁸ In fact, the NYS Office of Temporary and Disability Assistance ("OTDA") must inform all individuals affected by the Penalty Period in writing of the hardship waiver process.²⁹ The Commissioner of the OTDA must develop a hardship waiver process that is timely so that the A/R has a sufficient opportunity to appeal an adverse decision.³⁰ Under current regulations, A/Rs in New York may establish undue hardship if (1) they are otherwise eligible for institutional Medicaid, (2) they are unable to obtain appropriate medical care without Medicaid, (3) despite best efforts are unable to have transferred assets returned or obtain fair market value for the transferred assets.³¹ "Best efforts" to obtain the transferred assets or their fair market value includes cooperating with the DSS to pursue such assets or obtain their fair market value, perhaps through litigation, from the donee (i.e., children, charity, trust).³² Unfortunately, however, hardship waivers under pre-DRA law were rarely granted in New York.³³

One positive addition under the DRA and the Budget Bill, as it existed in the Budget Bill on April 1, 2006, is the fact that if the A/R is an institutionalized individual, the nursing home, with the A/R's consent, may file a request for a hardship on the A/R's behalf.³⁴ While this may not increase the likelihood of success, this provision does provide for a Medicaid-paid bed hold for the A/R at the facility for up to thirty (30) days (if certain criteria to be promulgated by the OTDA are met).³⁵ Also, the A/R's case would be handled by the nursing home's attorney who may have a higher level of expertise in such matters.

PRACTICE NOTE: An opportunity exists to expand our practice in this area by representing nursing homes that pursue hardship waivers for A/Rs who are admitted into their facility.

III. The Challenge for the Elder Law Attorney

With the elimination of rule of halves planning, asset preservation planning is turned on its head for the elder law attorney. Instead of creating a penalty and self-paying for care throughout the penalty period until the A/R is Medicaid eligible, in a post-DRA world, the A/R will have to be made *immediately* "otherwise eligible" for Medicaid to start the Penalty Period. How can the elder law attorney accomplish the seemingly impossible?

The elder law attorney will probably rely on often-overlooked strategies, such as: caregiver agreements, exempt transfers, and litigation to overcome the presumption that a transfer was made for the purpose of obtaining Medicaid. Also, the DRA appears to sanction the purchase of a life estate interest if the A/R resides in the home for a year after such purchase.³⁶ The use of the life estate in this fashion may need to be explored. In addition, the elder law attorney may investigate the existence, viability and use of products such as a short-term immediate annuity (assuming it meets stringent requirements of the DRA). Likewise, long-term care insurance will be an important tool in future asset preservation planning (assuming that a client can financially afford it and medically qualifies). Finally, the irrevocable income only trust may become a more attractive alternative to clients who decide, wisely, to plan well before the five (5) year look-back is an issue. The trust may offer more protection and flexibility over a direct gift and now has parity with the direct gift with regard to the look-back period.

IV. Conclusion

There can be no doubt that in a post-DRA environment, the ones who will suffer are the chronically ill and medical providers. One can only hope, for the sake of our Nation's chronically ill citizens, that either a constitutional challenge to the DRA will prevail or that repeal legislation, once the impact of the DRA is truly understood, will march through the halls of Congress and the White House. Thanks to the tireless efforts of the New York State Bar Association, the Elder Law Section's Officers and Executive Committee, the Budget Bill includes language that provides for New York's Medicaid eligibility laws to retreat to pre-DRA rules if either event occurs.

With the devastating change in the Penalty Period start date, asset preservation planning is no longer an area where the generalist can "dabble" in elder law.

THE DRA: THE NUTS, BOLTS AND IMPACT

Given the intricacies of the DRA and the level of sophisticated planning needed in a post-DRA world, clients will require advice from elder law attorneys that thoroughly understand the Medicaid rules to safely navigate them through the uncharted waters of the DRA.

Endnotes

1. Public Law 109-171 (2006).
2. 42 U.S.C.A. § 1396p(c)(1)(B)(i).
3. 42 U.S.C.A. § 1396p(c)(1)(B)(ii)(I) and 42 U.S.C.A. § 1396p(c)(1)(C)(i).
4. 42 U.S.C.A. § 1396p(c)(1)(B)(ii)(II).
5. Public Law 109-171 § 6011(a).
6. S. 6457-C, A. 9557-B (January 20, 2006).
7. *Id.*
8. *Id.*
9. Social Services Law § 366[5](d)(3).
10. Social Services Law § 366[5](d)(4).
11. Social Services Law § 366[5](d)(4); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iv).
12. OMM GIS 04 MA/033.
13. Social Services Law § 366[5](d)(3)(i)(A)-(D); 18 N.Y.C.R.R. § 360-4.4(C)(2)(iii)(8)(1)-(4).
14. *Id.*
15. Social Services Law § 366[5](d)(3)(ii).
16. Social Services Law § 366[5](d)(4).
17. Public Law 109-171 § 6011(b).
18. *Id.*
19. 42 U.S.C.A. § 1396p(c)(1)(C)(i).
20. Social Services Law § 366.
21. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iii)(B). *E.g., Cacchillo v. Perales*, 172 A.D.2d 98, 576 N.Y.S.2d 916 (3d Dep't 1991); *Kulikowski v. New York State Dept. of Social Services*, 166 A.D.2d 858, 563 N.Y.S.2d 536 (3d Dep't 1990).
22. S. 6457-C § 50-a; Social Services Law § 366[5](e)(2)-(5).
23. The reference to subparagraph 4 is a misprint in the Budget Bill, as the appropriate reference should be to subparagraph 5.
24. The Budget Bill continues to amend Social Services Law § 366[5](e)(3) by stating that the following transfers are uncompensated unless they meet stringent parameters:

For purposes of this paragraph: (i) the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless: the state is named as a beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the state is named in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value; and the annuity meets the requirements of section 1917(c)(1)(G) of the federal social security act; (ii) the purchase of a life estate interest in another person's home shall be treated as the disposal of an asset for less than fair market value unless the purchaser resided in such home for a period of at least one year after the date of purchase; (iii) the purchase of a promissory note, loan, or mortgage shall be treated as the disposal of an asset for less than fair market value unless such note, loan, or mortgage meets the requirements of section 1917(c)(1)(I) of the federal social security act.
25. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(i)(A)-(D).
26. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iii)(B). *E.g., Cacchillo v. Perales*, 172 A.D.2d 98, 576 N.Y.S.2d 916 (3d Dep't 1991); *Kulikowski v. New York State Dept. of Social Services*, 166 A.D.2d 858, 563 N.Y.S.2d 536 (3d Dep't 1990).
27. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iii)(A) & (C).
28. Public Law 109-171 § 6011(d), S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
29. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
30. *Id.*
31. 18 N.Y.C.R.R. § 360-4.4(c)(1)(ii)(d)(2).
32. *Id.*
33. Vincent J. Russo and Marvin Rachlin, *New York Elder Law Practice*, § 8:35 (West 2005).
34. S. 6457-C § 50-a; Social Services Law § 366[5](e)(4)(iv).
35. *Id.*
36. S. 6457-C § 50-a; Social Services Law § 366[5](e)(3)(ii).

DRA Update

By David Goldfarb and Ira Salzman on behalf of the NYSBA Elder Law Section DRA Committee

This is to advise members of the Elder Law Section of the various parts of the NYS Budget bills impacting Medicaid eligibility which have been enacted, that is, which have passed the legislature and been signed by the Governor. Some of these provisions, particularly the imposition of transfer of asset rules for long term care services and the elimination of spousal refusal for home care and for nursing home care, may be subject to legal challenge. There are multiple bases for these possible challenges, including but not limited to the following:

1. These changes were made in an appropriations bill. It is not clear under the NY State Constitution whether this is proper procedure.
2. The legislature passed separate legislation in what is called an Article VII bill (Chapter 57 Section 50-a) which implemented some DRA provisions but would not have imposed transfer of asset rules on home care. The Governor line item vetoed this provision and the legislature overrode the veto. The Governor's veto message stated that the legislature did not have the authority to override his veto and he will not enforce this provision. An additional issue here is whether the Governor can use a line item veto on an Article VII bill.
3. The rule with regard to spousal refusal in institutional care may conflict with the decision of the Second Circuit in *Morenz v. Wilson Coker*, 415 F3d 230 (2d Cir. 2005). In fact, NYS DOH has stated that it needs Federal approval of a waiver to implement this change in the law, and that this provision cannot be implemented without such Federal approval.
4. The section of the appropriation bill (see below) that determines the date on which the penalty period starts to run (for both nursing home and long-term care services) cross-references "clause (i) of subparagraph 4 of paragraph (d) of subdivision 5 of section 366 of the social services law." There is no clause (i) in SSL § 366 subd. 5(d)(4). This may be an attempt to reference the first sentence of that paragraph.
5. This same section of the appropriations bill states that the penalty period for long-term

care services begins to run "on the first day the individual is receiving services for which medical assistance coverage would be available but for . . ." the transfer of asset rules. This appears to be inconsistent with the DRA; 42 U.S.C. § 1396p(c)(1)(D) states that the penalty period starts to run 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 medical assistance under the State plan and would otherwise be receiving *institutional level care . . . whichever is later . . .*" (emphasis supplied). It therefore appears that for non-institutional care the DRA requires that the penalty period start to run on the first of the month following the month of the transfer. The appropriations bill, which states that the penalty period starts to run when the provision of care begins, appears to be inconsistent with this requirement.

The statutes that the Governor (but not necessarily the legislature) believes were properly enacted and plans to instruct the local agencies to enforce are set forth below. There was an additional provision in Chapter 54 which indirectly expanded estate recovery which has been vetoed and the legislature has overridden the veto. However, there appears to be general consensus that this provision is not in effect.

Chapter 54 of the Laws of 2006 (Appropriation Bill) (Headings have been added and are not in the original). These provisions are part of an appropriations bill, therefore they are effective April 1, 2006, and continue in effect for one year.

ELIMINATES SPOUSAL REFUSAL FOR COMMUNITY BASED CARE UNLESS THE SPOUSE IS ABSENT

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department,

THE DRA: THE NUTS, BOLTS AND IMPACT

the income and resources of the responsible relative are not available to such applicant because of the absence of such relative and the refusal or failure of such absent relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title 6 of article 3 of the social services law and other applicable provisions of law.

