SUFFOLK ACADEMY OF LAW
The Educational Arm of the Suffolk County Bar Association
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The Good, The Bad, And The Ugly
Annuities in Elder Law Planning

FACULTY:

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The Toli Center East

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July 26, 2018
Suffolk County Bar Center, NY

The Good, the Bad, and the Ugly

Annuities in Elder Law Planning
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Henry Montag, an Independent Certified Financial Planner, has been in practice since 1976 with offices located on Long Island, NY. He is a principal of The TOLI Center East, providing independent consultative fee-based, individual & Trust Owned life Insurance performance evaluations for high net worth clientele, their trustees, advisors and Family Offices.

Authoring many articles including the *New York State Bar Association*, NYSSCPA's *Tax Stringer*, *Tax Facts*, *Trusts & Estate Magazine*, & *Accounting Today*, Montag has provided CLE & CPE credits at lectures to the New York State Bar Association, the New York State Society of CPAs, The American Institute of CPAs, and the National Conference of CPA Practitioners. He co-authored an American Bar Association Flagship publication titled; "*The Advisors &Trustees Guide to Managing Risk & Avoiding a Client Crisis* "*Jan 2017*.

Montag is a source for prestigious publications including The Wall Street Journal, Investor's Business Daily, Investment News, Long Island Business News, Wealth Management, Trust & Estates, National Underwriters Tax Facts, and Financial Planning magazine. He also appeared on Fox Business News, News 12 Business News, and 'Wall Street Week.'

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WELCOME

SUFFOLK ACADEMY OF LAW

July 26, 2018

WHAT THE ATTORNEY SHOULD KNOW

ABOUT

ANNUITIES

Annuity Defined

- Annuity (n.) a specified income payable at stated intervals for a fixed or a contingent period, often for the recipient's life, in consideration of a stipulated premium paid either in prior installment payments or in a single payment.

Annuitization

- Converting a deferred annuity to an guaranteed lifetime income stream .

- •Immediate annuities are "annuitized at issue"

Annuity Objectives

In planning for financial security in retirement, an annuity can help satisfy two basic objectives:

To accumulate retirement assets on a tax-deferred basis.

If you're already contributing the maximum to IRAs and any employer-sponsored retirement plans and need to save more for retirement, a deferred annuity may be the answer to your retirement savings need.

To convert retirement assets into an income that you cannot outlive.

On the other hand, if you're near or at retirement, an immediate income annuity can be used to convert existing retirement assets into a lifetime income.

3 Basic types of Annuities

- Immediate annuity –Income stream starts upon payment of the first premium.
- Deferred annuity –income stream begins later (or not at all, at owner's discretion)
- Longevity Ins - Income stream usually deferred till 80's in order to get a higher guaranteed lifetime income payout

Deferred Annuities vs. Immediate Annuities

When Annuity Payments Begin...

Deferred Annuities	VS.	Immediate Annuities
A deferred annuity has two distinct phases: the accumulation or savings phase and the income phase.		An immediate annuity has only one phase: the income phase.
During the accumulation or savings phase, annuity premiums, less any applicable charges, accumulate in the contract on a tax-deferred basis until the annuity starting date. Deferral of tax on annuity earnings is a major advantage that other non-qualified financial products cannot provide.		The single premium used to purchase an immediate annuity is converted into a stream of income immediately or shortly after the date the annuity is purchased.
On the annuity starting date, a deferred annuity enters the income phase, at which time the value of the annuity is converted into a stream of income.		

Two Types of Deferred Annuities

- Return based on fixed Interest rate
  (SPDA), Single Premium Deferred Annuity

- Return based on Indexed performance
  (FIA), Fixed Index Annuity
  (VA), Variable Annuity

Fixed Interest Annuities vs. Indexed Annuities

How Annuity Premiums are Invested

VS. Indexed Annuities

An indexed annuity has characteristics of both a fixed interest annuity and a variable annuity.

Similar to a variable annuity, the insurance company pays a rate of return on annuity premiums that is tied to a stock market index, such as the Standard & Poor's 500 Composite Index.

Similar to fixed interest annuities, indexed annuities also provide a minimum guaranteed interest rate*, meaning that they have less risk of loss of principal than variable annuities.

An investment in an indexed annuity is not a stock market investment. Instead, the rate of return is linked to the performance of a market index that tracks the performance of a specific group of stocks. Since the minimum guaranteed interest rate is combined with this interest rate linked to a market index, indexed annuities have the potential to earn returns better than fixed interest annuities when the stock market is rising.

Single Premium Deferred Annuity

- Minimum interest rate guaranteed
- Principal guaranteed by the insurer
- Current interest rate determined by Company board of directors or Index
- Low risk instrument
- General obligation of the insurer
- Surrender Charges
- Charges & Fees
- IRS Penalties

Single Premium Immediate Annuity

Turning a capital contribution into a Guaranteed Lifetime stream of income for annuitant.

Also known as a Private Pension , one of the most sought after financial vehicles as it guarantees a life time of income regardless of interest rates , the stock market, or even another recession .

Biggest Mistake at Retirement

- Taking Company payout without shopping
- May Not be Competitive
- HR responsibility to Separate from service
- Not to get you best payout That's your Job

Examples of Annuity Payouts

- Life only
- Life only with 10 year certain
- Joint Life and 50% survivor
- Joint life and 100% survivor
- Joint life and 50 survivor 10 year certain
- Joint life and 100 survivor 10 year certain
- 5 year certain
- 10 year certain

Taxation of Annuity Withdrawals

- Last in, first out
- Must exhaust all the interest (taxable) before getting to principal (tax free)
- WITH EXCEPTION OF LINKED ANNUITY

VARIABLE ANNUITIES

RETURN IS BASED ON S&P INDEX

HIGH FEES, M&E COSTS & COMMISSIONS

GROWS & ACCUMULATES TAX DEFERRED

NOT GUARANTEED & CAN LOSE PRINCIPAL

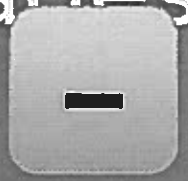
EARLY WITHDRAWAL PENALTIES & COSTS

Annuity Advantages &Disadvantages

Advantages

- Earnings on your annuity premiums are tax deferred so long as they remain in the annuity. When compared to an investment whose earnings are taxed each year, tax deferral offers the potential for accumulating significantly higher amounts of money over time.
- An annuity is used to provide a steady source of retirement income that you cannot outlive.
- Unlike an IRA or employer-sponsored retirement plan, there are no annual contribution limits .

Fixed Annuity Advantages and Disadvantages



Disadvantages:

- Premiums for a non-qualified annuity are not tax deductible they are made with after-tax dollars.
- While you can surrender or make withdrawals from a deferred annuity before you begin receiving income payments, the surrender or withdrawal may be subject to a charge if made within a stated number of years after the annuity is initially purchased.
- If made prior to age 59-1/2, a surrender or withdrawal will be subject to a 10% federal penalty tax unless one of the exceptions to this tax is met.
- When received, investment gains are subject to ordinary income tax rates and not the lower capital

ANNUITIES

A GOOD ACCUMULATION VEHICLE

BUT NOT A GOOD VEHICLE TO PASS ASSETS AT DEATH

PENSION PROTECTION ACT

MADE IT LESS COSTLY TO PURCHASE LTCI

CREATED COMBINATION/LINKED LTC & LIFE INS PRODUCT

Created Favorable Taxation for Transfers

Created Favorable Taxation for LTCI Riders

Created Favorable Tax Treatment for SPIA's, SPDA's

Linked Benefit Insurance

- 2 Types of Riders
  - LTCI Rider
  - Chronic Care Rider
- Shows affluent clients a better way to self Insure LTC
- Utilize untaxed gains in Annuities to pay for LTCI premiums

Withdraw up to $125,000 tax free annually from a Combo Life with an LTCI or Chronic Care rider to pay for LTC

Long Term Care Insurance Under the PPA

Old 1035 Rules

Life → Life

Annuity → Annuity

Life → Annuity

Annuity to Life is not Allowed

New 1035 Exchange Rules

1035 New Tax Free Options:

- **Annuity → LTCI**
- **Life → LTCI**
- **QLTCI → LTCI**

New, Tax Advantaged Opportunities For LTCI Planning

1035 Exchange Rules

OK to Transfer Cash Value from Life to Annuity

Can Not transfer Annuity Cash Value to Life

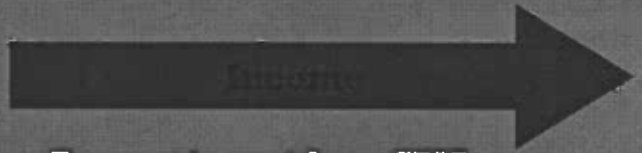
PPA – LTCI Planning Options

SPIA Funding Of Traditional LTCI

Before 2010

- Income may be part gain and part return of premium (Exclusion Ratio) until the premium is recovered
- Portion of income that constitutes **gain is taxable as ordinary income**

2010



- Payments sent from SPIA carrier to an LTCI carrier are tax-free

Insured & Annuity Owner must be the same.

CHANGE TO 1035 RULE

ALLOWS FOR TAX FREE EXCHANGE FROM ONE LIFE POLICY TO ANOTHER

ALLOWS FOR PARTIAL TRANSFERS

IRC 7702 B(e)