EXTENDS LOOK-BACK TO 60 MONTHS; CREATES PENALTY PERIOD FOR LONG- TERM CARE SERVICES FOR NON- INSTITUTIONALIZED INDIVIDUALS

Notwithstanding any inconsistent provisions of law, rule or regulation to the contrary, for the purpose of evaluation of transfer of assets provision "look-back period" means the 36-month period, or, in the case of payments from a trust or portions of a trust which are treated as assets disposed of by the individual pursuant to department regulations, the 60-month period, immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance, or in the case of a non-institutionalized individual, the date that such non-institutionalized individual applies for medical assistance coverage of long-term care services; provided, however, that the look-back period for all types of transfers shall be 60 months if the commissioner of health obtains all necessary approvals under federal law and regulation to implement such a look-back period; provided further that the use of a 60-month look-back period for all types of transfers shall continue only if and for so long as the use of such a look-back period does not prevent the receipt of federal financial participation under the medical assistance program; provid-

ed further that the commissioner of health shall submit such waiver applications and/or state plan amendments as may be necessary to obtain approval to implement a 60-month look-back period for all types of transfers and to ensure continued federal financial participation. In determining the medical assistance eligibility of an institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for nursing facility services for the period of time specified in law. In determining the medical assistance eligibility of a non-institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for longterm care services for the period of time specified in law. An individual shall not be ineligible for services solely by reason of any such transfer to the extent that the asset transferred was a home and title to the home was transferred to: (A) the spouse of the individual; or (B) a child of the individual who is under the age of 21 years or blind or disabled; or (C) in the case of an institutionalized individual, a sibling of the individual who has an equity interest in such home and who resided in such home for a period of at least one year immediately before the date the individual became an institutionalized individual; or (D) in the case of an institutionalized individual, a child of the individual who was residing in such home for a period of at least two years immediately before the date the individual became an institutionalized individual, and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

THE DRA: THE NUTS, BOLTS AND IMPACT

CHANGES START DATE OF PENALTY PERIOD TO FIRST DAY WOULD BE RECEIVING SERVICES BUT FOR THE IMPOSITION OF A PENALTY

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, the period of ineligibility described in clause (i) of subparagraph 4 of paragraph (d) of subdivision 5 of section 366 of the social services law shall begin on the first day the individual is receiving services for which medical assistance coverage would be available but for the provisions of subparagraph 3 of paragraph (d) of subdivision 5 of section 366 of the social services law, and which does not occur in any other periods of ineligibility, if the commissioner of health obtains all necessary approvals under federal law and regulation to implement such a period of ineligibility. The use of such a period of ineligibility shall continue only if and for so long as it does not prevent the receipt of federal financial participation under the medical assistance program. The commissioner of health shall submit such waiver applications and/or state plan amendments as may be necessary to obtain approval to implement the period of ineligibility described in this clause and to ensure continued federal financial participation.

CALCULATING THE PENALTY PERIOD FOR INSTITUTIONALIZED AND NON-INSTITUTIONALIZED INDIVIDUALS

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the purpose of evaluation of transfer of assets provisions, “noninstitutionalized individual” means an individual who is not an institutionalized individual, as defined in clause (vii) of subparagraph 1 of paragraph (d) of subdivision 5 of section 366 of the social services law, and “long term care services” means home health care

services, personal care services, assisted living program services and such other services for which medical assistance is otherwise available under the social services law which are designated as long-term care services in the regulations of the department.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, in the case of a transfer by an individual which results in a period of ineligibility for such individual or his or her spouse, such period of ineligibility will continue without regard to the individual’s becoming an institutionalized individual if the transfer was made while the individual was a non-institutionalized individual and without regard to the individual’s becoming a non-institutionalized individual if the transfer was made while the individual was an institutionalized individual. In no event shall the total period of ineligibility for longterm care services and nursing facility services resulting from the same transfer of assets exceed the period calculated pursuant to subparagraph 4 of paragraph (d) of subdivision 5 of section 366 of the social services law.

ELIMINATES SPOUSAL REFUSAL FOR INSTITUTIONAL CARE UNLESS IT WOULD CREATE UNDUE HARDSHIP

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, an institutionalized spouse shall not be ineligible for medical assistance by reason of excess resources determined under paragraph (a) of subdivision 5 of section 366-c of the social services law, if (i) the institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district and the department, or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, and (ii) to deny assis-

THE DRA: THE NUTS, BOLTS AND IMPACT

tance would create an undue hardship, as defined by the commissioner.

Chapter 57 of the Laws of 2006 (article VII bill) (Headings added and not in the original). These provisions are changes to the State law and there appears to be no State law controversy with regard to their effectiveness.

LIMITS HOMESTEAD EXEMPTION TO \$750,000

Section 50. Subparagraph 1 of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by chapter 184 of the laws of 1969, is amended to read as follows:

(1) (i) for applications for medical assistance filed on or before December thirty-first, two thousand five, a homestead which is essential and appropriate to the needs of the household;

(ii) for applications for medical assistance filed on or after January first, two thousand six, a homestead which is essential and appropriate to the needs of the household; provided, however, that in determining eligibility of an individual for medical assistance for nursing facility services, the individual shall not be eligible for such assistance if the individual's equity interest in the homestead exceeds seven hundred fifty thousand dollars; provided further, that the dollar amount specified in this clause shall be increased, beginning with the year two thousand eleven, from year to year, based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest one thousand dollars. Nothing in this clause shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the homestead. The home equity limitation established by this clause shall be waived in the case of a demonstrated hardship, as determined pursuant to criteria

established by the Secretary of Health and Human Services. The home equity limitation shall not apply if one or more of the following persons is lawfully residing in the individual's homestead at the time of application for medical assistance: (A) the spouse of the individual; or (B) the individual's child who is under the age of twenty-one, or is blind or permanently or totally disabled.

REQUIRES ANNUITIES TO NAME NEW YORK STATE AS REMAINDER BENEFICIARY

Section 50-b. Section 366-a of the social services law is amended by adding a new subdivision 10 to read as follows:

(10) As a condition for the provision of medical assistance for nursing facility services, the application of an individual for such assistance, including any recertification of eligibility for such assistance, shall disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument, regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that the state of New York becomes a remainder beneficiary under such annuity or similar financial instrument by virtue of the provision of such medical assistance.

APPLICABILITY REGARDING FEDERAL DEFICIT REDUCTION ACT OF 2005:

Section 50-c. Applicability of certain limitations on eligibility for medical assistance.

1. The federal deficit reduction act of 2005 mandates that New York state enact certain limitations on eligibility for medical assistance as a condition of receiving federal financial participation for that medical assistance. The amendments made to subparagraph (1) of paragraph (a) of subdivision 2 of section 366 of the social

services law and paragraphs (e) and (f) of subdivision 5 of section 366 of the social services law and the new subdivision 10 of section 366-a of the social services law, enacted respectively by sections 50, 50-a, and 50-b of the chapter of the laws of 2006 (referred to in this section as the “limitations on eligibility”), to the extent they limit eligibility for medical assistance, shall only be effective and apply as and when they are and continue to be mandated by applicable federal law as a condition for the state receiving federal financial participation for that medical assistance. If at any time a court of competent jurisdiction finds that any provision

of the limitations on eligibility, or any application thereof, is not so mandated by applicable federal law, then that provision, or that application of that provision, shall have no legal force or effect and the relevant provision of the social services law in effect immediately prior to this section becoming law shall apply.

2. If any provision of the limitations on eligibility, or any application thereof, is found under this section to have no legal force and effect, that finding shall not affect the legal force and effect of any other provision of the limitations on eligibility or any other application thereof.

Governor and DOH Taking Steps to Immediately Implement Changes to Medicaid Homecare Spousal Refusal and Transfer of Asset Rules

Update from David Goldfarb and Ira Salzman
on behalf of the NYSBA Elder Law Section DRA Committee

Representatives of the NYSBA Elder Law Section (and representatives of the NAELA NY Chapter) met with Megan Kearney, Sandy Pettinato, and Carolyn Kerr from the Governor’s office and Greg McMillan from the Department of Health regarding the Medicaid eligibility changes in the New York State budget.

The representatives from the Governor’s office and the Department of Health stated their position that the budget negotiation process is over. They are drafting ADMs to implement transfer of asset rules for community Medicaid and the elimination of spousal refusal in community Medicaid unless there is physical separation. They will be requesting a federal waiver to eliminate spousal refusal for institutional Medicaid unless there is a hardship. They agreed that the definition of “estate” for recovery purposes has not been expanded.

They are trying to have implementation at the county/city level by July 1, 2006, but the effective dates are not clear. They recognize that the provisions from the appropriations bill would expire at midnight on March 31, 2007.

Long-Term Care Insurance

By Carrianna C. Eurillo-Travinski

The Deficit Reduction Act of 2005 (the “DRA”)¹ has reaffirmed the importance of Long-Term Care Insurance as one of the best asset protection tools available to our clients. What follows is a re-introduction to the basic concepts associated with long-term care insurance as well as a discussion of the DRA and the anticipated impact the DRA will have on the role of long-term care insurance.

I. The Basics²

A. What Is Long-Term Care Insurance?

Initially, it should be acknowledged that the policy benefits of long-term care insurance are something that insureds almost certainly hope never to require. However, this insurance product offers reasonably healthy and reasonably affluent individuals a valuable tool to contain the financial costs of providing for long-term care should this eventually become necessary. Most long-term care insurance policies are pure “casualty” insurance. That is, they provide payments only when the insured satisfies the policy criteria. If the criteria are never satisfied, there will have been no direct benefit from the policy. Some policies, however, have life insurance components, usually as an alternative benefit to long-term care coverage.³

The consequences of obtaining long-term care insurance, however, are far greater than such an analysis suggests. When the insured elder is freed from the constraints of reserving funds to pay for the (full) costs of long-term care, there is a substantial increase in the flexibility of other spending that can occur. Even the likely substantial annual premiums (of \$5,000, \$7,500 or more) present a very different financial burden from nursing home or home care costs of often \$100,000 or more per year. Moreover, the increasing emphasis on home care benefits in long-term care insurance policies not only fulfills consumers’ wishes, but serves the insurance industry’s need to reduce the costs of the coverage such policies provide.⁴

Although long-term care insurance has traditionally been viewed by many clients, and their professional advisors, as relatively exotic or a luxury, the likelihood of requiring long-term care is far greater than that of one’s house burning down! In fact, the

strongest argument against long-term care insurance—its cost—is almost the same as the strongest argument in its favor—its cost relative to that of long-term care itself. Thus, decisions about whether to purchase long-term care insurance essentially require an analysis of the risk the client wishes to leverage. The following sections discuss some of the considerations that need to be addressed in assisting clients with such decisions and in determining when it is appropriate to suggest the purchase of long-term care insurance as a part of the estate and financial planning process.

B. Evaluating the Need for Long-Term Care Insurance

Evaluating the need for long-term care insurance parallels the process for evaluating the need for life insurance, the one difference being that the long-term care insurance analysis will often emphasize the financial needs of the insured rather than those of his or her family. In other respects, however, the similarities are significant: What funds will be available to one’s spouse, children or other loved ones, upon the event triggering the insurance benefit (be it the need for long-term care or death)? What planning opportunities may be created or facilitated by the insurance benefit? What, in short, is the relative cost-benefit of the insurance, not only to the insured, but to his or her family?

In many cases, merely posing the question provides the answer: either there are adequate funds to bear the financial burden of long-term care without affecting the family lifestyle or the insurance will be necessary to protect against the financial devastation of such care. Even when confronted with the financial reality, however, many clients will resist long-term care insurance not only because of the cost, but also because they are unwilling to acknowledge that, for them at least, “life” in an institution could ever be a possibility. (This objection may be overcome to some extent by pointing out the home care benefits that most long-term care insurance policies now offer.)

Special consideration must be taken in addressing the planning needs of unmarried couples and same-sex couples, whether married, in a civil union or otherwise. The federal protections against spousal

THE DRA: THE NUTS, BOLTS AND IMPACT

impoverishment do not extend to these couples, although they also will not be treated as an “assistance unit” in determining eligibility for Medicaid. The planning opportunities and pitfalls these situations present must be carefully examined.

Although the appeal of long-term care insurance to individuals and families with significant assets is obvious, those of modest means are also potential insureds. A desire to avoid reliance upon Medicaid is reportedly an important motivating factor for many insureds whose financial resources might not appear to indicate the need for such protection.⁵

A number of treatises contain checklists for use by practitioners in evaluating the need for long-term care insurance.⁶ The questions to be posed range from the ability to pay future premiums, to the projected cost of long-term care care, to the client’s desire to provide for family members, to the impact of qualifying for Medicaid upon the client and his or her family.⁷ While these questions are an extremely useful way to focus the discussion, if the funds to pay the premiums are available, the decision whether to purchase long-term care insurance is largely a subjective (and usually not terribly difficult) one. The greater challenge is to assist the client in evaluating the long-term care insurance policy that he or she is considering purchasing.

C. Evaluating Long-Term Care Insurance Policies⁸

Once a client has decided to purchase long-term care insurance, the task of evaluating potential policies will often be assigned to the estate planning attorney. Since most estate planners do not have extensive experience in this specific area, the utility of working with an agent who specializes in long-term care insurance cannot be over-emphasized. While there is no doubt that the long-term care insurance industry is just emerging from its infancy, there are vast numbers of products and an insurance company’s AAA rating is, in itself, no assurance that the policies it offers will be appropriate, let alone the best available, for the prospective insured.

New York law requires insurers to provide or offer certain policy features, including level premiums, no prior level of care requirements, and restrictions on preexisting condition exclusions.⁹ Policies, especially older policies, should be reviewed to ensure that they comply with the law. Nonetheless, the policy features that many clients seek will include some or all of the following:

1. No prior hospitalization requirement.¹⁰
2. A significant home care benefit, if possible as indemnity coverage.¹¹
3. A broad list of activities of daily living with deficits in a minimum number required to satisfy coverage criteria.¹²
4. Premium waiver in the event benefits become payable.
5. Increasing coverage based on an inflation factor or on a compounding percentage of the initial per diem rate.¹³
6. Limitations on premium increases.¹⁴
7. Deductibility of premiums.¹⁵
8. Stability of the insurer.¹⁶
9. Flexibility in applying benefits (“alternative plan of care”).¹⁷
10. Elimination periods.¹⁸

Since most policies provide for a per diem¹⁹ benefit, the proper amount of coverage is most easily determined by identifying the daily cost of the care the client would wish to receive and deducting the amount already believed to be available from other sources. While there is probably no harm in “over buying” (assuming the cost is not prohibitive) the risk of “under buying” is significant. If a client will, despite the insurance, nevertheless require Medicaid to pay for long-term care, or a disabled child or a spouse nevertheless will be impoverished, the insurance-buying exercise—and the resulting expense—may prove utterly futile. Thus, a clear articulation of the client’s goals in purchasing long-term care insurance is necessary before the appropriate level of coverage can be determined.

Another issue that deserves careful consideration is the appropriate duration of the insurance coverage. Many policies provide for three or five years of benefits (reflecting Medicaid rules for outright transfers and transfers in trust respectively) but some policies may provide an even shorter period of coverage (usually two years) and some provide “lifetime” benefits. Aside from the obvious cost considerations, any plan that provides for less than lifetime coverage probably anticipates Medicaid as a contingent source of payment for long-term care. It is thus necessary to look at the role of long-term care insurance in Medicaid planning.

D. Long-Term Care Insurance as a Planning Tool for Medicaid Eligibility

Long term care insurance has an important role in Medicaid transfer and eligibility planning. This role is likely to increase as the changes to the Medicaid laws under the DRA begin to take effect. As all elder law practitioners are aware, the primary benefit of Partnership long-term care insurance (see below) is Medicaid Extended Coverage. That is, once the minimum benefit duration is reached, regardless of whether the policy's benefits have been exhausted, the policy holder, if *income eligible*, will be eligible for Medicaid in New York for the remainder of his or her life without consideration of his or her assets.

E. The "Partnership" Policies²⁰

While certainly subject to change post-state enactment of the DRA, a few states currently offer long-term care insurance Partnership policies.²¹ New York State offers four Partnership policies. Traditional Partnership insurance (also known and referred to "Total Asset Protection") continues to offer unlimited asset protection when the policyholder exhausts the policy benefits and applies for Medicaid Extended Coverage. Dollar for Dollar Asset Protection policies allow policyholders to establish asset protection based on the amount of benefits paid from the policy when they exhaust the policy benefits and apply for Medicaid Extended Coverage.

Regardless of the type of Partnership insurance contemplated, the following benefits must be offered by all participating insurers as part of all plans sold in New York State:²²

1. Nursing home care
2. Home care
3. Home health care
4. Personal care
5. Assisted living care
6. Skilled nursing care
7. Adult day care
8. Respite care (14 nursing-home equivalent days per year)
9. Care management (2 days of long-term care planning services by a professional)
10. Alternate level of care
11. Nursing home bed reservation (20 days per year)
12. Hospice care
13. Inflation protection equal to 5% compounded annually

The following benefits may be in addition to the core benefits and may increase the premium costs:²³

1. Waiver of premium
2. Combined home care benefit
3. Independent provider benefit
4. Non-licensed/non-certified provider benefit (not offered as part of the Dollar for Dollar 50 and Total Asset 50 policies)

Partnership policies offer a significant planning opportunity for families of relatively modest financial means. However, lack of portability of the accelerated Medicaid eligibility and estate recovery protection features to other states is a significant limitation.²⁴

F. Tax Considerations in Purchasing Long-Term Care Insurance

Federal and state law provides tax incentives for the purchase of long-term care insurance.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") offers federal tax incentives for the purchase of what are known and referred to as "qualified long-term care insurance contracts" ("Qualified Contracts").²⁵ Qualified Contracts must meet stringent requirements concerning the variety of services covered and the policy features.²⁶

For example, regardless of whether the Qualified Contract is individually purchased or provided under an employer plan, the policy is treated as accident and health insurance for purposes of the Internal Revenue Code.²⁷ Moreover, subject to certain exclusions, benefits received under a Qualified Contract are generally excludable from gross income.²⁸ Furthermore, long-term care insurance premiums may be deductible as medical expenses.²⁹

New York State law offers state tax incentives for the purchase of long-term care insurance. For example, beginning in 2005, New York State offers a twenty percent (20%) tax credit against income for premiums paid during the tax year for the purchase of or for continuing coverage under a qualifying long-term care insurance policy (subject to certain maximums).³⁰

THE DRA: THE NUTS, BOLTS AND IMPACT

While the available income tax savings will most likely not serve as an overriding factor in determining whether long-term care insurance is appropriate for the client, it may be an inadvertent benefit of purchase.

II. The Deficit Reduction Act of 2005³¹

A. Expansion of State Long-Term Care Partnership Program (Sec. 6021)

The DRA expands the number of states that may participate in qualified long-term care insurance partnership programs. A “qualified State long-term care insurance partnership” is defined in sec. 6021 as an approved state plan amendment “that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy” provided special requirements are met, including:

1. The policy covers a resident of the state at the time coverage first becomes effective.
2. The policy meets the IRS requirements for a qualified long-term care insurance policy [I.R.C. sec. 7702B(b)].
3. The policy meets 9 identified sections of the Long-Term Care Insurance Model Act and 19 identified sections of the Model Regulation of the National Association of Insurance Commissioners (“NAIC”). The State’s Insurance Commissioner must certify the policy as meeting the requirements. There is also a process permitting DHSS to adopt future revisions of the NAIC Model Act and Regulations.
4. The policy provides for “compound annual inflation protection” for individuals under age 61 as of the date of purchase, and provides “some level of inflation protection” for individuals 61 through 75. At age 76 and older, inflation protection is entirely optional.
5. The State Medicaid Agency “provides information and technical assistance to the State insurance department on the insurance department’s role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.”
6. The insurer provides regular reports to the Secretary of the U.S. Department of Health

and Human Services that include when benefits have been paid, the amount, and the termination of benefits, and such other information as the Secretary determines.

7. The state does not impose requirements on Partnership policies that it does not impose on all long-term care insurance policies.

B. Effect on Existing Participating Partnership States

For states that already have approved partnership programs (Connecticut, California, Indiana and New York), the above requirements are deemed to have been met if the Secretary determines that the state’s consumer protection standards are no less stringent than the standards applicable in the state as of December 31, 2005.

C. Ensuing Obligations of the Department of Health and Human Services

DHHS must consult with NAIC and several other constituencies in developing reporting regulations. DHSS must also develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under Partnership programs. The data set must have a centralized electronic query and report-generating mechanism.

DHSS must develop standards for “uniform reciprocal recognition” of Partnership policies across state lines, so that “benefits paid under such policies will be treated the same by all such States.” However, states will have the option of exempting themselves from the standards by notifying the Secretary in writing of the state’s election to be exempt.

DHSS must: (1) report annually to Congress on the Partnership programs, including its impact on access to care and on Medicare and Medicaid expenditures and (2) establish a National Clearinghouse for Long-Term Care Information, by means of contract or interagency agreement, that will focus on consumer information and education.

D. Effective Date

The changes concerning long-term care Partnership take effect on October 1, 2007 and apply to long-term care insurance policies sold on or after that date. Of course, New York (as of the date of submission of these materials) has yet to adopt the DRA.

III. What Does It All Mean?

Change always brings opportunity. No doubt, the DRA will bring its fair share of opportunities to elder law practitioners as we position our clients and our practices to weather the DRA.

Long term care insurance, while not a panacea, certainly appears to be an available means of protecting our clients' assets from the costs of long-term care post-DRA when other tried and true strategies are stripped away from our arsenal of asset protection tools. Since long-term care insurance provides little opportunity for clients who are, due to illness or financial limitations, unable to purchase the policies, raising the need for long-term care planning, including the potential purchase of long-term care insurance, should become a regular part of estate planning representation with all clients who wish to pass on their wealth to their loved ones.

Selected Bibliography

Carlson, E.M. Long Term Care Advocacy, Matthew Bender (1999) (regular updates).

Regan, J.J., Gilfix, M., Morgan, R.C., and English, D.M., Tax, Estate & Financial Planning for the Elderly: Forms and Practice (two vols.), Matthew Bender (1991) (regular updates).

Regan, J.J., Gilfix, M., Morgan, R.C., and English, D.M., Tax, Estate & Financial Planning for the Elderly, Matthew Bender (1985) (regular updates).