ALLOWS ANNUITY TO LTCI TAX FREE

ALLOWS LIFE TO LTCI BE TAX FREE

ONLY APPLIES TO NON QUAL MONEY

SUMMARY OF LINKED BENEFITS

ON ANNUITIES

SPIA CAN BE USED TO PAY LTCI TAX FREE

DEFERRED ANNUITY CAN BE CONVERTED TO LINKED ANNUITY/COMBO TAX FREE

THE LTC ANNUITY

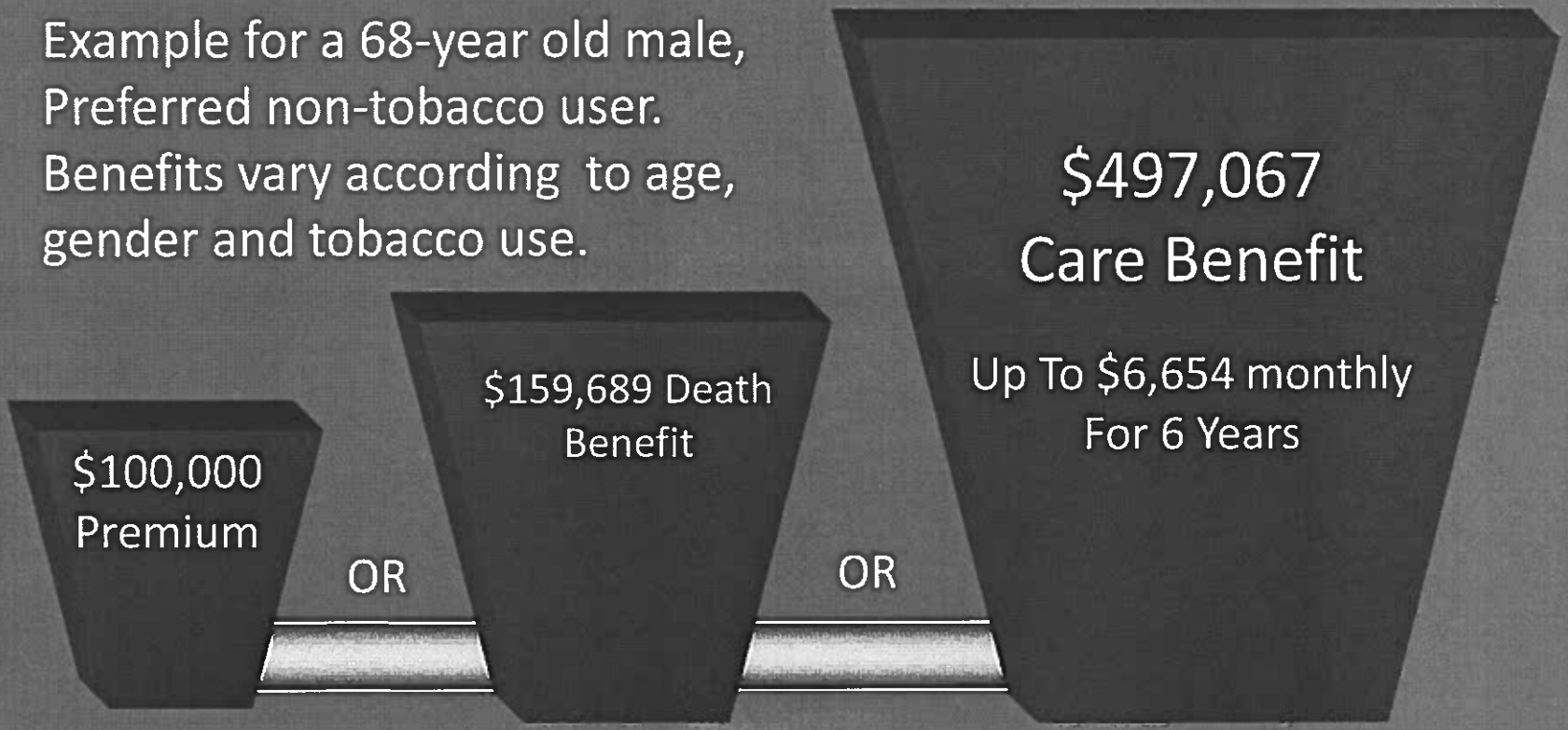
INCREASE AVAILABLE LUMP SUM $$ TO PAY FOR LTC EXPENSES

PAYS SMALL INTEREST RATE BUT MAXIMIZES LTCI FUNDS

PERFECT LTCI STRATEGY/VEHICLE IN LOW INTEREST RATE ENVIRONMENT

How Total Living Coverage(TLC) Works

Example for a 68-year old male,
Preferred non-tobacco user.
Benefits vary according to age,
gender and tobacco use.



Supplemental Executive Retirement Plan

Life Ins has Two Purposes

- Maximize Tax Free Death Benefit
- Use Life Ins as an Asset Class

Overfunding Life Policy Allows for ;

Accumulation on Tax Deferred Basis

Distribution on Income Tax Free Basis

Summary of Features

Correctly utilizing the various types of Annuities , Life Insurance & LTCI products can match clients risk with desired outcome

Not doing so can either waste assets or subject a client to unnecessary risk.

All Insurance Policies Must be Reviewed FOR CURRENT RELEVANCY & BEST USE STRATEGY

Leave Your Clients More Income
Insurance /Annuity Arbitrage

Situation

Male 76 has $600,000 in Taxable CD earning 3.0% gross and 2.0% net =

Solution

Purchase $285,000 SPIA paying

Purchase $315,000 SPIA paying $29,000 Net & use to purchase life insurance.

Result

Net Lifetime Income(2 times) & Guaranteed against any risk

Annuities Must Be Reviewed

- Interest Rates Change
- Insurer Ratings Change
- New Benefits Become Available
- Update Beneficiary Designations
- Accumulate Prior to Death
- Not to be Distributed at Death

MEDICAID ANNUITY

- Aaron will discuss in context of Medicaid planning opportunities

Thank You

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AARON E. FUTTERMAN, CPA, ESQ.

Mr. Futterman established the Law Firm of **Futterman & Lanza, LLP** in Smithtown, New York with Ronald Lanza over a decade ago. Prior to this firm, Mr. Futterman worked for several years at a premier Long Island Elder Law and Estate Planning firm.

The legal and tax experience Mr. Futterman has acquired over the course of his career helps him to better serve his clients. He has helped many individuals and families plan for their future while alleviating the fears, anxieties, and concerns many families experience when facing the unknown or inevitable.

The Partners of the firm are active in the National Academy of Elder Law Attorneys, the New York State Bar Association Elder Law Section, Suffolk County Bar Association Elder Law Committee and the Florida Bar Association Elder Law Section.

Mr. Futterman's work experience as a Certified Public Accountant with two of the world's largest public accounting firms enhances his ability to resolve the complex legal issues that arise in his Estate Planning, Tax, and Elder Law practice.

We also have a Valley Stream office to better serve the community. **We offer a free consultation in both offices.**

Please visit our website at www.trustedattorneys.com to learn more about our firm.

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ANNUITIES & MEDICAID 2018

Aaron E. Futterman, CPA, Esq.

I. Types of Annuities Generally.

There are two types of annuities: immediate and deferred. An immediate annuity begins paying upon the owner making the initial investment. A deferred annuity delays annuity payments. Tax-deferred annuities may be further broken down into: Qualified Tax-Deferred Annuities and Non-Qualified Tax-Deferred Annuities.

Qualified Tax-Deferred Annuities are typically part of an employment related retirement plan, such as a "401(k)" or "403(b)", or an ("IRA") or a ("SEP Plan"). Generally, withdrawals can be taken from a Qualified Tax-Deferred Annuity, such as an IRA, without penalty, upon the participant reaching the age of 59 ½, but periodic distributions must be taken upon reaching the age of 70 ½.

Non-Qualified Tax-Deferred Annuities are not part of an employment related retirement plan Contributions are not deductible for income tax purposes. While the investment within the annuity may grow tax-deferred – the account owner is not taxed on the earnings inside of the annuity; earnings are only taxed when the account owner elects a withdrawal from the account.

II. Annuities & Medicaid -06 OMM/ADM-5

06 OMM/ADM-5 or the Deficit Reduction Act of 2005 ("DRA") changed the way annuities are treated for Medicaid eligibility purposes.

A. Background. The DRA addressed the growing use of annuities to shelter resources in excess of the allowable Medicaid resource limit. In its background section, the purpose of the changes were described as follows:

> "The purchase of an annuity was effectively used by individuals to convert excess resources into an income stream. The annuity was required to be actuarially sound, meaning the anticipated return on the annuity's principal and interest must not exceed the annuitant's life expectancy. Upon the death of the annuitant, any remaining monies in the annuity pass to the named beneficiary rather than to the individual's estate. The DRA requires, as a condition of eligibility for nursing facility services, that the State be named the remainder beneficiary of an A/R's and community spouse's annuity. The DRA also made several amendments to Section 1917(c) of the Act to address the issue of annuities as a

potential transfer of assets for less than fair market value. These changes include imposing a transfer penalty unless an annuity meets certain criteria...."

B. The Section 366-a of the SSL is amended to require as a condition of Medicaid eligibility for nursing facility services, that the A/R disclose a description of any interest the A/R or the A/R's spouse has in an annuity regardless of whether the annuity is irrevocable or treated as an asset.

C. For annuities purchased on or after February 8, 2006, the A/R must be informed of the right of the State to be named remainder beneficiary by virtue of the provision of Medicaid.

D. In addition, effective August 1, 2006, if an A/R or the A/R's spouse purchased an annuity on or after February 8, 2006, and the A/R is seeking Medicaid coverage for nursing facility services, the State must be named as a remainder beneficiary in the first position or the purchase of the annuity will be considered an uncompensated transfer of assets.

1. In cases where there is a:

a. community spouse or

b. minor child or

c. disabled child, the State must be named the remainder beneficiary in the second position, and named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

2. The Medicaid application is being revised to inform applicants with annuities that the State becomes the remainder beneficiary under an annuity by virtue of the provision of Medicaid.

3. If the A/R or the A/R's spouse fails or refuses to name the State as the remainder beneficiary of an annuity purchased on or after February 8, 2006, the purchase will be considered a transfer of assets for less than fair market value.

4. In addition, if an annuity is purchased by or on behalf of an A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

• an annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or

• purchased with the proceeds from an account described in subsection (a),(c),(p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408(k) of such Code); or a Roth IRA described in Section 408A of such Code; or

• the annuity is:

• irrevocable and non-assignable;

• is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); --- [***see FH # 7487955J***] and

• provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

E. The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include:

1. additions of principal,

2. elective withdrawals,

3. requests to change the distribution of the annuity,

4. elections to annuitize the contract and similar actions.

F. Disclosure of Annuities Purchased on or After February 8, 2006

1. Effective for applications filed on or after August 1, 2006 for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, A/Rs are required to disclose a description of any interest the A/R or the A/R's spouse has in an annuity, regardless of whether the annuity is irrevocable or treated as an asset.

2. In order to inform A/Rs of their obligation to disclose information concerning annuities purchased on or after February 8, 2006, and the requirement for Medicaid coverage of nursing facility services that the State be named the remainder

beneficiary of the A/R's or the spouse's annuity, the LDSS-2921 "Application for Public Assistance/Medical Assistance/Food Stamps/Services" is being revised. Until the revised form is available, districts must include a copy of Attachment VII with all applications for nursing facility services. The attachment must also be given to individuals who request an increase in Medicaid coverage for nursing facility services.

3. For annuities purchased by the A/R or the A/R's spouse on or after February 8, 2006, the purchase of the annuity shall be treated as a transfer of assets for less than fair market value unless:

• the State is named as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or

• the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

4. The social services district must require a copy of the annuity contract owned by the A/R or A/R's spouse in order to verify that the State has been named the remainder beneficiary. If the A/R or the A/R's spouse fails or refuses to provide the necessary documentation, the district must treat the purchase of the annuity as a transfer of assets for less than fair market value.

5. In addition to naming the State as a remainder beneficiary on an annuity, the purchase of an annuity by or on behalf of an A/R is to be treated as a transfer of assets for less than fair market value unless:

• the annuity is an individual retirement annuity contract or endowment issued by an insurance company that is not transferable, has fixed premiums and the entire interest is non-forfeitable by the owner; or

• the annuity is a voluntary employee funded account that is established under, but is separate from a qualified employer plan; or

• the annuity is:

o purchased with the proceeds from an individual retirement trust or account as described in subsection (a), (c) or (p) of Section 408 of the Internal Revenue Code;

o a simplified employee pension plan. A simplified employee pension plan is an individual retirement annuity as described in Section 408(k) of the Internal Revenue Code; or

o a Roth IRA. A Roth IRA is an individual retirement plan described in Sect ion 408A of the Internal Revenue Code; or

• the annuity is:

o irrevocable and non-assignable;

o actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (see Attachment VIII life expectancy table); and

o provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

6. The annuity provisions apply to transactions, including purchases, which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

III. GIS 18 MA/08, 6/21/18

The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).

As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is

provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table.

SEE ATTACHMENT

IV. GIS 98 MA/024, 08/11/98

This message is to clarify the Department's policy concerning the treatment of retirement funds for purposes of determining Medicaid eligibility. The clarification reflects the eligibility requirements of the Supplemental Security Income (SSI) program, however, the clarification applies to all Medicaid applicants/recipients.

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans.

Treatment as a Resource

A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that the individual can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the resource's value.

As advised in 90 ADM-36, retirement funds owned by an ineligible or non-applying community spouse are countable for purposes of determining the total combined countable resources of the couple. However, the retirement funds are not considered available to the institutionalized spouse. The retirement fund owned by the community spouse is counted first toward the maximum community spouse resource allowance.

V. A Confusing Intersection

IRAs and retirement funds are excluded from 06 OMM/ADM-5 because they fall within Section 408 of the Internal Revenue Code ("Code"). Under the Code, the Required Minimum Distributions ("RMDs"), in the case of IRAs, are based on the IRS Life Expectancy Tables. For an Medicaid applicant or recipient ("A/R") over the age of 70 ½, whose spouse's age is within 10 years of the A/R's age, RMDs will be determined utilizing the IRS Life Expectancy Table III attached to Publication 590. For an A/R over the age of 70 ½, whose spouse's age is not within 10 years of the A/R's age, RMDs will be determined utilizing the IRS Life Expectancy Table II attached to Publication 590.

VI. Matter of Entz v. Reed (Index # 2009-10454 Monroe Co. Sup. Ct. March 9, 2009)

An 80 year old institutionalized A/R had a single premium annuity within her IRA. The annuity had been purchased in 2005 when the applicant had inherited her deceased spouse's IRA. The distributions from the account satisfied the Social Security life expectancy tables. The annuity did ***not*** name the state as remainder beneficiary. The court concluded that the purchase of an annuity within a retirement account cannot be treated as a transfer of assets for less than fair market value provided that the required distributions are made. There is no further requirement that the IRA owned annuity must also name the State as beneficiary. Interesting note = the A/R in this case purchased the annuity in 2005.

A. Compare recent Fair Hearing decision **FH #: 7618249Z, 9/25/17 (Erie County).**

B. Compare CMS letter dated July 27, 2006 (See Attachment to this outline).

VII. FH# 6541818P, 11/4/2013 (Chemung County).

The A/R resided in a nursing facility was in receipt of Medicaid. The A/R received both Social Security and income from a IRA in payout status. The only issue was the RMD amount.

As of April 2013, the A/R had a balance of $183,262.13 in his Retirement Account. The Agency admitted that it had been using the IRS Life Expectancy Tables to determine the A/R's RMD since the time that the A/R became eligible for Medicaid. The Agency testified that, upon the submission of the A/R's recertification, it had determined that A/R's Retirement Account now needed to be maximized pursuant to GIS 98 MA/024. This resulted in an increase to the A/R's NAMI of over $1,000.00.

The A/R argued that his Retirement Account was already being maximized according to generally accepted IRS Life Expectancy Tables, therefore, his current distribution should not be increased.

The Administrative Law Judge ("ALJ") determined in favor of the A/R and stated that GIS 98 MA/024 governs IRAs or retirement funds. The ALJ then cited the Suffolk County FH #5337190z on the same legal issue (See below for the FH)

The Agency's reliance on Life Expectancy tables attached to 06 OMM/ ADM-5 was determined to be an error of law. That Life Expectancy Table is applicable to the annuities that are governed by 06 OMM/ADM-5. The A/R's Retirement Account is an annuity excluded from 06 OMM/ADM-5 because it falls within Section 408 of the IRS Code and

the cited 98 GIS. Under the IRS code the RMD of the A/R's Retirement Account should be based on the IRS tables.

The Agency failed to use the correct Life Expectancy Table when calculating the Appellant's RMD from his Retirement resulting in an erroneous increase to the Appellant's NAMI.

VIII. FH# 5337190Z, 8/3/09 (Suffolk County).

A. Facts:

1. On May 7, 2009, an application for Medicaid was filed for a married 76 year old man. His spouse was sixty eight years old and resided in the community. Her Life Expectancy of 16.80 years was based on Attachment VIII of 06 OMM/ADM-5. The A/R's Life Expectancy factor in this attachment is 9.29. The A/R entered the Long Island State Veteran's Home, on June 26, 2009.

2. On June 10, 2009, the Agency denied the A/R's application for Medicaid on the grounds of excess resources. A/R argued that the Agency misapplied the Regulations and incorrectly considered his IRAs, which were not maximized according to the Agency's policy (Attachment VIII of 06 OMM/ ADM-5), as non-exempt resources.

3. The 2009 monthly distributions for the A/R's IRA accounts was based on the Life Expectancy factor of the Appellant's younger spouse·(16.80) as contained in Attachment VIII of 06 OMM/ ADM 5).

B. Arguments

1. The Agency's position was that the A/R's Retirement Accounts, which were in payout status and revocable were not maximized pursuant to GIS 98 MN024. The A/R was required to use a Life Expectancy factor of 9.29 as described in Attachment VIII of 06 OMM/ADM 5 to maximize this distribution. The Life Expectancy factor of 16.80 for his younger spouse to obtain the monthly distribution was insufficient to exempt these IRAs as resources. The Agency denied the Appellant's application on the grounds that the A/R's Resources exceeded the statutory Resource Limit

2. The A/R disputed the Agency's determination that the IRA accounts were non-exempt as resources because they are not disbursed at the maximum level. The A/R contended that under the GIS 98 MA 024, the pertinent IRS table must be utilized to determine the RMD. Under the IRS Uniform Life Time table the Life Expectancy factor of a 76 year old is 22.0 years. Alternatively, the Life Expectancy Table of 16.80 years, as

set forth in 06 OMM/ ADM 5 for the Appellant's spouse should have been allowed to comply with the Agency's requirement of a maximized distribution. The A/R further argued that if there is a non-applying spouse, the age of the spouse with the greater Life Expectancy can be used. Furthermore, the evaluation of the IRAs under the Deficit Reduction Act 2005 was not correct. Annuities described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986 or purchased with the proceeds from an account described in subsection (a),(c), (p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408 (K) of such code) or a Roth IRA described in Section 408 A of such code are excluded from the DRA of 2005.

C. Decision:

The ALJ decided that the Agency actions were not correct and were reversed as they have not established that the Appellant's household has Excess Resources. The ALJ stated that GIS 98 MA/024 governs IRAs or retirement funds. The Agency's reliance on Life Expectancy tables attached to 06 OMM/ ADM-5 is an error of law. That Life Expectancy Table is applicable to the annuities that are governed by 06 OMM/ADM-5.

The IRAs are annuities excluded from 06 OMM/ADM-5 because they fall within Section 408 of the IRS Code and the cited 98 GIS. Under the IRS code the RMD of IRAs should be based on the IRS tables. These IRAs were in payout status based on the wife's life expectancy or 16.80 years as set forth in 06-0MM/ ADM-5.

Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource. Thus, the Agency's June 10, 2009 Notice denying Medicaid because of excess non-exempt resources cannot be sustained.

IX. Recent Decisions

A. FH# 6276969N, 4/25/2013 (Onondaga County).

1. Facts: A/R, age 91, unmarried, made a Medicaid application for nursing home care. The Agency denied the A/R's application because the A/R failed to submit proof that he changed the first beneficiary of his annuity to DSS.

2. A/R argued that he would have gladly change the beneficiary as directed by DSS, but "was advised by the A/R's attorney that he is in the process of creating a trust and will be putting items into the trust."

3. The Agency responded that the A/R could not create an SNT with the annuity since the A/R is over the age of 65 and already in a nursing home.

4. The A/R then argued that the A/R has a letter from his indicating "their intent to change the beneficiary of the annuity, which has been in pay status for about a year, to [DSS]." However, proof of that change of beneficiary was never produced.

5. The ALJ determined that the Agency was correct, in that the A/R never produced proof that the beneficiary was changed, even though given ample opportunity to do so.

B. FH# 6378238Q, 7/18/2013 (Erie County).

1. Facts: A/R, unmarried, made a Medicaid application for nursing home care. DSS denied the A/R's application because the A/R had an uncompensated transfer of $45,153.27.vThe A/R owned an annuity worth $111,766.28. On April 10, 2011, the A/R was annuitized. On April 11, 2013, the beneficiary was changed to DSS. The A/R provided DSS a letter from the annuity company, which stated "The above referenced annuity contract was annuitized on April 10, 2011 with a life cash refund. This contract does not allow commutations and unfortunately the monthly distribution cannot be changed."

2. The Agency measured the A/R's life expectancy pursuant to the tables attached to SSA tables, which calculated the A/R's life expectancy at 4.69 years. The Agency then multiplied the monthly payment the A/R was receiving from the annuity $1,183.60 – by 12 months to arrive at $14,203.20 as the yearly amount being paid to A/R from the annuity. The Agency then multiplied $14,203.20 by the A/R's life expectancy of 4.69 years and arrived at $66,613.01 as the amount that would be paid to the A/R from

the annuity over her lifetime. The Agency determined that the difference between the value of the annuity on April 10, 2011 (when it was annuitized) of $111,766.28 and the amount the A/R was projected to receive over her lifetime of $66,613.01, or $45,153.27, was an uncompensated transfer which resulted in a penalty period of 5.20 years. The Agency also divided the value of the annuity on April 10, 2011 (when it was annuitized) of $111,766.28 by the A/R's life expectancy of 4.69 years and arrived at $1,985.90 as the monthly payment that the A/R should have received had the A/R computed her life expectancy pursuant to the SSA tables.