Endnotes

1. Deficit Reduction Act of 2005, Pub. Law 109-171, 120 Stat. 4.
2. The author wishes to acknowledge and thank Keith Bradoc Gallant for his gracious permission to borrow several passages from his article, *Long Term Care Insurance: Planning and Paying for Long Term Care* published in the materials presented during ALI-ABA's *Elder Law: Issues, Answers and Opportunities*, Scottsdale (Phoenix) Arizona, February 2006.
3. In some cases the purchase of long-term care insurance should be considered as an alternative to purchase of (additional) life insurance. It can also function as a means to protect life insurance policies with significant cash values since such policies, if owned by the Medicaid applicant or his or her spouse, would be considered "available" (and consequently disqualifying) assets for the purposes of determining Medicaid eligibility. A transfer of the ownership of such life insurance policies into an irrevocable trust or to most individuals would create a disqualifying "penalty period" if the transfer were within the Medicaid "look back" period.
4. Many long-term care insurance policies pay a reduced per diem benefit (often 50% of the institutionalized per diem) for home care costs.

5. For a discussion of the long-term care insurance market see, Regan, J.J., Gilfix, M., Morgan, R.C., and English, D.M., Tax, Estate & Financial Planning for the Elderly, Matthew Bender (1985) (regular updates), § 10.19. For an example of on-line marketing see www.aarp.org.
6. See, e.g., Carlson, E.M., Long Term Care Advocacy, Matthew Bender (1999) (regular updates), § 9.201 and Regan, § 10.19 [2]; see also National Association of Insurance Commissioners ("NAIC"), Sample Personal Worksheet, in Carlson, § 9.404.
7. For Medicaid planning purposes it is essential that the nature of the client's assets (exempt versus non-exempt), the sources of the client's income ("countable" investments versus an "uncounted" pension), and state specific transfer and qualification rules be understood thoroughly in order to analyze the client's eligibility for benefits.
8. Anything resembling a thorough discussion of this topic is beyond the limited scope of this article. The treatises listed in the bibliography contain excellent analyses. See, e.g., Carlson, Chapter 9.
9. See 11 N.Y.C.R.R. §§ 52.10, 52.12, 52.13, 52.16, 52.17, 52.25, 52.29 52.45, 52.65, and 52.90.
10. Older policies often include such a requirement; but many insureds need long-term care without ever entering a hospital and such a requirement is now often prohibited by state law.
11. This benefit is often equal to 50% of the institutionalized benefit (on a per diem basis); the need to submit documentation of home care cost to obtain reimbursement should be avoided, if at all possible.
12. The inability to perform a specific number of activities of daily living normally triggers coverage; activities of daily living vary by policy but typical examples are: dressing, toileting, mobility, eating, and transferring. Cognitive impairment and medical care requirements are usually additional bases to activities of daily living for triggering coverage under long-term care insurance policies.
13. For younger insureds this is obviously essential, given the ever-increasing costs of health care. Three kinds of inflation adjustment are:

(i) Compound-interest increases: The annual benefit-increases compound at 5% per year. The premium is highest on this type because this is the highest increase in benefit. This is the best choice for those under 65 because of escalating costs of health care.

(ii) Simple-interest increases: There is a 5% benefit increase each year, calculated as simple interest. This choice might be best for those are 65 to 70. The compounding interest-rate benefit doesn't overcome the simple interest-rate benefit until 12 to 14 years into the policy.

(iii) Flat benefit: There is no change in absolute value of the benefit over the years. This is the least expensive option. This is the best choice for those in their early to late 70s.

Note that inflation protection options can make premiums cost 50% more.

14. Many policies limit increases to those imposed upon a "class" of insureds (thus implicating state regulatory authorities).

THE DRA: THE NUTS, BOLTS AND IMPACT

15. Although largely a chimera, the deductibility of premiums is often used by agents as a major selling point.
16. It is important to look for highly rated carriers that have been in long-term-care insurance over the long term.
17. With an "alternate plan of care" type of policy, insureds, depending upon their needs, may be able to choose among a nursing home, assisted living, an adult day care center, or care at home.
18. Assuming the insured has met all other eligibility criteria, the elimination period is a number of days the insured must pay out of pocket before the policy benefits will begin. A longer elimination period usually means lower insurance premium. Elimination period choices are usually: 0 days, 30 days or 90 days.
19. Although some policies limit the per diem amount to actual costs incurred (known as "reimbursement" policies), others pay a fixed sum regardless of such costs once coverage is triggered (known and referred to as "indemnity" policies). Regardless of which type is selected, once the maximum benefit is exhausted, the client must either absorb the full cost of care or qualify for governmental assistance programs, such as Medicaid.
20. For a detailed discussion, see Regan, § 10.19[3].
21. These include California, Connecticut, New York and Indiana. (Note: A fifth state, Illinois, has a Partnership program which is technically still in effect but few or no policies are being sold.) Additional information concerning Partnership policies can be found by visiting www.nyspltc.org.
22. 11 N.Y.C.R.R. Pt. 39.
23. *Id.*
24. One commentator argues that it is precisely the coordination of the Partnership policies with Medicaid eligibility that has discouraged their purchase. See Carlson, § 9.15.
25. See Pub. L. No. 104-191, I.R.S. Notice 97-31 (May 6, 1997), and 63 Fed. Reg. 237 (1998).
26. See I.R.C. § 7702B.
27. *Id.*
28. *Id.* Dividends and premium refunds are generally excluded from this exemption.
29. I.R.C. § 213(d).
30. See New York State Tax Law § 606(aa).
31. Deficit Reduction Act of 2005, Pub. Law 109-171, 120 Stat. 4.

Available on the Web
Elder Law Attorney
www.nysba.org/elderlaw



Back issues of the *Elder Law Attorney* (2000-present) are available on the New York State Bar Association Web site

Back issues are available in pdf format at no charge to Section members. You must be logged in as a member to access back issues. Need password assistance? Visit our Web site at www.nysba.org/pwhelp. For questions or log-in help, call (518) 463-3200.

***Elder Law Attorney* Index**

For your convenience there is also a searchable index in pdf format. To search, click "Find" (binoculars icon) on the Adobe tool bar, and type in search word or phrase. Click "Find Again" (binoculars with arrow icon) to continue search.

Medicaid Planning: The Purchase of Life Estates

By Vincent J. Russo

Introduction

There are many Medicaid changes under the Deficit Reduction Act of 2005 (DRA) that will be devastating to seniors and people with disabilities. One of these changes may be helpful to seniors in clarifying that a purchase of a life estate in another's home may not be treated as a transfer for purposes of Medicaid eligibility, if certain conditions are met.



1. Pre-DRA Law

Under pre-DRA law, the purchase of a life estate interest in another individual's home was not a transfer of assets if the purchase was for full consideration, whether or not the purchaser resided in the home. Some practitioners were concerned that the local Medicaid agency would treat part, if not all, of the purchase as a disqualifying transfer under Medicaid.

2. Post-DRA Law

Under the DRA, the purchase of a life estate interest in another individual's home will be treated as a transfer of assets if the purchaser does not reside in the home for a period of at least one year after the date of the purchase, even if the purchase was for full consideration.

3. Language of the DRA

42 U.S.C. 1396p(c)(1)(J) provides:

For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

4. Analysis and Issues

In the past, there had been some question as to whether a purchase of a life interest in another person's home for full consideration would be treated as

a transfer by the local Medicaid agency. Now for the first time, there is a "safe harbor rule" for the purchase of a life interest in another person's home. It is now clear that if the purchaser resides in the home for at least one year after the purchase of the home for full consideration, the purchase will not be considered a transfer for purposes of Medicaid eligibility.

Residency Rule. Under a literal reading of this new statutory provision, it is clear that the purchaser will qualify for this safe harbor rule if the one year test is met by residing in the home 365 days regardless as to whether the days of residency are consecutive or not and regardless as to when the one year residency rule was met. It would be helpful if the Center for Medicare and Medicaid Services (CMS) was to confirm this position so the States or the local Medicaid agencies do not attempt to take a contrary position.

Example #1: A parent purchases a life estate interest in a child's home for full consideration and moves into the child's home. Six months later, the parent is hospitalized and then receives rehabilitation in a facility for a period of three months. The parent then returns to the home and resides there for another six months. At that point, the parent has met the one year residency requirement.

Example #2: A parent purchases a life estate interest in a child's home for full consideration and moves into the child's home and resides there for two years. Subsequently, the parent moves into an assisted living community for a period of six years, and then into a nursing facility. The parent has met the one year residency requirement even though it was a number of years prior to entering the nursing facility.

Valuation. This new provision does not change the rule that the purchase of a life estate interest must be for full consideration or else it will be considered a transfer of assets. At a practical level, two valuations will be required. First, the entire interest in the real

THE DRA: THE NUTS, BOLTS AND IMPACT

estate must be valued. Second, the life estate interest must be valued. The latter valuation raises an issue as to which method or methods will be acceptable to the local Medicaid agency. Under current Medicaid law, the HCFA (CMS) tables are applied to determine whether a Medicaid disqualifying transfer has been made. Under the HCFA tables, there is a greater value placed on a life estate interest than other tables, such as the IRA tables for valuing gifts. It is likely that the local Medicaid agency will apply the HCFA (CMS) tables. Also, how will the local Medicaid agency determine whether full consideration was received? This is not a new issue as the States have set policy as to the valuation method of real property. Should CMS direct the States as to the acceptable valuation method(s) or should the State be allowed to determine the acceptable method(s) for the valuation of a life estate interest?

5. Planning Issues

One view of this law change is that now we have a safe harbor rule which eliminates subjective intent and replaces it with a factual residency test for purposes of determining whether the purchase should be treated as a transfer. This provision now gives the senior another option which will allow the senior to remain in the community. Under existing law, a child could move into the parent's home and care for the parent for two years and then the transfer of the home at the time of institutionalization would be exempt under the Medicaid transfer penalty rules. Now, it is clear that the senior will have another choice: to move in with his or her child and purchase a life estate interest. After only one year (instead of two years) of residency in the home, the purchase by the senior will not be considered a Medicaid disqualifying transfer.

Shortening of a Penalty Period. This provision will provide a planning option for seniors who are attempting to stay in the community and protect their assets. For example, a senior may consider purchasing a life estate interest in a child's home with the senior moving into the home. After one year, the money paid to the child for the purchase of the life estate interest will not be subject to the transfer penalty rules, as long as the purchase was for full consideration.

Tax Consequences. One potential adverse consequence is the tax impact on the seller (for example, a child) who sells a life estate interest to a purchaser (for example, a parent) which would be subject to the

capital gains tax rules. If the seller meets the qualifications of Section 121 of the Internal Revenue Code, then the gain on the sale of the life estate interest would be offset by the use of the \$250,000 capital gains exclusion to the extent of the gain attributable to the life estate interest in the property.

For example, if the gain on the sale of the life estate interest was \$200,000 and the life estate interest was 50% of the value of the property, then \$100,000 of the capital gain can be offset by the \$250,000 capital gain exclusion.