3. The ALJ agreed with the Agency that the A/R would have to receive a monthly payment of $1,985.90 in order for the annuity to be actuarially sound based on the SSA Tables

4. Note: Compare this decision to FH# 6246435P (below). In both fair hearing decisions, it was determined that both A/Rs failed to take the maximum distributions from their annuities. In FH# 6246435P it was decided that because GIS 98 MA/024 mandates that once an individual is in receipt of or has applied for periodic payments, the principal in the retirement account is not a countable resource, DSS should not have denied the A/R's application but should have approved it and added the monthly income shortfall to the A/R's NAMI. Whereas, in this fair hearing decision, the Agency was correct to deny the A/R's application subject to a 5.20 month penalty period. The difference lies in the type of annuity(ies). In FH# 6246435P, the A/R owned IRAs which are governed by GIS 98 MA/024, whereas in FH# 6378238Q, the A/R owned nonretirement annuities which are governed by GIS 12 MA/025.

B. **FH# 6178546H, 9/30/2013 (Broome County).**

1. Facts: a. A/R, age 92, unmarried, made a Medicaid application for nursing home care. On June 24, 2005, A/R purchased an annuity for $120,000.00. The annuity was annuitized on March 28, 2010, resulting in monthly payments of $1,188.87 for a 10 year period. The beneficiaries of the annuity were A/R's three children. DSS determined a 13 month penalty period, based on the uncompensated transfer of available resources.

b. On August 20, 2012, the caseworker told the A/R's son that by changing the beneficiary of the annuity to NYS, DSS would remove the transfer penalty and accept the Medicaid application. On September 14, 2012, the caseworker sent the A/R's son a letter, which stated: "Please accept this letter as written notification that the Department is required to offer you the opportunity to change the status of the Medicaid Coverage by changing the beneficiary of the annuity at [] to New York State in the first position. By doing this, the purchase of annuity will no longer be considered an uncompensated transfer of assets and [A/R]'s eligibility will be re-determined."

c. The Department subsequently also determined that the annuity was not actuarially sound since it provided for payments for 10 years but that the A/R had a life expectancy of 4.47 years, pursuant to the Life Expectancy Tables attached to 06 OMM/ADM-5.

2. At Fair Hearing, the Agency admitted that the information told to the A/R's son was in error. Nevertheless, the ALJ's decision was as follows: "As noted above, the [Department] conceded that it gave [A/R's] son incorrect information .... However, the Commissioner is obligated to ensure that New York state law is properly applied in all circumstances. Thus, despite the incorrect information given to the [A/R]'s son, the provision requiring the annuity to have a term that is actuarially sound must still be applied to the facts in the [A/R]'s case.... The ten-year term chosen by the [A/R] is not actuarially sound. Therefore, the annuity does not meet the criteria to be considered a transfer with compensation."

C. **FH# 6246435P, 7/24/2013 (Oneida County).**

1. Facts: A/R, age 88, made a Medicaid application for nursing home care. DSS denied the A/R's application on the grounds that the A/R's annuities were countable resources because the A/R was not taking the maximum distributions. The A/R's life expectancy was calculated according to the IRS's Table. The A/R's life expectancy was calculated at 4.81 years. Based on this, DSS calculated the maximum income distributions from the A/R's annuities as follows: Annuity #1: $27,770.34/4.81 = $5,773.45 annually, and Annuity #2: $9,065.00/4.81 = $1,884.61 annually. From these annuities, the A/R was withdrawing $2,256.00 annually and $718.00 annually, respectively. Because the A/R was not taking the maximum distributions, these annuities were considered available resources.

2. A/R argued use of IRS life expectancy tables to calculate RMDs.

3. The ALJ decided that the Agency used the correct life expectancy table because "this is the correct table for individuals that are not married." "The table presented by the [A/R]'s attorney does not apply in the Appellant's case because she is a widow. In addition, the prior fair hearing decisions cited by the [A/R]'s attorney is [sic] not applicable in this instance because the individual in these cases were married couples."

D. **FH #: 6585996R, 12/23/13 (Oneida County).**

1. Facts: A/R applied for Medicaid and was denied for a transfer of assets below FMV; A/R's annuity was not maximized.

2. The Agency used the SSA chart

3. The A/R used the IRS chart.

4. The ALJ decided in favor of the Agency. The MRG page 136, which references GIS 98 MA/024, provides that by "federal law, if the Medicaid A/R has a living spouse, the maximum income payment option that is available will usually be less than the maximum income payment option available to a single individual." While the cases cited by the A/R's counsel indicate that the IRS Life Expectancy Table is the appropriate table to be used in determining a maximum distribution, the distinguishing factor to the case at hand is that there were surviving spouses, where here there is none. Medicaid policy provides for the use of the SSA table rather than the IRS table to determine a maximum distribution for a single individual. In this matter, that Agency submitted an Interoffice Memo indicating that it would use the Life Expectancy Table attached to GIS 13 MA/020 for annuities even if involving IRAs. The Memo further indicates that in certain situations when there is a married individual, it will look to the IRS table. As the A/R is a single individual, the Agency's use of the SSA table is affirmed.

E. **FH# 6474202Q, 3/27/2014 (New York County).**

1. Facts: A/R, age 74, married, made a Medicaid application for nursing home care. The Agency denied the A/R's application because the A/R's countable resources of $293,696.07 (comprised solely of "Retirement Annuities") were in excess of the allowable Medicaid resource limit.

2. A/R presented evidence showing that these "Retirement Annuities" were traditional IRAs that were in mandatory distribution status. Thus, the A/R argued, the "Retirement Annuities" were not countable resources for purposes of determining the A/R's Medicaid eligibility.

3. The ALJ's decision was to reverse the Agency's decision and to direct the Agency to re-determine the A/R's proper excess resource amount, including allowing the A/R an opportunity to establish that the "Retirement Annuities" are exempt from the calculation of the excess resources amount.

F. **FH #: 6799394P, 8/6/14 (Onondaga County).**

1. Facts: On or about January 15, 2013, A/R (83 years old) applied for Medicaid. A/R's husband predeceased the A/R, and passed away on July 12, 2011. The Agency determined A/R not eligible for Medicaid because the A/R transferred assets for

less than fair market value claiming A/R was entitled to one half (½) of deceased Husband's Individual Retirement Annuity.

2. The Agency's position was that the A/R did not pursue her right of election of her late husband's life annuity. Instead, this money was transferred to the A/R's daughter.

3. The A/R's daughter testified that she was the beneficiary named on the annuity. The bank holding the annuity had a policy to transfer the annuity to the beneficiary upon the passing of the holder of the annuity and this was done automatically after the bank received proof of death. The A/R also indicated that she was entitled to half of the monies at that time.

4. The ALJ decided in favor of the A/R and stated, the annuity was not an asset owned by the A/R. She was not named as a holder of the annuity with her late husband, and it is categorized as a retirement account. Upon her husband's death, the accounts passed to the A/R's daughter by virtue of the A/R's daughter being the beneficiary. Although the Agency raises the issue of the A/R's claim to a right of election to this annuity, the right of election would have had to be filed after her husband's death. There is no evidence that the A/R refused to sign a right of election or executed a renunciation of this right, which would constitute a transfer of assets for purposes of Medicaid eligibility. Moreover, the A/R's daughter's testimony is found to be credible with respect to not knowing, at the time of the transfer, that the monies should not go to her as the beneficiary. Thus, there is insufficient evidence in the record to find a transfer of assets by the Appellant based on a renunciation or refusal to file a right of election against the annuity at issue.

G. **FH# 6983953Q, 3/20/15 (Erie County).**

1. Facts: A/R owned an annuity valued at approximately **$2,200.00** as of the date she was seeking Medicaid. The Agency determined that based on the Appellant's life expectance of 3.63 years, this account could be annuitized to generate yearly income $605.23 that could be used to offset the A/R's skilled nursing facility expense. As a result, the Agency requested that the A/R elect to receive periodic payments as a condition of eligibility for Medicaid, and the A/R refused to do so.

2. The A/R argued that she should not be required to elect to receive periodic payments under her annuity contract as a condition of eligibility because the annuity is not a retirement account, and because the Appellant's total combined resources including the annuity fall under the resource limit.

3. The ALJ determined for the Agency because the Appellant failed to present requested documentation that she had elected to receive periodic income payments under her annuity. The ALJ's reasoning was:

a. Regulations at 18 NYCRR 360-2.3(c)(1) provide that, in determining whether Medicaid applicant is financially eligible, the social services district must review all sources of income and resources available or potentially available to the applicant/recipient. To be eligible for Medicaid, the applicant must pursue any potential income and resources that may be available.

b. Pursuant to GIS 98 MA/024, annuities of any type are expressly included in the definition of retirement funds for Medical Assistance purposes. The GIS further requires that Medicaid applicants who are eligible for periodic payments from retirement funds "must apply for the maximum periodic payment available as a condition of eligibility". **There is no exception to this requirement based on the value of the annuity**, and the Appellant offered no legal support for reading such an exception into the existing policy. The Medicaid Reference Guide at page 317 (updated January 2012) provides that if an applicant does not choose to apply for available periodic payment benefits, the Agency can deny Medicaid based on the failure to pursue potential income that may be available. Here, it was undisputed that the Appellant was eligible to receive periodic payments from the annuity and elected not to receive such payments. Accordingly, the Agency's determination to deny the case on these grounds was correct.

H. **FH# 7038751M, 5/22/15 (Broome County).**

1. Facts:

a. In March 2014, A/R made a Medicaid application. The Agency determined that the A/R was not eligible for Medicaid because the A/R transferred assets for less than fair market value.

b. The A/R's late husband had purchased a non-qualified annuity in June 2004. He passed away in February 2006 leaving his spouse (A/R), the recipient of the annuity.

c. The annuity was put into payout by the A/R effective March 1, 2006. The annuitization rate was $174.30 per month. At the time the A/R placed the annuity in payout, she was 75 years of age and her life expectancy as of that date was 12.77 years. The value of the annuity at time of purchase was $30,878.28. According to the value and her life expectancy, the annuity would have needed to payout $201.50 per month to meet the guidelines and be actuarially sound.

d. The Agency determined that since the annuity payout was not actuarially sound, a penalty period must be imposed.

2. In deciding for the Agency the ALJ cited Social Services Law 366.5(e), 06 OMM/ADM-5 which provides that an annuity must be irrevocable and non-assignable; actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments. The annuity provisions also apply to transactions, including purchases, which occur on or after February 8, 2006 that include election to annuitize the contract and similar actions. In the case at hand, the Appellant's annuity is not actuarially sound as the Agency submitted evidence to establish that the Appellant's payout of her annuity beginning March 1 2006 is for an annuitization rate less than the amount determined actuarial sound. At the time the Appellant placed the annuity in payout, she was 75 years of age and her life expectancy as of that date was 12.77 years. The value of the annuity at time of purchase was $30,878.28. According to the value and her life expectancy, the annuity would need to payout $201.50 per month to meet the guidelines and be actuarially sound. The annuity was put into an irrevocable payout at a lower amount of $174.30 per month. The Agency correctly determined that since the annuity payout is not actuarially sound, a penalty must be imposed.