Under this new rule, there will be an incentive for a child to take care of a parent for at least one year who may well need nursing home care after that time as a way to protect some or all of the parent's assets. The parent may well benefit from this new planning option by staying out of a nursing home for a period of time (at least one year).

Conclusion

Under this new provision, seniors may be able to maintain themselves in the community with the support of family members. The senior can benefit from the services provided by the child caregiver while the child benefits from the monies paid to the child by the parent. These monies can be used by the child to help the parent, even though not legally bound to do so. In many cases, this may be a much better alternative than the transfer of funds from a parent to a child which would otherwise be subject to a five year look-back and the transfer penalty start date rules.

One cautionary note: There are a number of ambiguous DRA Medicaid provisions. Until directives are issued by CMS or New York State, the elder law attorney should advise his or her clients of the uncertainty in the new laws and their impact on the client's Medicaid eligibility. At the same time, the elder law attorney will have an opportunity to advocate for his or her client by taking the most favorable interpretations under DRA, until there is certainty as to these provisions under the law.

Vincent J. Russo is the Managing Partner of the Elder Law and Estate Planning Firm of Vincent J. Russo & Associates, P.C., of Westbury, Islandia, Woodbury, and Lido Beach, New York. He is Past Chair and Co-Founder of the Elder Law Section of the NYSBA and Co-author of *New York Elder Law Practice*, published by West Group.

NEW YORK CASE NEWS

By Judith B. Raskin

Medicaid Recovery

DSS appealed from a decision denying it the right to recover from the estate of a community spouse. Denied. *Matter of Tomack*, 2006 N.Y. Slip Op 1683, 2006 N.Y. App. Div. LEXIS 2659 (March 9, 2006, App. Div. 3d Dep't).



Medicaid paid \$324,812.16 in nursing home costs for John Tomack. When his wife died, DSS claimed that she was a refusing spouse and therefore it was entitled to payment from her estate. DSS also claimed that the transfer of Mrs. Tomack's residence after Mr. Tomack's application was approved for less than adequate consideration rendered Mr. Tomack ineligible for benefits at the time they were provided. The estate argued that Mrs. Tomack was wrongfully denied her request at a fair hearing to increase her CSRA in order to raise her income to the MMMNA. Instead, the Dept. of Health allocated Mr. Tomack's Social Security to his wife, therefore raising her income to the MMMNA. Mrs. Tomack was forced to sign a spousal refusal because of the denial.

The Surrogate's Court of Saratoga County granted summary judgment to the estate and denied the DSS claim. DSS appealed.

The Appellate Division affirmed. The court said that *Robbins v. DeBuono* was good law, that Social Security benefits could not be subject to legal process and that Mrs. Tomack should have been granted a raised CSRA to supplement her income. The decision distinguishes this case and *Robbins* from *Washington State Dept. of Social and Health Services v. Guardianship Estate of Keffler*. The court dismissed the agency's argument regarding the transfer of the residence as it was transferred after the application was approved.

DSS brought an action to recover from a refusing spouse. The spouse moved to dismiss the action because DSS did not first investigate whether recovery would cause undue hardship to him. Motion denied. *Clement v. Montwill*, 2006 Slip Op 26019, 2006 N.Y. Misc. LEXIS 114 (Jan. 25, 2006, Sup. Ct., Nassau County).

Mr. Montwill's wife received institutional Medicaid for 5 years. Her Medicaid application included Mr. Montwill's statement of spousal refusal because Mr. Montwill had assets of approximately \$237,000 over

the community spouse resource allowance (CSRA). In seeking reimbursement, DSS sent Mr. Montwill several letters over a 4-year period beginning in 2000 and scheduled two conferences in 2003. Mr. Montwill did not respond. The Department then brought this action.

Mr. Montwill submitted an affirmative defense that DSS had an obligation to investigate whether the recovery would result in undue hardship to him before bringing the action for recovery. The Department moved to dismiss the defense and Mr. Montwill moved for summary judgment.

The court granted the DSS motion to dismiss the affirmative defense and denied Mr. Montwill's summary judgment motion. The provision relied upon by Mr. Montwill, subdivision 5 of Section 369 of the Social Services Law, states that recoveries for benefits correctly paid will be waived in cases of undue hardship but only regarding liens on real property and actions against a trustee. Even in those situations, the applicant for an undue hardship waiver is required to apply for the waiver. Mr. Montwill, by his actions, indicated he had no intention of applying for a waiver.

Medicaid Denials

An executor appealed, inter alia, from a decision denying a Medicaid application because an amendment making a trust irrevocable was deemed invalid. Appeal denied. *Rice Jr. v. Novello*, 2006 NY Slip Op 292, 2006 N.Y. App. Div. LEXIS 335 (Jan. 19, 2006, App. Div. 3d Dep't).

In 2001, Mr. Rice established a revocable trust appointing himself as the income beneficiary and providing that the trust agreement could not be amended by an agent. Mr. Rice had also executed a durable power of attorney appointing his daughter as attorney in fact. Although the trust agreement did not permit amendment by an agent, the power of attorney included the power to amend trusts and make them irrevocable. In 2002, Mr. Rice's daughter executed a trust amendment stating the trust was irrevocable.

In the fall of 2004, Mr. Rice's application for institutional Medicaid was denied. Medicaid deemed the trust revocable because by its terms the trust could not be amended by an agent. Five days after the denial, Mr. Rice ratified, in writing, his daughter's previous amendment. He then applied for a fair hearing, arguing that the trust was irrevocable. Mr. Rice did not prevail in the fair hearing or a subsequent article 78 proceeding. Mr. Rice's estate appealed from a lower court decision affirming the denial.

The appellate division heard the case despite initially finding that no issues of law were involved and upheld the denial. Although Mr. Rice had the ability to ratify the amendment to the trust retroactively, ratification is not effective retroactively “when the rights or interests of a third party have intervened.” In this case DSS had the right to deny the application before the ratification and the subsequent ratification had no effect on the decision.

A Medicaid applicant appealed from a Supreme Court decision denying her application based upon transfer of assets. Appeal denied. *Rogers v. Novello*, 2006 N.Y. Slip Op 610, 2006 N.Y. App. Div. LEXIS 956 (Feb. 2, 2006, 3d Dep’t).

In May 2004, Delaware County DSS denied Mrs. Rogers’ Medicaid application for nursing home benefits but approved it for other services effective February 1, 2004. The denial was based upon uncompensated transfers of assets during the look-back period for which the period of ineligibility had not yet run. The transfers at issue were

1. 12/03—\$22,000 was gifted by Mr. and Mrs. Rogers to their two children.
2. 1/04—\$15,746 of above gift was placed into a joint account with Mr. Rogers and their two children.
3. 2/04—the above \$15,746 was put in an account entirely in the children’s names.
4. 1/04—\$98,000 was transferred from Mr. and Mrs. Rogers to a joint account with Mr. Rogers and their two children.
5. 1/04—\$47,923 was transferred from Mr. and Mrs. Rogers to a joint account with Mr. Rogers and their two children.

The Department deemed two-thirds of the monies transferred to the joint account were gifts to the two children for which a period of ineligibility was incurred. One-third of that transfer was an exempt transfer to a spouse. Mr. Rogers argued that the entire account was an exempt gift as he is deemed by Medicaid to be the sole owner of the account. The Department cited the clear language of 96 ADM-8 § IV(I)(1)(b) for its conclusion that only a Medicaid applicant or recipient (A/R) is deemed to be the sole owner of a bank account when titled jointly with others. Mr. Rogers then argued the Department should have deemed him an A/R pursuant to section IV(A)(4) which states that the term A/R includes the spouse. He argued that therefore putting the children’s names on the account was not a gift and that the February 2004 redistribution to the children of \$15,746 was a post eligibility transfer and should not be penalized.

The Appellate Division, Third Dep’t, affirmed. The Department’s determination was based upon substantial evidence. Section IV(A)(4) cited by Mr. Rogers deals with creation of trusts and transfers of assets, not the ownership of a bank account. The applicant did not add her children’s names to her account but transferred the funds to another account. In addition, the removal by the children of the \$15,746 from the account indicates the children had assumed ownership rights over the account. The February 2004 retransfer to the children was not a post eligibility transfer because Mrs. Rogers’ application had not been approved.

Article 81—Validity of Will

The parties appealed from a decision in an Article 81 proceeding that invalidated executed documents except a will. Daughter sought to validate all documents. Son sought to have the will invalidated. Will invalidated. *Matter of Rita R. and Richard R.*, 2006 N.Y. Slip Op 1493, 2006, N.Y. App. Div. LEXIS 2352 (Feb. 28, 2006, App. Div., 2d Dep’t).

In 2001 and 2002, Rita R. executed a health care proxy, durable powers of attorney, a will, and an amended and restated trust agreement. Subsequently, her daughter, Andrea K., executed trust agreements as attorney in fact for her mother. In an Article 81 proceeding in 2003, Rita R. was determined to be an incapacitated person. In 2004, the Surrogate’s Court, Nassau County, invalidated all of the executed documents except for the will after determination that Rita R. was incapacitated at the time of execution.

Andrea K. appealed and argued that none of the documents should be invalidated. Rita R.’s son, Richard R., cross appealed, arguing that the will should also have been invalidated.

The Appellate Division, Second Department, held that the Surrogate’s Court properly invalidated the documents. Richard R. had provided clear and convincing evidence that his mother was incapacitated when the documents including the will were executed. The court, pursuant to its authority in MHL § 81.29(d), additionally invalidated the will.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky. She is a Certified Elder Law Attorney (CELA); and maintains memberships in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau County, Inc., and NYS and Nassau County Bar Associations. She is the current chair of the Legal Advisory Committee of the Alzheimer’s Association, Long Island Chapter.

MEDIATION NEWS

By Robert A. Grey

Welcome back to Elder Law Mediation! We actively solicit your mediation questions, comments and experiences, positive or negative. Please send them to Robert A. Grey, Esq., 38 Stiles Drive, Melville, NY 11747-1016 or rgrey@nysbar.com.

Some Thoughts on Conflict

Conflict is unavoidable in an Elder Law practice. There may be conflict between a client and family members, or conflict with a service or health care provider. There might even be conflict between you and your client (of the non-ethical variety of course). Conflict may exist within your law office. It would be a safe bet to say that there is conflict in your home.

In short, there is conflict or the potential for conflict in virtually every facet of our lives and our clients' lives. I would like to share some thoughts on conflict with you; they may help reduce the level of stress in your life or the life of a client. It is axiomatic that stress leads to shorter and less healthy lives. Vocalizing any of these thoughts at the mediation table often has a positive effect on the participants. I hope they can have a positive effect for you, a client or a loved one. Please feel free to use them yourself or share them with others. The sayings without attribution were written by me.

*Conflict and change are intertwined.
No matter which comes first, the
other follows.*

*The road to Resolution passes
through Conflict.*



Conflict is inevitable, but combat is optional.

Max Lucade

The most intense conflicts, if overcome, leave behind a sense of security and calm that is not easily disturbed. It is just these intense conflicts and their conflagration which are needed to produce valuable and lasting results.