3. Query: Wouldn't this be a good fact pattern to argue that the "transfer" was made for a purpose other than to qualify for Medicaid?

I. FH# 7259544N, 3/11/16 (Erie County).

1. Facts:

a. On March 1, 2015 A/R applied for Medicaid.

b. A/R had purchased an Annuity on June 8, 2011 for $80,000.00. This Annuity was annuitized with monthly payments of $584.39 beginning on July 8, 2011. A/R's three children were the beneficiaries of this Annuity.

c. The Agency determined that the A/R's life expectancy at the time she purchased the annuity on June 8, 2011 was 9.03 years.

d. The Agency determined that according to the value and the A/R's life expectancy at the time of the purchase on June 8, 2011, the annuity would have needed to payout $738.28 per month to meet the guidelines and be actuarially sound.

e. The Agency determined that the annuity was not actuarially sound because the monthly payout amount of $584.39 was below the required amount of $738.28.

f. The Agency subtracted the actual payout amount of the annuity of $584.39 from the required amount of $738.28 and arrived at a shortfall of $153.89 per month. The Agency multiplied the $153.89 by 12 months to arrive at a yearly shortfall of $1,846.68. The Agency then multiplied the yearly shortfall of $1,846.68 by the life expectancy of 9.03 years to arrive at $16,675.52 as the total shortfall.

g. The Agency that the transfer of $16,675.52 was an uncompensated transfer by the A/R and imposed a penalty period.

h. On December 20, 2015 the Appellant died.

2. A/R's daughter argued that her mother transferred the asset (i.e., payout not sound) exclusively for a purpose other than to qualify for Medicaid.

3. ALJ decided in favor of the Agency.

a. The ALJ stated that per Social Services Law Section (5)(d)(3)(iii)(B) it is presumed that any transfer of resources within five years prior to an application for medical assistance is done for the purpose of qualifying for Medical Assistance. The burden of proof is therefore on the Appellant to show that the transfer was made "exclusively for a purpose other than to qualify for Medical Assistance"

b. The ALJ felt that the testimony that the A/R or her Daughter never considered the possibility that the A/R might have to go in to a nursing home was implausible due to A/R's age, heart problems, compression fracture of her spine, Diabetes and Macular Degeneration.

c. The ALJ also noted that the A/R used all of her remaining assets, except for her mobile home, when she bought the Annuity for $80,000.00 in 2011 and that the policy payout exceeded her life expectancy.

d. The A/R's advanced age, medical issues and the fact that she spent all of her liquid assets on the Annuity make it wholly implausible that the A/R did not consider at all the possibility of her needing Medicaid or having to go to a nursing home.

J. **FH# 7260458Y, 3/15/16 (Wyoming County).**

(Note: State must be named - just do it.)

1. Facts: On December 16, 2014, A/R applied for Medicaid. While A/R was in the nursing home, the Agency determined that during the look back period he transferred $25,616.44 to an annuity and annuitized it with a monthly payment of $136.90 beginning October 1, 2014. The A/R's children were named as beneficiaries. The annuity did not name the State as a beneficiary. The Agency determined that the value of the annuity of $25,616.44 when it was annuitized on October 1, 2014 was an uncompensated transfer because the State was not named as a remainder beneficiary.

2. ALJ: The ALJ decided in favor of the Agency. The ALJ stated that as to the creation of an annuity, Social Services Law 366.5(e) and 06 OMM/ADM-5 provide that if an applicant seeking coverage for nursing facility services purchased an annuity on or after February 8, 2006 the State must be named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the State must be named in the second position after a community spouse or minor or disabled child and must be named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value. If the applicant/recipient or applicant or recipient's spouse fails or refuses to so name the State as the remainder beneficiary the purchase will be considered a transfer of assets for less than fair market value. Here, it was undisputed that the State was not named as a beneficiary. Although the A/R testified that it was her intent to have the State listed and that she was taking action to have the State added in the future, it was undisputed that as of the date the Agency issued the notice as well as the date of the hearing that only the A/R's children were named beneficiaries. As such the Agency's determination that the value of the Annuity of $25,616.44 when it was annuitized on October 1, 2014 was an uncompensated transfer was correct.

K. **FH #: 7487955J, 3/6/17 (Erie County).**
(Note: Which table should be used? SSA or IRS?)

1. Facts: A/R applied for Medicaid on August 26, 2016 after being admitted to a nursing home on August 3, 2016. The A/R subsequently died on January 20, 2017. Agency conducted the five year look back period review and determined that the A/R made an uncompensated transfer. Specifically, the Agency claimed that the A/R purchased a Single Premium Immediate Annuity that was not actuarially sound.

The A/R was the owner and primary annuitant, and his wife, was the joint owner and secondary annuitant. On November 10, 2011, the A/R received his first payment of $447.34, which, per the terms of the annuity, would continue until the death of both the primary and secondary annuitant.

2. The Agency, using the Life Expectancy tables of the Office of the Chief Actuary of the Social Security Administration, determined the A/R's life expectancy at age 80 to be 8.20 years. The Agency multiplied $447.34 by 12 months to calculate the yearly annuity payout to the Appellant, which was $5,368.08. The yearly amount was then multiplied by 8.20, the life expectancy of the Appellant in 2011 at age 80 as stated in the Social Security Administration tables to arrive at a total expected return value of $44,018.26. Because the total expected return was less than the annuity purchase price of $70,000, the Agency found that the purchase was not actuarially sound, and the resulting difference of $25,981.74 was transferred for less than fair market value. The Agency then divided the uncompensated amount by the regional rate to come up with the penalty period of 2.69 months.

3. The A/R's sole argument in response was that the Agency should have used the IRS Life Expectancy Tables to determine if the annuity was actuarially sound. The A/R claims that had the Agency used the IRS tables, the A/R's life expectancy increases to 18.7 years and therefore the annuity would be actuarially sound.

4. The ALJ found the A/R's argument not persuasive and found in favor of the Agency. The ALJ stated that both the underlying federal law, and the state policy implementing such law, expressly state that for the purposes of calculating a transfer penalty, the actuarial soundness of an annuity will be "determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration." This plain language leaves no discretion to the Agency to apply the IRS tables when determining the actuarial soundness of an annuity for transfer penalty purposes.

L. **FH# 7509492Z, 4/6/17 (Erie County).**

1. Facts: The A/R entered the nursing home in May 2015 and applied for Medicaid on September 1, 2016. The Agency reviewed the A/R's assets and resources for a five-year look back. The Agency determined an uncompensated transfer in the amount $31,289.63 on July 9, 2014 when an Annuity owned by the Appellant automatically commenced into a default repayment option providing monthly payments of $678.22 for a duration of "life with 10 years period certain," which the Agency determined was "not actuarially sound" pursuant to the regulations and 06 OMM/ADM-5.

The A/R Appellant purchased the Annuity on September 3, 2004. Pursuant to the terms of annuity contract, the annuity automatically annuitized on July 9, 2014 with monthly payments of $678.22. The A/R's four adult children were named as the beneficiaries of the Annuity at the time the Annuity was purchased, nearly 10 years prior to the time it was annuitized. The Appellant's four children were the named beneficiaries for the Annuity until November 23, 2016 when the primary beneficiary was changed to the DSS.

2. The A/R argued that there was no uncompensated transfer at the time the Annuity was annuitized on November 23, 2016 because the original annuity contract had been purchased by the Appellant on September 3, 2004, prior to the effective date February 8, 2006 under the DRA and had not been changed or altered in any manner by the Appellant or her representatives prior to the change in beneficiary designation made at the request of the Agency in November 2016.

3. The Agency argued that the monthly payments were not actuarially sound.

4. The ALJ decided in favor of the A/R stating that the record establishes that at the time of her application in September 2016, the Appellant was receiving the maximum possible monthly payment under the fixed terms of the annuity contract. Hence, the Agency's determination to find an uncompensated transfer based on the automatic, contractual annuitizing of the Annuity on July 9, 2014 cannot be affirmed.

M. **FH# 7535817K, 6/5/17 (Erie County).**

1. Facts: The A/R purchased an Annuity on March 3, 1992 that automatically annuitized on February 5, 2013 with monthly payments of $381.29. The A/R's sibling and another relative were named as the beneficiaries of the Annuity at the time the Annuity was purchased, but the primary beneficiary was changed to the Erie County Department of Social Services when Medicaid was applied for in January 2017. The Agency reviewed the A/R's assets during the five-year look back and determined that A/R made an uncompensated transfer in the amount $24,207.17 on February 5, 2013 when the Annuity automatically commenced into a default repayment option providing monthly payments of $381.29 for a duration of "10 Years Certain and Life," which the Agency determined was "not actuarially sound" pursuant to the regulations and 06 OMM/ADM-5 and GIS 16 MA/15.

2. A/R argued that there was no uncompensated transfer at the time the Annuity was annuitized on February 5, 2013 because the original annuity contract had been purchased by the Appellant on March 3, 1992, prior to the effective date February 8, 2006 under the DRA and had not been changed or altered in any manner by the

Appellant or her representatives prior to the change in beneficiary designation made at the request of the Agency in March 2017.

3. The Agency argued that A/R engaged in a "transaction" regarding the Annuity during the five year look back period by letting the default occur despite correspondence from the annuity company requesting a repayment option. As a result the Agency stated the A/R did not maximize her repayment.

4. The ALJ decided in favor of the A/R and decided no penalty should occur. The ALJ stated that although the A/R was advised that she was required to specify a repayment option prior to December 2012, the annuity was automatically annuitized with a default repayment option on February 5, 2013.The ALJ decided that at the time of her application in January 2017, the Appellant was receiving the maximum possible monthly payment under the fixed terms of the annuity contract. Thus, the Agency's determination to find an uncompensated transfer based on the automatic, contractual annuitizing of the Annuity on February 3, 2015 cannot be affirmed and is reversed.

N. **FH# 7547924R, 6/5/17 (Eric County).**
(Note: structured lawsuit settlement found a transfer of assets).

1. Facts: the A/R was receiving Medicaid in the skilled nursing facility since 2014. In 2016, the A/R settled a personal injury law suit and chose a structured settlement annuity for the net settlement proceeds of $210,000.00.

2. The Agency argued that the A/R's choice of a structured settlement, which prevented any payments to the A/R until 2026, effectively placed the settlement proceeds out of her control, and were thus "transferred" for the purpose of maintaining her eligibility for Medicaid. The Agency determined to impose a penalty period during which the A/R may not receive Medicaid.

3. The A/R argued that the A/R did not have actual or constructive receipt of the $210,000 in settlement proceeds used to purchase the annuity and that therefore she could not have transferred the funds.

Alternative argument: because IRS rules prohibit the taxing of a structured settlement annuity as income, it could not be deemed an asset for Medicaid purposes, and therefore would not be subject to a transfer penalty.