Carl Gustav Jung

Change means movement. Movement means friction. Only in the frictionless vacuum of a nonexistent abstract world can movement or change occur without that abrasive friction of conflict.

Saul Alinsky

Remember, a kite rises against, not with, the wind.

Hamilton Mabie

Life is a grindstone. Whether it grinds us down or polishes us up depends on us.

Thomas L. Holdcroft

Florida Legislature Proposes Bill to Implement Provisions of the Deficit Reduction Act of 2005

By Howard S. Krooks and Scott Solkoff

There is a bill pending in the Florida Legislature (Senate Bill 2532) that attempts to implement at least part of the Deficit Reduction Act of 2005 (the "DRA").

A summary of the bill's more significant provisions (as it exists at the time of this writing in late April 2006) is set forth below:



Howard S. Krooks

1. The new asset transfer provisions would be effective for transfers made on or after October 1, 2006. The other parts of the bill, if passed into law, would become effective on July 1, 2006.
2. The penalty period for transfers begins on the first day of the month in which the individual applies for Medicaid and is otherwise eligible.
3. The Agency for Health Care Administration (similar to the Department of Health in New York) is required to create a method to reimburse facilities receiving Medicaid dollars for bad debts incurred as a result of penalties applied to applicants, during which periods the facility would otherwise have to provide care without payment. This would apply for two years after passage of the federal DRA.
4. Individuals who enter into a Personal Services Contract with a relative will be considered to have transferred assets without fair compensation unless all of the following criteria are met:
 - a. The contracted services do not duplicate services available through other source providers, such as Medicaid, Medicare, private insurance, or another legally obligated third party;
 - b. The contracted services directly benefit the individual and are not services normally provided out of love and consideration for the individual;
 - c. The actual cost to deliver services is computed in a manner that clearly reflects the actual number of hours to be expended,

and the contract clearly identifies each specific service and the average number of hours of each service to be delivered each month;



Scott M. Solkoff

- d. The hourly rate for each contract service must be equal to or less than the amount normally charged by a professional who traditionally provides the same or similar services;
 - e. The contracted services are provided on a prospective basis only (contract cannot allow for reimbursement of past services);
 - f. The contract must provide fair compensation to the individual in his/her lifetime according to life expectancy tables adopted in Florida.
5. A financial instrument signed within the new 5-year look-back period that allows deferred, graduated, balloon payments, or debt forgiveness will be considered a countable asset to the extent of the outstanding value of the financial instrument when determining Medicaid eligibility.
 6. The following limitations apply to annuities purchased by the applicant or the applicant's spouse on or after October 1, 2006 (excluded from these rules are work-related pension annuities, such as civil service annuities, railroad retirement annuities, or similar pension annuities), such that the annuity must:
 - a. Be purchased from an insurance company or financial institution that is subject to licensing or regulation by the Office of Insurance Regulation or a similar regulatory agency of another state;
 - b. Be irrevocable;
 - c. Pay out principal and interest in equal monthly installments within the annui-

tant's life expectancy based on the life expectancy table used by the Social Security Administration or based on a shorter life expectancy, if the annuitant has a condition that would shorten the annuitant's life and that was diagnosed by a physician before funds were placed into the annuity;

- d. Name the State of Florida or the Agency for Health Care Administration, or its successor agency, as the beneficiary of any funds remaining in the annuity, not to exceed the amount of any Medicaid funds paid on the individual's behalf during his or her lifetime (this applies only to the applicant's annuity and does not apply to the spouse's annuity if the spouse is not also seeking Medicaid benefits).

If all of the foregoing criteria are not met, the annuity's fair market value is counted as a resource in the amount of its fair market value with the following exception: When an annuity does not provide for payout of principal and interest in equal installments within the annuitant's lifetime and the issuing company indicates the payout arrangement cannot be changed, the annuity will be excluded as a resource if the contract is amended to name the State of Florida as the beneficiary of any funds remaining in the annuity, not to exceed the amount of Medicaid funds paid on the individual's behalf during his or her lifetime.

7. The income first rule would apply when the spouse requests an adjustment in support from the applicant spouse's income or an increase in the resource allowance, such that

all income (community spouse and applicant) must be considered before raising the community spouse's income or resource allowance.

There is no House companion bill to Senate Bill 2532. Furthermore, as of the time of this writing in late April 2006, there is no proposed rulemaking designed to implement the DRA. We will keep readers posted as to any developments regarding the implementation of the DRA in Florida.

Howard S. Krooks, J.D., CELA, is a partner in Elder Law Associates, P.A., with offices located in Boca Raton, Aventura, Wellington, West Palm Beach and Weston, Florida. Mr. Krooks also serves as Of Counsel to Littman Krooks LLP, with offices located in New York City and White Plains, New York. Mr. Krooks is a Past Chair of the Elder Law Section of the New York State Bar Association where he is the Co-Chair of the Compact Working Group. He is a member of the Joint Public Policy Task Force of the Florida Bar Elder Law Section and the Academy of Florida Elder Law Attorneys. He also is Certified as an Elder Law Attorney by the National Elder Law Foundation and currently serves on the Board of Directors of the National Academy of Elder Law Attorneys. Mr. Krooks may be reached at hkrooks@elderlawassociates.com or (561) 750-3850.

Scott Solkoff, Esq. is a former Chair of the Florida Bar's Elder Law Section and a principal with Solkoff Associates, P.A., a law firm exclusively representing the interests of the elderly and disabled throughout Florida.

FAIR HEARING NEWS

By Ellice Fatoullah and René H. Reixach

We actively solicit receipt of your fair hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your fair hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or René H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.



Ellice Fatoullah

In the Matter of the Appeal of A. C.

Holding

Income of a disabled individual over the age of 65 placed in a Supplemental Needs "Pooled" Trust will reduce the individual's net available monthly income ("NAMI") by the amount of the income placed in the Trust.

Findings of Fact

On January 27, 2004, the Appellant, age 77, applied for Medical Assistance for a household of one consisting of the Appellant. At that time, the Appellant claimed to be disabled.

The Appellant resides at the Palm Beach Adult Home in Brooklyn, New York.

On June 8, 2004, the Agency determined to accept the Appellant's application for Medical Assistance subject to a monthly spenddown of \$1,926.00 retroactive to February 1, 2004.

On July 6, 2004, David Churba, Committee of the Appellant, signed a Sponsor/Participant Agreement and created a Trust Account under the Lifetime Care Foundation For the Jewish Disabled Inc. Community Trust II. The Trustees accepted this agreement.

The Appellant is not contesting any spenddown for the period of January 2004 through June 30, 2004.

In 2005, the Appellant is in receipt of gross monthly Social Security benefits in the amount of \$739.20 and Veteran's Disability pension in the amount of \$2,239.00, the amounts of which are not in dispute herein.

By a notice dated February 13, 2005, the Agency advised the Appellant of its determination to reduce the Appellant's Medical Assistance by increasing the Appellant's monthly excess to \$2,267.00.

The Appellant requested this fair hearing to review the Agency's determinations.



René H. Reixach

Applicable Law

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, Food Stamp benefits or services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, Food Stamp benefits or services, the social services agency must establish that its actions were correct. 18 N.Y.C.R.R. § 358-5.9(a).

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law § 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result—net income—is compared to the statutory "standard of need" set forth in Social Services Law § 366.2(a)(7) and 18 N.Y.C.R.R. Subpart 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

The amount by which net income exceeds the standard of need is considered "excess income." If

the applicant or recipient has any excess income, he/she must incur bills for medical care and services equal to or greater than that excess income to become eligible for Medical Assistance. In such instance Medical Assistance coverage may be available for the medical costs which are greater than the excess income. If a person has expenses for in-patient hospital care, the excess income for a period of six months shall be considered available for payment. For other medical care and services the excess income for the month or months in which care or services are given shall be considered available for payment of such care and services. 18 N.Y.C.R.R. §§ 360-4.1, 360-4.8.

Regulations at Section 360-4.6(a) list the income which is disregarded for all applicants for or recipients of Medical Assistance except for those who are being budgeted using Safety Net criteria.

Regulations at 18 N.Y.C.R.R. § 360-4.6 provide for additional income disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled. These disregards include:

- The first \$20 per month of any unearned income. Only one \$20 disregard is permitted per couple. A certified blind or certified disabled child living with parents is entitled to a separate \$20 disregard from his/her total unearned income. If a person's unearned income is under \$20, the balance will be deducted from earned income;
- Health insurance premiums.

Administrative Directive 87 ADM-4 provides detailed instructions regarding the appropriate application of medical bills to offset excess income so that an individual can become eligible for Medical Assistance. This offsetting process is called "spenddown." The Directive further provides that whenever a spenddown is indicated, the Agency is required to include a copy of the letter "Explanation of the Excess Income Program" along with the Notice to the recipient whenever an acceptance, intended change, denial, or discontinuance indicates a spenddown liability situation. Administrative Directive 87 ADM-4 provides that some over-the-counter drugs and medical supplies such as bandages and dressings may be applied to offset determined excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items may not be so applied.

Section 7-1.12(a)(5) of the Estate, Powers and Trusts Law (EPTL) states in part that:

"Supplemental needs trust" means a discretionary trust established for the

benefit of person with a severe and chronic or persistent disability (the "beneficiary") which conforms to all of the following criteria:

(i) The trust document clearly evidences the creator's intent to supplement, not supplant, impair or diminish, government benefits or assistance for which the beneficiary may otherwise be eligible or which the beneficiary may be receiving, except as provided in clause (ii) of the subparagraph;

(ii) The trust document prohibits the trustee from expending or distributing trust assets in any way which may supplant, impair, or diminish government benefits or assistance for which the beneficiary may otherwise be eligible or which the beneficiary may be receiving; provided, however that the trustee may be authorized to make such distributions to third parties to meet the beneficiary's needs for food, clothing, shelter or health care but only if the trustee determines (A) that the beneficiary's basic needs will be better met if such distribution is made, and (B) that it is in the beneficiary's best interests to suffer the consequent effect, if any, on the beneficiary's eligibility for or receipt of government benefits or assistance;

(iii) The beneficiary does not have the power to assign, encumber, direct, distribute or authorize distributions from the trust.

(iv) If an inter vivos trust, the creator of the trust is a person or entity other than the beneficiary or the beneficiary's spouse.

Social Services Law § 366(2)(b)(2)(iii) provides in part that

[n]otwithstanding the provisions of clauses (i) and (ii) of the subparagraph, in the case of an applicant or recipient who is disabled, as defined . . . in the federal social security act, the department must not consider as available income or resources the corpus or income of the following trusts which comply with the provi-

sions of the regulations authorized by clause (iv) of this subparagraph; (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of the disabled individuals, but, for the purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust funds are established solely for the benefit of individuals who are disabled as such term is defined . . . in the federal social security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and to the extent that amounts remaining in the individuals account are not retained by the trust upon the death of the individual, the state will receive all such remaining amounts up to the total value of all medical assistance paid on behalf of such individual.