4. The ALJ rejected A/R's arguments and stated,

a. Under Section 360-4.4 of the Regulations, "assets" are defined to include all income and resources of the individual, including income or

resources to which the individual is entitled, but does not receive, because of any action or **inaction** by the individual, a person with legal authority to act in place of or on behalf of the individual, a person acting at the direction of or upon the behalf of the individual, or a court or administrative body with legal authority to act in place of or on behalf of the individual or at the direction or upon the request of the individual.

b. Examples of actions which would cause income or resources not to be received include "not accessing injury settlements" or "settling a tort action so as to have the defendant place settlement funds directly into a trust or similar device to be held for the benefit of the recipient". See, 96 ADM-8, pages 5-6.

c. Here, the record showed that the A/R was legally entitled to the settlement proceeds from which she expressly assigned $210,000.00 to purchase an annuity as part of a structured settlement. The A/R's authorization of the terms of the settlement, with the assistance of counsel, to include the purchase of the annuity and its structure in which any payments of income were delayed until 2026, demonstrates her control over the settlement funds.

d. The effect of her decision prevented the A/R from accessing assets that could otherwise have been used to meet her skilled nursing facility expenses.

e. Furthermore, the type of annuity selected by the A/R would not otherwise exempt it from the imposition of a transfer penalty because the annuity selected does not provide for immediate payments in equal amounts with no deferral and no balloon payments, and the State was not named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant. See, 06 OMM/ADM-5.

f. Alternative argument discussion: Without questioning the A/R's interpretation of the IRS guidelines as they relate to taxable income, the A/R was unable to point to any Medicaid law or regulation that would otherwise exempt the settlement proceeds at issue herein. In the absence of such authority, the IRS guidelines are not binding on the Medicaid transfer penalty policy at issue herein.

O. **FH #: 7618249Z, 9/25/17 (Erie County).**
(Note: Compare to Matter of Entz v. Reed.)

1. Facts:

a. The A/R sought Medicaid retroactive to April 1, 2017.

b. The A/R's spouse is deceased.

c. The A/R had no minor or disabled children.

d. On March 21, 2007, for $105,363.86, the A/R purchased an annuity without listing the State as a remainder beneficiary. The annuity at issue is an IRA held Annuity.

e. The Agency determined that the A/R was not eligible under Medicaid for nursing facility services because the A/R transferred assets for less than market value.

2. Agency Argument: the Agency maintains that the value of the annuity as of the date the Appellant was seeking Medicaid coverage of nursing facility services ($105,363.86) must be considered an uncompensated transfer because the annuity was purchased after February 8, 2006, that subsequent additions to principal and elective withdrawals have been made in the annuity, and the State has not been named as a remainder beneficiary for at least the amount of Medicaid paid on the Appellant's behalf.

3. A/R Argument:

a. The annuity at issue is not an "asset" subject to a Medicaid transfer penalty, and therefore the requirement to name the State as a remainder beneficiary does not apply.

b. The DRA added new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006. These new requirements impact the annuity at issue herein, which was purchased by the Appellant on March 21, 2007. Specifically, Section 6012(b) of the DRA added a new section 1917(c)(1)(F) to the Social Security Act, which provided that the purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named as a remainder beneficiary. See, 42 U.S.C. Section 1396p(c)(I)(F). In addition, Section 6012(c) of the DRA amended section 1917(c)(1) of the Social Security Act by adding a new subparagraph (G) which provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services shall be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria. See, 42 U.S.C. Section 1396p(c)(I)(G). One of the criterion exempts an annuity described in subsection (b) of Internal Revenue Code Section 408. See, 42 U.S.C. Section 1396p(c)(I)(G)(i)(I).

c. The A/R argues that the annuity under review is one described in subsection (b) of section 408 of the IRC, and therefore is not an asset that can be subject

to a Medicaid transfer penalty. The A/R made the annuity contract part of the record, which is titled as an IRA annuity, and includes an endorsement that indicates the annuity contract was issued under the Internal Revenue Code of 1986, as amended, IRS Code Section 408(b). The Agency did not otherwise challenge this evidence, and for purposes of this decision, the annuity contract at issue will be found to be an asset exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(I)(G).

d. The A/R next argued that because the annuity at issue is exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(I)(G), it must also be exempt from transfer penalty under 42 U.S.C. Section 1396p(c)(I)(F), even if the State is not named as a remainder beneficiary. In support of this position, the attorney cited In the Matter of the Application of Virginia Entz v Reed (see above) where a Department of Health (DOH) determination to impose a transfer penalty for an IRA annuity where the State was not named as the remainder beneficiary was reversed. In Entz, the court analyzed the provisions of 42 U.S.C. Section 1396p(c)(I)(F) and 42 U.S.C. Section 1396p(c)(I)(G), concluding that DOH policy requiring adherence to both Sections (F)and (G) was incorrect. In its analysis the Court stated: 'This court reads (c)(I)(G) not conjunctively with (c)(I)(F), but explicitly excluding from the term "assets" the qualified retirement annuities and IRAs described in section (G). Therefore, to give fair credence to federal law, the State must be named as remainder beneficiary of an annuity unless the annuity is accepted by the requirements of (c)(I)(G)'.

4. The ALJ found the A/R's argument, as supported by the Entz decision unpersuasive, and found the transfer penalty appropriate - decided for Agency. The ALJ noted that the Centers for Medicare and Medicaid Services (CMS) issued a "Dear State Medicaid Director" letter on July 27, 2006 that clarified the interplay between paragraphs (c)(1)(F) and (c)(1)(G) at issue herein. Specifically, enclosure 6012 II(c) of that letter clarifies the requirement under subparagraph (G) "is in addition to those specified in 1917(c)(1)(F) pertaining to the State's position as a remainder beneficiary". The CMS letter further distinguishes the two sections by pointing out that 1917(c)(1)(F) applies to annuities purchased by an applicant or a spouse, while 1917(c)(1)(G) applies only to annuities purchased by an applicant. ***The interpretation of CMS is entitled to significant deference with regard to Medicaid law and policy, and supports the conjunctive interpretation followed in State law and policy***. See, Social Services Law 366.5(e)(3)(i)'s use of the conjunctive "and" to separate the two annuity requirements, and 06 OMM/ADM-5's use of the designator "in addition" to separate the two annuity requirements.

P. **FH #: 7657088R, 12/1/17 (Erie County).**

(NOTE: The deferred distributions after DRA are not "transactions" subject to the DRA rules)

1. Facts:

a. On December 29, 2016, an application for Medicaid was made by or on behalf of A/R after having a stroke. Her stay was originally non-permanent. On August 12, 2017, the Appellant was converted to permanent absence status.

b. The A/R sought Medicaid coverage effective September 1, 2016.

c. The A/R did not have a community spouse.

d. On June 14, 2002, approximately 14 years before entering the skilled nursing facility, the A/R purchased for a single premium of $37,550.77, a single premium deferred fixed annuity, "rolling over" the proceeds from her IRA. The A/R is the annuitant, and the annuity is categorized as an individual retirement annuity. Four family members are named as remainder beneficiaries.

d. Pursuant to the express terms of the annuity contract, the annuity accumulated principal until June 14, 2015, at which time it began to make periodic payments to the A/R.

e. The terms of the annuity, which have remained unchanged since the initial purchase in 2002, state the Appellant will receive semi-annual payments of $1,500.00 ($3,000.00 yearly). The last payment date in the amount of $1,500.00 is due December 14, 2029. A final payment of $398.70 is scheduled to be made on June 14, 2030.

f. The A/R has taken no action, made no election, or executed any decision that has changed the terms of the annuity since her original purchase in 2002.

g. As of August 10, 2017, the value of the annuity was $32,908.10.

h. The A/R provided the Agency with a letter from the annuity company dated August 30, 2017. The letter stated in part, "The gross semi-annual payment from your contract is $1,500.00. Since the contract has been annuitized, the payment cannot be changed."

i. The Agency determined that the Appellant's life expectancy at the time of her Medicaid application was 6.44 years.

j. The Agency took the value of the annuity of $32,908.10 and divided it by 6.44 to determine the minimum payment ($5,109.95) the Appellant would need to receive on a yearly basis to be considered "actuarially sound". The Agency subtracted

the current annual payout of $3,000.00 from $5,109.95 to determine the amount of the uncompensated transfer to be 2,109.95 per year. The Agency multiplied this amount for the Appellant's 6.44-year life expectancy to determine the total amount of the uncompensated transfer to be $13,588.08.

2. The ALJ found for the A/R; the ALJ stated that the Agency was correct insofar as the A/R's annuity distribution is not actuarially sound, but the determination to impose a sanction was not. The ALJ reasoned as follows:

a. The Social Security Act 1917(c)(1)(G), and as reflected in Social Services Law §366, and 06 OMM/ADM-5 page 6, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid will not be treated as a transfer of assets if the annuity meets any of the following conditions, including an annuity that is considered an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or an annuity purchased with proceeds from a traditional IRA (IRC sec. 408a) or from accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 § (c)).

b. The burden of proof is on the A/R to establish the statutory exception. The A/R met that burden in this case. The Appellant's attorney presented verification from the financial institution that issued the annuity, which included the application and annuity contract itself. The application was signed on May 20, 2002 and expressly indicates that the purchase of the annuity is an IRA annuity and is being funded by a direct rollover from the A/R's previous IRA. The Certificate Date Page of the annuity contract shows an initial single premium amount of $37,550.77 and an issue date of June 14, 2002. The "income date" is listed as June 14, 2015. The annuity contract includes an "Individual Retirement Annuity Endorsement" that is expressly made part of the contract, and which states, "The following provisions apply to a contract which is issued on a qualified basis as an individual retirement annuity under IRC section 408." Finally, the financial institution verified that the Appellant was provided an "IRA Disclosure Statement" at the time the annuity was purchased, advising her of her rights and the IRC requirements that apply to her IRA. The Agency offered no rebuttal in response to the evidence presented by the A/R, and the evidence established that the annuity under review qualifies as an individual retirement annuity, and was purchased with proceeds from a prior IRA. Accordingly, the Agency determination to impose a transfer penalty based on the A/R's ownership of the annuity in question cannot be sustained.

c. It will also be noted that the A/R's purchase of the annuity at issue in June 2002 predates the DRA's annuity rules, which went into effect February 8, 2006, when a new subparagraph (G) was added to the Social Security Act §1917(c)(1), providing that the purchase of an annuity **on or after February 8, 2006** by an annuitant who has applied for medical assistance with respect to nursing facility services shall be

treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria (emphasis added).

d. The DRA changes go beyond mere purchases to include subsequent "transactions" involving the annuity on or after February 8, 2006. Such transactions would include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of income or principal of the annuity, like additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions taken by the individual on or after February 8, 2006. See, 06 OMM/ADM-5, page 6. However, these types of "actions" are distinguished from routine changes and automatic events that do not require any action or decision on the part of the annuitant, which would not be considered transactions that would subject the annuity to treatment under the provisions of the DRA. See, Center for Medicare and Medicaid Services (CMS) letter to State Medicaid Directors dated July 27, 2006, entitled "Enclosure Section 6012". The CMS letter expressly provides that changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision, election or action to take effect are not subject to the DRA.

e. The only event that took place regarding the A/R's annuity within the five-year lookback period and after the DRA's enactment was the A/R's deferred annuity began distributions in 2015. However, it was undisputed that this distribution date was set when the A/R purchased the single premium deferred fixed annuity in June 2002, as reflected in the certificate page of that contract. The hearing record is devoid of any other decision, election, or action taken by the A/R following her purchase of the annuity. Because the A/R's purchase of an annuity in June 2002 included terms which required distribution to begin in June 2015, and such distribution began as scheduled, the required distribution in 2015 would not be considered a transaction subject to the DRA, since no action was required, post-enactment, to initiate that change. Consequently, any transfer penalty imposed based on such automatic distribution would be outside the scope of the DRA's annuity transfer penalty rules.

Q. **FH #: 7699380Y, 2/6/18 (New York City).**

1. Facts: The A/R, age 75, has been in receipt of Medicaid for herself only. By Notice of Decision dated January 30, 2018, the Agency informed the A/R of its determination to discontinue the A/R's Medicaid on the grounds of excess resources due to ownership of an annuity.

2. At the hearing, the Agency presented an account statement which showed the annuity with a value of $110,067.09. The Annual Statement also showed no withdrawals, but stated that the guarantee term of the annuity contract is seven years with

a beginning date of June 19, 2014 and ending date of June 18, 2017. The Agency contended that the annuity is a countable resource for purposes of Medical Assistance eligibility.

3. The A/R testified that the annuity is not an available resource because it is an annuity contract that prevents the A/R from withdrawing funds during the term of the annuity contract. The A/R also testified that she cannot withdraw funds from the annuity due to the terms of the contract. The A/R stated that she receives interest payments from the annuity via direct deposit into a bank account.

4. The ALJ decided that the Agency failed to establish that the annuity is an available resource. The ALJ stated:

a. 18 NYCRR 360-4.1 and 360.4.6 states that an applicant/recipient's available resources are counted and a determination made as to the net available resources. However, the Agency did not establish that the annuity is an available resource as defined by18 NYCRR 360-4.4(b), meaning that the annuity is in the control of the A/R.

b. The Agency presented the Annual Statement to support its determination, but it does not show that A/R has made withdrawals during the one-year period of June 19, 2016 through June 18, 2017 or that A/R may elect to make such withdrawals within the seven-year contract term.

c. Additionally, the Agency did not establish that it sent the A/R a request to submit the annuity contract policy/terms as such additional information/documentation is necessary to determine whether the annuity is an available resource; and such, the A/R's eligibility for Medical Assistance. As such, the Agency's reliance on the Annual Statement was not reasonable and an insufficient basis to determined that the annuity is an available resource for the Appellant.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2018 Update to the Actuarial Life Expectancy Table
ATTACHMENT:	2018 Life Expectancy Table
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).

As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table.

Please direct any questions to your local district support liaison.

Appendix B. Uniform Lifetime Table

Table III
(Uniform Lifetime)

(For Use by:
- **Unmarried Owners,**
- **Married Owners Whose Spouses aren't More Than 10 Years Younger, and**
- **Married Owners Whose Spouses aren't the Sole Beneficiaries of Their IRAs)**

Age	Distribution Period	Age	Distribution Period
70	27.4	93	9.6
71	26.5	94	9.1
72	25.6	95	8.6
73	24.7	96	8.1
74	23.8	97	7.6
75	22.9	98	7.1
76	22.0	99	6.7
77	21.2	100	6.3
78	20.3	101	5.9
79	19.5	102	5.5
80	18.7	103	5.2
81	17.9	104	4.9
82	17.1	105	4.5
83	16.3	106	4.2
84	15.5	107	3.9
85	14.8	108	3.7
86	14.1	109	3.4
87	13.4	110	3.1
88	12.7	111	2.9
89	12.0	112	2.6
90	11.4	113	2.4
91	10.8	114	2.1
92	10.2	115 and over	1.9

2018 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	76.15	80.97	30	47.75	51.95
1	75.63	80.41	31	46.82	50.99
2	74.67	79.44	32	45.90	50.03
3	73.69	78.45	33	44.98	49.07
4	72.71	77.47	34	44.06	48.11
5	71.72	76.48	35	43.14	47.16
6	70.73	75.48	36	42.22	46.20
7	69.74	74.49	37	41.30	45.25
8	68.75	73.50	38	40.38	44.30
9	67.76	72.51	39	39.46	43.35
10	66.76	71.51	40	38.54	42.41
11	65.77	70.52	41	37.63	41.46
12	64.78	69.53	42	36.72	40.52
13	63.79	68.53	43	35.81	39.59
14	62.80	67.54	44	34.90	38.65
15	61.82	66.56	45	34.00	37.72
16	60.84	65.57	46	33.11	36.80
17	59.88	64.59	47	32.22	35.88
18	58.91	63.61	48	31.34	34.96
19	57.96	62.63	49	30.46	34.06
20	57.01	61.65	50	29.60	33.15
21	56.08	60.67	51	28.75	32.26
22	55.14	59.70	52	27.90	31.37
23	54.22	58.73	53	27.07	30.49
24	53.29	57.76	54	26.25	29.61
25	52.37	56.79	55	25.43	28.74
26	51.44	55.82	56	24.63	27.88
27	50.52	54.85	57	23.83	27.02
28	49.59	53.88	58	23.05	26.17
29	48.67	52.92	59	22.27	25.32

2018 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	21.51	24.48	90	4.03	4.76
61	20.75	23.64	91	3.73	4.41
62	20.00	22.81	92	3.46	4.09
63	19.27	21.99	93	3.21	3.80
64	18.53	21.17	94	2.99	3.54
65	17.81	20.36	95	2.80	3.30
66	17.09	19.55	96	2.63	3.09
67	16.38	18.76	97	2.48	2.90
68	15.68	17.98	98	2.34	2.73
69	14.98	17.20	99	2.22	2.57
70	14.30	16.44	100	2.11	2.42
71	13.63	15.69	101	2.00	2.27
72	12.97	14.96	102	1.89	2.14
73	12.33	14.24	103	1.79	2.00
74	11.70	13.54	104	1.69	1.88
75	11.08	12.85	105	1.59	1.76
76	10.48	12.17	106	1.50	1.64
77	9.89	11.51	107	1.41	1.53
78	9.33	10.86	108	1.33	1.43
79	8.77	10.24	109	1.25	1.33
80	8.24	9.63	110	1.17	1.24
81	7.72	9.04	111	1.10	1.15
82	7.23	8.48	112	1.03	1.06
83	6.75	7.93	113	0.96	0.98
84	6.30	7.41	114	0.89	0.90
85	5.87	6.91	115	0.83	0.83
86	5.45	6.43	116	0.77	0.77
87	5.06	5.98	117	0.71	0.71
88	4.69	5.54	118	0.66	0.66
89	4.35	5.14	119	0.61	0.61

Enclosure

Sections 6011 and 6016

New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005

Centers For Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6011 and Section 6016

I. Extension of the Look-Back Period to 60 Months

II. Penalty Period

A. Start Date of the Penalty Period

B. Partial Month Transfers

C. Option to Combine Multiple Transfers Made In More Than One Month

III. Purchase of Promissory Notes, Loans or Mortgages

IV. Purchase of Life Estates

V. Undue Hardship

A. Establishment of Procedures

B. Authority of Facility to Request Undue Hardship Waiver for Resident

C. Bed Hold Payments

VI. Effective Dates

I. Extension of the Look-Back Period to 60 Months

Section 6011(a) of the Deficit Reduction Act (DRA); P.L. 109-171, amends section 1917(c)(1)(B)(i) of the Social Security Act (the Act). The amendment provides that for any transfer of assets made on or after the date of enactment of the DRA (February 8, 2006), the look-back period is 60 months.

II. II.Penalty Period

A. Start Date of the Penalty Period

Section 6011(b) of the DRA amends section 1917(c)(1)(D) of the Act to change the start date of the penalty period, which is the period during which an individual is ineligible for Medicaid payment for long term care services because of a transfer of assets for less than fair market value. Prior to the amendment, the penalty period began either in the month of transfer, or at State option, in the month following the month of transfer. Prior law resulted in some individuals being able to calculate the length of the penalty period that would result from an asset transfer and avoid the penalty by not applying for Medicaid coverage of institutional level care (or at State option, certain care provided to non-institutionalized individuals) until the expiration of that time period.

For transfers of assets made on or after February 8, 2006, the period of ineligibility will begin with the later of:

- The first day of a month during, or at State option the month 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 is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid.

The penalty period cannot begin until the expiration of any existing period of ineligibility. The penalty period will continue to run for the number of months determined by dividing the total value of assets transferred within the look-back period by the State's average monthly cost to a private patient of nursing facility services in the State, or at the option of the State, in the community in which the individual is institutionalized, as under present law. Once the penalty period is imposed, it will not be tolled (i.e., will not be interrupted or temporarily suspended), but will continue to run even if the individual subsequently stops receiving institutional level care.

States should be aware that imposition of a penalty period for new applicants for Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already eligible for Medicaid, the State must provide a 10-day adverse action notice. As well as complying with existing legal requirements (see regulations at 42 CFR 431 Subpart E), this notice must contain information about the undue hardship exception (see below).

B. Partial Month Transfers

Prior to enactment of the DRA, States had the option to impose penalty periods for transfers in a month that were less than the State's average monthly cost to a private patient of nursing

facility services in the State, or to impose no penalty period for such "partial month" transfers. Additionally, some States elected not to impose a penalty for transfers made within a month that were under a certain threshold e.g., $500. In States that elected to impose no penalty period for such partial month transfers, individuals were able to transfer amounts less than the average monthly cost of nursing facility services in successive months, but never incur a penalty.

To address this, section 6016(a) of the DRA amended section 1917(c)(1)(E) of the Act, to add a new subsection (iv) that prohibits a State from rounding down or otherwise disregarding any fractional period of ineligibility. The result is that States are now required to impose penalty periods even in the case of smaller asset transfers, where the period of ineligibility would be less than a full month. In imposing penalties on such transfers, if the calculation of the penalty period produces a fractional amount, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the monthly nursing home rate used to calculate the penalty period.