Section 360-4.5 (b)(5) provides that the principal and income of the following trusts must not be considered as available income or resources: (a) a trust containing the assets of a disabled individual if the trust was created for the benefit of the disabled individual when the disabled individual was under the age of 65; the trust was established by a parent, grandparent legal guardian, or court of competent jurisdiction; and the trust agreement provides that upon the death of the individual the State must receive all amounts remaining in the trust up to the total value of all MA paid on behalf of the individual. (b) A trust containing the assets of a disabled individual if the trust is established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts; each account in the trust is established solely for the benefit of a disabled individual

by the individual, by the parent, grandparent, or legal guardian of the individual, or by a court of competent jurisdiction; and upon the individuals death amounts remaining in the individuals account which are not retained by the trust must be paid to the State up to the total value of all MA paid on behalf of the individual.

Administrative Directive 96 ADM-8 provides for the treatment of trusts in the Medical Assistance program. Section IV of Administrative Directive 96 ADM-8 states in pertinent part:

DEFINITIONS:

* * *

7. Trusts

In general, a trust is a legal instrument by which an individual gives control over his/her assets to another (the trustee) to disburse according to the instructions of the individual creating the trust. There are a number of different types of trusts, including escrow accounts and investment accounts.

* * *

b. Exception trusts—Exception trusts are trusts which are required to be disregarded as available income and resources for purposes of determining MA eligibility pursuant to the provisions of Section 366(2)(b)(2)(iii) of the Social Services Law and 18 NYCRR 360-4.5(b)(5).

[N.B., a letter dated September 23, 1997, from the Director of the Office of Medicaid Management for the NYS Department of Health, advises that the following sentence should be added at this point in the paragraph:

While most exception trusts are created using the individuals resources, some may be created using the individual's income, either solely or in conjunction with resources. Income diverted directly to a trust or income received by an individual and then placed into a trust is not counted as income to the individual for Medicaid eligibility purposes. Verification that the income was placed into the trust is required. In order to eliminate the need to verify this on a

monthly basis, it is recommended that you advise the recipient to divert the income directly to the exception trust.]

Exception trusts generally will conform to the definition of supplemental needs trusts found in Section IV.A.7.e of this ADM. There are two types of exception trusts.

i. One type of exception trust is a trust created for the benefit of a disabled person under the age of 65. It must:

- be created with the individual’s own assets,

- be created by the disabled person’s parent or grandparent, legal guardian of the individual, or by a court of competent jurisdiction, and

- include language specifying that upon the death of the disabled person, the social services district will receive all amounts remaining in the trust, up to the amount of MA paid out on behalf of the individual.

Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets, and would require the imposition of a penalty period. It is the Department’s position that if a district has imposed a Social Services Law Section 104-b or Section 369 lien against assets to be used to establish an exception trust, the district should attempt to have the lien satisfied (or, in the district’s discretion, compromised) before the trust is established. Litigation is pending on the issue of whether enforcing such liens is allowed when the assets are to be put into an exception trust; when this litigation is concluded, the Department will notify districts promptly of the outcome and of an necessary policy changes. . . .

e. Supplemental Needs Trust (SNT)—A supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trusts Law, is a

trust established for the benefit of an individual of any age with a severe and chronic or persistent impairment, designed to supplement government benefits for which the individual is otherwise eligible. Under the terms of such a trust:

- i. the beneficiary does not have the power to assign, encumber, direct, distribute, or authorize distributions from the trust; and

- ii. the trust document generally prohibits the trustee from expending funds in any way that would diminish the beneficiary’s eligibility for or receipt of any type of government benefit.

Attachment II to Administrative Directive 96 ADM-8 provides suggested procedure for monitoring exception trusts.

Discussion

On January 27, 2004, the Appellant filed an application for Medical Assistance and made a claim that he was disabled.

On June 8, 2004, the Agency determined to accept the Appellant’s application for Medical Assistance subject to a monthly spenddown of \$1,926.00 retroactive to February 1, 2004.

The Appellant, through his attorney, is not disputing the income utilized by the Agency in its determination nor is the spenddown for the period of January 1, 2004 through June 30, 2004 being contested.

The record establishes that on September 16, 1977, Lifetime Care Foundation For the Jewish Disabled Inc., established the Lifetime Care Foundation for the Jewish Disabled Inc. Community Trust II.

The uncontroverted evidence establishes that on July 6, 2004, the Appellant’s brother, as the Committee for the Appellant, signed a Sponsor/Participant Agreement and created a Trust Account on behalf of the Appellant under the Lifetime Care Foundation for the Jewish Disabled Inc. Community Trust II. The trustees accepted this agreement. It seems that this is a “Pool Trust.” The Sponsor/Participant Agreement states that an initial sum of \$1,926.00 was placed with the trustees.

The Appellant’s attorney contends that the Appellant should not have been subject to a spenddown since July 1, 2004 because \$1,926.00 of his income has been deposited into a “pool trust” on an ongoing basis since executing a joinder agreement

with the Lifetime Care Foundation for the Jewish Disabled Community Trust II on July 6, 2004. By a letter dated July 23, 2004 addressed to the Human Resources Administration, the Appellant's attorney advised the Agency that the Appellant had established a "Supplemental Needs Trust" and submitted supporting documentation.

A Supplemental Needs Trust may be utilized by those who are 65 years of age and over if they are disabled. The Appellant contends that he is disabled, submitting medical evidence in support including an eye exam report dated May 9, 2002 where the Appellant was diagnosed as blind in both eyes, July 31, 2002 doctor's letter stating that the Appellant was registered with the New York State Commission for the Blind and Visually Handicapped, and a May 15, 2005 doctor's letter stating that the Appellant is suffering from multiple medical problems.

It is noted that being in receipt of disability benefits from the Veterans Administration does not establish disability under the SSI Regulations.

Upon the January 27, 2004 application, copy submitted by the Agency, the Appellant notified the Agency that he was asserting a claim that he was disabled. The Agency failed to make an evaluation of the Appellant's disability at the time of its June 8, 2004 determination, copy submitted by the Appellant. Thus, the Agency's determinations that the Appellant would be subject to a monthly spenddown are not supported by the record.

The Appellant's representative is advised that he has an obligation to verify to the Agency in a timely manner of all payments deposited with the Lifetime Care Foundation for the Jewish Disabled Community Trust II.

Decision and Order

The Agency's determination as to the Appellant's monthly excess income for the purpose of computing Medical Assistance is not correct and is reversed.

The Agency's determination dated February 13, 2005 to reduce the Appellant's Medical Assistance is not correct and is reversed.

The Agency is directed to provide the Appellant with an opportunity to submit a completed disability form DSS-486 and other supportive medical documentation necessary to establish disability status at the time of the Medical Assistance application.

The Agency is directed to make a determination regarding the Appellant's disability status.

The Agency is directed to recompute the Appellant's eligibility for Medical Assistance benefits for

the period July 1, 2004 to the present, taking into account that the Appellant as a disabled person may be eligible to create a "pool trust" and has made deposits to the Lifetime Care Foundation for the Jewish Disabled Community Trust II.

Thereafter, the Agency is directed to render a new determination regarding the Appellants eligibility for Medical Assistance and to advise the Appellants Committee and attorney in writing of its determination.

Should the Agency need additional information from the Appellant's representatives in order to comply with the above directives, it is directed to notify the Appellant's representatives promptly in writing as to what documentation is needed. If such information is requested, the Appellant's representatives must provide it to the Agency promptly to facilitate such compliance.

Editor's Comment

This decision raises many important issues. First, Medicaid must be provided with a \$0.00 NAMI in the instant case because income is resources for transfer of assets purposes, 42 U.S.C. § 1396p(e)(1); and transfers of income belonging to a disabled individual over the age of 65 into a pooled trust, validly created in accordance with 42 U.S.C. § 1396p(d)(4)(C), while not ordinarily exempt under federal law, 42 U.S.C. § 1396p(c)(2)(B)(iii), are exempt in New York State, so long as the transfer is a "fractional" transfer, i.e., a transfer in an amount which is less than the average cost of a nursing home for the month. In the case of a monthly fractional transfer, the amount transferred is rounded down and disregarded. No transfer of asset penalty period is applied. 96 ADM-8. Thus, a disabled individual over 65 years old can transfer his or her income into a pooled trust—so long as the income is less than the average cost of a nursing home in the individuals locality—have the income disregarded, and require Medicaid to reduce the NAMI by the amount transferred.

The problem in the instant case was that the NYC Department of Social Services did not honor the pooled income trust. This fair hearing, therefore, establishes the principle that the local Agency must reduce the NAMI by the amount of income transferred to the pooled trust—even if the disabled individual is over 65.

Second, this fair hearing raises the important planning point that it is probably best to get your home care case established, get the client's hours set, and then go for the reduction of the NAMI by transferring income into a pooled trust. As the instant case shows, the pooled trust was not established at the point of initial eligibility.

Third, and unfortunately, this case also raises the issue of how the Deficit Reduction Act of 2005 will be applied to pooled income trusts established for those over 65. Under the new law, the DRA requires States to impose penalty periods for assets (or income) creating a penalty period of a partial month. DRA of 2005, Section 6016, amending 42 U.S.C. § 1396p(c)(1)(E). Thus, New York State is constrained—for transfers made after February 8, 2006 (when the new law was enacted)—to deny cases where fractional penalty periods are created by transferring income into a pooled trust, such as was done in this case. Whether the State will actually do this—as of February 8th—is another matter. But attorneys should counsel their over 65-year-old clients with existing pooled income trusts that they may be acting at their peril. Also, elder care attorneys should know that establishing pooled income trust for those over 65 after February 8th is now problematical.

There is at least one possible way to save both existing and future trusts. New York State could allow income pooled trusts to continue as a hardship exception to the transfer of assets rules in instances where it is shown that the trust is necessary to keep the individual at home, and without such a trust the individual would be deprived of his or her existing shelter. *See* DRA of 2005, § 6011 (d), amending 42 U.S.C. § 1396p(c)(2)(D), giving the States the discretion to establish a hardship waiver where imposition of the transfer of assets rules would deprive the individual of “food, clothing, shelter, or other necessities of life.”

The Appellant at this Fair Hearing was represented by **Charles Goldfarb, Esq.**, of Brooklyn, New York.

Copies of the fair hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnyslc.net/fairhearingbank

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality

of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimers Association, NYC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to serve on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State Legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her along with René Reixach, the first Outstanding Practitioner Award “in recognition of her dedication and achievements in the practice of Elder law.”

René H. Reixach is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Law Practice Group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the *Rochester Business Journal* and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach's civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.

GOLDEN STATE NEWS

Not Happy with the DRA? Consider Moving to California

By Steven M. Ratner

Are you concerned about the practice of elder law after the passage of the Deficit Reduction Act of 2005? Are you scrambling to CLE classes to learn what the new law means? Do you yearn for the good old days before the passage of OBRA in 1993?

Perhaps you should think about moving to California. Not only do we have the best weather in the country (at least here in San Diego), we also have the most generous Medicaid program (called Medi-Cal in the Golden State).

I thought New York had the most generous Medicaid program. Little did I know that California had yet to implement many of the reform provisions in OBRA 1993, yet alone even start considering how to implement the DRA.

This article provides a brief overview of the Medi-Cal program in California:

- The Medi-Cal program is administered at the state level by the Department of Health Services (DHS). Applications are filed at the local level in each county.
- Unlike New York, there is no elder law section of the California State Bar. The majority of training and advocacy is conducted by the California Advocates for Nursing Home Reform (CANHR). CANHR provides education on two fronts: Medi-Cal and litigation against nursing homes. The National Academy of Elder Law Attorneys (NAELA) has two chapters in California, a Southern and Northern Chapter. The local NAELA chapters provide education through quarterly meetings.
- Medi-Cal is provided to the categorically eligible (those on SSI) and those who are Medically Needy (those on spenddown). For seniors, the primary benefit is long-term care coverage in skilled nursing facilities. Home care coverage is very limited and is similar in scope to the home care benefit under Medicare.
- The resource limit in California is \$2,000. The MMMNA in 2006 is \$2,489 and the CSRA is \$99,540. California law permits an increase in the MMMNA and the CSRA through both administrative and civil hearings. Local attorneys have had success in civil hearings, and this is the preferred route.
- California's look back is 30 months (pre-OBRA law) for outright transfers and 60 months for trust-related transfers.
- California also does not impose a transfer penalty on the transfer of an exempt asset (for example, the homestead). An applicant who owns a homestead



may give that homestead to *anyone* without incurring a transfer penalty. The transfer can take place before or after an applicant enters a nursing home. No lien is placed on the homestead where the applicant declares an intent to return home (a subjective standard).

- The Average Private Pay Rate is \$5,031 in 2006. California rounds down partial months. The state also starts the clock on the first of the month of transfer. *Example:* A gift of \$10,000 on January 31, will incur a one-month penalty from January 1 to January 31.

- California also does not aggregate gifts. Thus, staggered gifts can be made each month to shorten the penalty period. The policy debate here is not whether staggered gifts are appropriate, but whether to stagger gifts on a daily, weekly, or monthly basis. A well-respected commentator believes that monthly gifts are appropriate, but daily or weekly gifts are abusive.
- California also does not impose a transfer penalty on income. Thus, an inheritance or other windfall may be given away during the month of receipt without incurring a penalty.
- With respect to estate claims, California will impose a claim against both probate and non-probate assets. Proposed regulations issued recently allow for recovery against annuities and life estates.

At a recent meeting of the local NAELA chapter, the leadership was reluctant to even discuss the impact of the DRA on the practice of elder law in California. The consensus was that until California conforms its law to the DRA, discussion of the DRA was simply speculation. Frankly, I believe local practitioners are short-sighted. But considering that 13 years after OBRA, the state has yet to enact many of those reforms, perhaps my local colleagues are right.

Steven M. Ratner practices elder law with offices at 11622 El Camino Real, Suite 100, San Diego, CA 92130. Mr. Ratner can be reached by e-mail at smr_law@yahoo.com or by telephone at 800-836-1124. Mr. Ratner is the immediate past Editor of the *Elder Law Attorney* and a former member of the Executive Committee of the Elder Law Section of the NYSBA. Mr. Ratner is of counsel to Littman Krooks LLP with offices in White Plains and Manhattan.

Section Committees and Chairs

Burial Rights Legislation

Michel Haggerty
6367 Mill Street
Rhinebeck, NY 12572
(845) 876-3300

Bylaws

Joan L. Robert
Kassoff Robert Lerner & Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Client and Consumer Issues

Margaret Z. Reed
The Law Office of
Margaret Z. Reed
203 Delaware Avenue
Delmar, NY 12054
(518) 439-6001

Coalition of Bar Advocates

Walter T. Burke
Burke & Casserly, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

Communications

Steven T. Rondos
Raia & Rondos
466 Bay Ridge Parkway
Brooklyn, NY 11209
(718) 833-6338

Elder Law Practice

Sharon Kovacs Gruer
Sharon Kovacs Gruer, P.C.
1010 Northern Boulevard, Suite 302
Great Neck, NY 11021
(516) 487-5400

Estate and Tax Planning

Michael J. Amoruso
Amoruso & Amoruso, LLP
2975 Westchester Avenue, Suite 207
Purchase, NY 10577
(914) 253-9255

Family Law Issues

Rita K. Gilbert
Hyman & Gilbert
1843 Palmer Avenue
Larchmont, NY 10538
(914) 833-5297

Financial Planning and Investments

Timothy E. Casserly
Burke & Casserly, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

Guardianships and Fiduciaries

Hon. Charles F. Devlin
Office of Court Administration
Guardian and Fiduciary Services
140 Grand Street, Suite 701.
White Plains, NY 10601
(914) 824-5721

Anthony J. Enea
Enea, Scanlan & Sirignano LLP
245 Main Street, 3rd Floor
White Plains, NY 10601
(914) 948-1500

Health Care Issues

Ellyn S. Kravitz
Littman Krooks LLP
655 Third Avenue, 20th Floor
New York, NY 10017
(212) 490-2020

Insurance

Bruce L. Birnbaum
1025 Old Country Road, Suite 325
Westbury, NY 11590
(516) 794-9696, ext. 21

Leadership Task Force

Michael J. Amoruso
Amoruso & Amoruso, LLP
2975 Westchester Avenue
Suite 207
Purchase, NY 10577
(914) 253-9255

Legal Education

Bernard A. Krooks
Littman Krooks LLP
81 Main Street
White Plains, NY 10601
(914) 684-2100

Liaison to the Judiciary

Hon. Edwin Kassoff
Kassoff Robert Lerner &
Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Liaison to Law School Professors and Students

Rose Mary K. Bailly
Law Review Commission
80 New Scotland Avenue
Albany, NY 12208
(518) 472-5858

Liaison to Legal Services and Nonprofit Organizations

Valerie J. Bogart
Selfhelp Community Services Inc.
520 Eighth Avenue, 5th Floor
New York, NY 10018
(212) 971-7693

Liaison to Public Agency and Legislation

Ronald A. Fatoullah
Ronald Fatoullah & Associates
425 Northern Boulevard, Suite 20
Great Neck, NY 11021
(516) 466-4422

Litigation

Gary E. Bashian
Bashian & Farber, LLP
235 Main Street, 6th Floor
White Plains, NY 10601
(914) 946-5100

Living Will Legislation

Amy S. O'Connor
McNamee, Lochner, Titus &
Williams, P.C.
677 Broadway, P.O. Box 459
Albany, NY 12201
(518) 447-3335

Stephen J. Silverberg
Certilman Balin Adler Hyman LLP
90 Merrick Avenue, 8th Floor
East Meadow, NY 11554
(516) 296-7044

Lobbying

Howard S. Krooks
Elder Law Associates, P.A.
7000 W. Palmetto Park Road
Boca Raton, FL 33433
(561) 750-3850

Vincent J. Russo
Vincent J. Russo & Associates, P.C.
1600 Stewart Avenue, Suite 300
Westbury, NY 11590
(516) 683-1717

Long-Range Planning

Ami S. Longstreet
Mackenzie Hughes LLP
101 S. Salina Street, Suite 600
Syracuse, NY 13202
(315) 233-8263

Ellen G. Makofsky
Raskin & Makofsky
600 Old Country Road, Suite 444
Garden City, NY 11530
(516) 228-6522

Long Term Care Reform

Louis W. Pierro
Pierro & Associates, LLC
20 Corporate Woods Boulevard
3rd Floor
Albany, NY 12211
(518) 459-2100

Medicaid

René H. Reixach
Woods Oviatt Gilman LLP
2 State Street, Suite 700
Rochester, NY 14614
(585) 987-2858

Medicaid Legislation

Howard S. Krooks
Elder Law Associates, P.A.
7000 W. Palmetto Park Road
Boca Raton, FL 33433
(561) 750-3850

Vincent J. Russo
Vincent J. Russo & Associates, P.C.
1600 Stewart Avenue, Suite 300
Westbury, NY 11590
(516) 683-1717

Membership Services

Martin B. Petroff
Lamson & Petroff
9 East 40th Street, 13th Fl.
New York, NY 10016
(212) 447-8690

Persons Under Disability

Joan L. Robert
Kassoff Robert Lerner &
Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Power of Attorney Legislation

Robert Kruger
225 Broadway, Room 4200
New York, NY 10007
(212) 732-5556

Publications

Anthony J. Enea
Enea, Scanlan & Sirignano LLP
245 Main Street, 3rd Floor
White Plains, NY 10601
(914) 948-1500

Real Estate and Housing

Neil Rimsky
Cuddy & Feder, LLP
90 Maple Avenue
White Plains, NY 10601
(914) 761-1300, ext. 224

Technology

David Goldfarb
Goldfarb Abrandt Salzman &
Kutzin LLP
350 Fifth Avenue, Suite 1100
New York, NY 10118
(212) 387-8400

Catch Us on the Web at
WWW.NYSBA.ORG/ELDERLAW



ELDER LAW ATTORNEY

Section Officers

Chair

Ellen G. Makofsky
Raskin & Makofsky
600 Old Country Road, Suite 444
Garden City, NY 11530
(516) 228-6522

Chair-Elect

Ami S. Longstreet
Mackenzie Hughes LLP
101 S. Salina Street, Suite 600
Syracuse, NY 13202
(315) 233-8263

Vice-Chair

Timothy E. Casserly
Burke & Casserly, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

Secretary

Michael J. Amoruso
Amoruso & Amoruso, LLP
2975 Westchester Avenue, Suite 207
Purchase, NY 10577
(914) 253-9255

Treasurer

Stephen J. Silverberg
Certilman Balin Adler Hyman LLP
90 Merrick Avenue, 8th Floor
East Meadow, NY 11554
(516) 296-7044

Elder Law Attorney is published by the Elder Law Section of the New York State Bar Association. Members of the Section receive a subscription to the publication without a charge.

© 2006 by the New York State Bar Association.
ISSN 1070-4817

Editor-in-Chief

Anthony J. Enea
Enea, Scanlan & Sirignano LLP
245 Main Street, 3rd Floor
White Plains, NY 10601
(914) 948-1500
Fax: (914) 948-9316

Board of Editors

Vincent Mancino
Littman Krooks LLP
81 Main Street
White Plains, NY 10601
(914) 684-2100
Fax: (914) 684-9865

Joan L. Robert
Kassoff Robert Lerner & Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700
Fax: (516) 766-0738

Brian Andrew Tully
444 New York Avenue
Huntington, NY 11743
(631) 424-2800
Fax: (631) 271-9084



Elder Law Section
New York State Bar Association
One Elk Street
Albany, New York 12207-1002

ADDRESS SERVICE REQUESTED

NON PROFIT ORG.
U.S. POSTAGE
PAID
ALBANY, N.Y.
PERMIT NO. 155