C. Option to Combine Multiple Transfers Made In More Than One Month

While the DRA prohibits States from rounding down or disregarding fractional periods of ineligibility, it does give States the option to combine multiple transfers for less than fair market value in more than one month and impose a single period of ineligibility, rather than applying multiple penalty periods. This flexibility is the result of a new subsection (H), added to section 1917(c)(1) of the Act by section 6016(b) of the DRA. Under subsection (H), States may treat the total, cumulative value of all uncompensated transfers made within the look-back period as a single transfer and calculate a single period of ineligibility, which would begin on the earliest date applicable under section 1917(c)(1)(D). See Section II A. above.

For example, if an individual, or the individual's spouse, makes an uncompensated transfer of assets of $1,000 in each of the 60 months of the look-back period, the State would have two options. It may calculate a separate period of ineligibility for each month and impose the resulting periods of ineligibility separately. Or, exercising the option provided under subparagraph (H), the State may add the transfers together, arrive at a total amount of $60,000, divide that total by the average private payment for nursing facility care and impose one continuous period of ineligibility. In either case, the penalty period would start with the earliest date applicable under section 1917(c)(1)(D).

States must include information about whether they elect to combine multiple fractional transfers into a single transfer in their State Medicaid plans.

NOTE: It is important to understand that if a State elects to combine multiple fractional transfers into a single transfer for purposes of imposing a penalty period, the earliest date applicable under section 1917(c)(1)(D) is always the LATER of the start dates discussed in Section II A above.

III. Purchase of Promissory Notes, Loans, or Mortgages

Some States have experienced problems with individuals who have attempted to circumvent rules penalizing transfers of assets by obtaining promissory notes, loans, or mortgages containing a promise of repayment from transferees. Individuals would then present the note, loan or mortgage instruments at the time of their Medicaid application for long-term care services in order to establish that these transactions were actually loans, not gifts. In some

cases, these were merely sham transactions, and repayment of the full amount transferred was neither expected nor enforced. Various techniques, such as balloon payments, in which token payments are made for most of the term of the loan with the balance due in a lump sum at the very end of the loan, and cancellation of the loan upon the death of the transferor, were used to ensure that the transferee would in fact retain most, if not all, of the funds.

In order to prevent improper use of promissory notes, loans or mortgages, section 6016(c) of the DRA amended section 1917(c)(1) of the Act by adding a new subparagraph (I) containing additional rules related to the purchase of these instruments. With respect to the transfer of assets, the term assets (see definition of "assets" at section 1917(e)(1) of the Act) includes funds used to purchase a promissory note, loan or mortgage unless all of the following criteria are met:

- The repayment term must be actuarially sound;
- Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

The actuarial standards to be applied are those determined by the Office of the Chief Actuary of the Social Security Administration (SSA). This table (called the Period Life Table, which can be found on SSA's Actuarial Publications Statistical Tables Web page under the heading "Life Table") may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

If the above criteria are not met, the purchase of the promissory note, loan or mortgage must be treated as a transfer of assets. In determining the amount of the asset transfer, the value of the note, loan or mortgage is the outstanding balance due as of the date of the individual's application for Medicaid coverage of services listed in section 1917(c)(1)(C) of the Act.

IV. Purchase of Life Estates

Another technique used by individuals in some States to avoid transfer of assets penalties was the purchase of a life estate interest in another individual's home. The individual purchasing the life interest in the home would allege that something of value, i.e., the life estate, had been received in exchange for the funds paid. However, in many cases, the purchaser never lived in the home nor derived any benefit from the life estate, and was in effect making a gift to the owner, who still retained the remainder interest. Since some States have elected to use more liberal resource methodologies and do not count life estate interests as resources, the value of the life estate was excluded in determining Medicaid eligibility. Thus, the acquisition of a life estate in the property of another would serve to transform countable resources (cash) into a non-countable resource (the life estate).

To deter the abuse of the life estate and transfer of assets rules, section 6016(d) of the DRA amended section 1917(c)(1) of the Act by adding a new subparagraph (J). This amendment provides that unless an individual purchasing a life estate in another individuals' home actually resides there for a period of at least one year after the date of purchase, the transaction should be treated as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. This amount should not be reduced or prorated to reflect an individuals' residency for a period of time less than a year.

States should note that the new rules pertaining to purchase of life estates add a criterion for evaluating whether a transfer of assets has occurred, but do not replace existing provisions of title XIX. Thus, States should still apply Medicaid resource eligibility and transfer of assets rules, even in cases where individuals purchasing life estates in the home of another individual do live there for at least one year. In determining the value of life estates, States should continue to follow Centers for Medicare & Medicaid Services (CMS) instructions at Section 3258.9 of the State Medicaid Manual. These instructions permit use of the life estate tables published by SSA for the Supplemental Security Income (SSI) program, which may be found in the Program Operations Manual System (POMS) at Section SI 01140.120.

If payment for a life estate exceeds the fair market value of the life estate as calculated in accordance with the POMS table, the difference between the amount paid and the fair market value should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate, as calculated under the POMS life estate and remainder interest table, should be treated as a transfer of assets. Finally, unless a State has a provision for excluding the value of life estates in its approved State Medicaid plan, or the property in which the individual has purchased the life estate qualifies as the individual's exempt home, the value of the life estate should be counted as a resource in determining Medicaid eligibility.

The DRA provision pertaining to life estates does not apply to the retention or reservation of life estates by individuals transferring real property. In such cases, the value of the remainder interest, not the life estate, would be used in determining whether a transfer of assets has occurred and in calculating the period of ineligibility.

V. Undue Hardship

A. Establishment of Procedures

Section 6011(d) of the DRA requires that each State provide a hardship waiver process in accordance with section 1917(c)(2)(D) of the Act. Previously the State was required to establish procedures for determining undue hardship, but the criteria, notice, and appeal requirements were not specifically addressed in the statute.

Under the DRA, undue hardship exists when application of a transfer of assets penalty 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.

Further, the statute specifically requires that States provide the following:

- Notice to individuals that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted; and
- A process, which the notice describes, under which an adverse determination can be appealed.

While these criteria and procedural requirements are listed in the statute for the first time, they are the same criteria and procedures that CMS has provided to States in the State Medicaid Manual at Section 3258.10(C)(5). Thus, States should already be applying these criteria to the determination of undue hardship. In addition, as long as they adhere to the DRA criteria, States still have considerable flexibility in deciding the circumstances under which they will not impose penalties under the transfer of assets provisions because of undue hardship.

States should note that in cases where application of the DRA provisions defining purchases of promissory notes, loans, mortgages, or life estates as transfers of assets would result in the imposition of a period of ineligibility (see sections III and IV above), the undue hardship rules apply.

States must include information about their implementation of the DRA undue hardship waiver requirements in their State Medicaid plans.

B. Authority of Facility to Request Undue Hardship Waiver for Resident

Section 6011(e)(1) of the DRA amends section 1917(c)(2)(D) of the Act by adding a new requirement that the procedures established by the State for determining undue hardship must permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of an individual who would be subject to a penalty period resulting from a transfer of assets. Before filing such an application, the facility must have the consent of the individual or the individual's personal representative. States may allow individuals authorized to act on behalf of the individual with respect to a Medicaid application to provide such consent to the facility. In addition to filing an undue hardship waiver application, the facility may present information on behalf of the individual to the State and may, with the specific written consent of the individual or the individual's personal representative, represent the individual throughout the appeals process.

C. Bed Hold Payments

Under the DRA (subsection 6011(e)(2)), States may, but are not required to, make bed hold payments to facilities on behalf of individuals for whom an undue hardship waiver application is pending, but not for more than 30 days. The application for an undue hardship waiver must meet the criteria specified in section 1917(c)(2)(D) of the Act, as described above. The State must include information about whether it will elect to make such payments in its State Medicaid plan.

VII. VI.Effective Dates

The provisions of the DRA discussed above in sections I (Extension of the Look-Back Period to 60 Months) and II A (Penalty Period) are effective for transfers of assets made on or after the date of enactment, February 8, 2006.

The provisions of the DRA discussed above in sections II.B. and II.C. (Partial Months and Accumulation of Multiple Transfers Into One Penalty Period), III (Purchase of Promissory Notes, Loans, or Mortgages) and IV (Purchase of Life Estates) are effective for payments made under title XIX of the Act for calendar quarters beginning on April 1, 2006, and thereafter. These provisions do not apply to:

- Medicaid provided for services furnished before February 8, 2006;
- Disposal of assets made on or before February 8, 2006; or
- Trusts established on or before February 8, 2006.

The date by which States must implement the provisions discussed in sections II.B., II.C., III, and IV above may be extended if the Secretary of Health and Human Services determines that the State Medicaid plan requires State legislation in order for the plan to meet the additional requirements imposed by these amendments.

If your State requires such legislation, please submit a letter so stating to your CMS regional office. The letter should include the date the State will begin implementing the statutory provisions of the DRA relating to partial month transfers. For States with annual legislative sessions, this date must be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after February 8, 2006. For States with biannual legislative sessions, this date must also be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the legislature that begins after February 8, 2006.

Enclosure

Section 6012

Changes in Medicaid Annuity Rules
Under the
Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6012

I. Application Requirements
   A. Disclosure of Interest in an Annuity
   B. Requirement to Name the State as a Remainder Beneficiary
   C. Applications for Coverage of Long-Term Care Services in 1634 States
   D. Consideration of Income and Resources from an Annuity

II. Evaluation and Treatment of Purchases of Annuities and Certain Transactions Related to Annuities on or after February 8, 2006

   A. Annuity-Related Transactions Other than Purchases.
   B. Requirement to Name the State as a Remainder Beneficiary on Annuities
   C. Annuities Purchased by or on Behalf of an Annuitant Who Applied for Medical Assistance

III. Effective Date

The Deficit Reduction Act of 2005 (DRA), P.L. 109-171, adds new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006, as well as certain other transactions involving annuities that take place on or after the date of enactment. The DRA amends section 1917 of the Social Security Act (the Act) which pertains to Liens, Adjustments and Recoveries, and Transfers of Assets. The DRA adds new provisions to section 1917, which include:

- The requirement to disclose, in an application for long-term care services, information regarding any interest an applicant or community spouse may have in an annuity;
- The requirement to name the State as a remainder beneficiary in annuities in which the applicant or spouse is the annuitant; and
- Provisions for the treatment of the purchase of certain annuities as a transfer for less than fair market value.

I. Application Requirements

A. Disclosure of Interest in an Annuity

Section 6012(a) of the DRA adds a new section 1917(e) to the statute. Under the new section 1917(e)(1), all States, including those with "1634 agreements", are required to alter their applications for medical assistance for long-term care services, including applications for recertification, to include a disclosure and description of any interest the applicant or the community spouse may have in an annuity. This disclosure is a condition for Medicaid coverage of long-term care services described in section 1917(c)(1)(C)(i), which include:

- Nursing facility services;
- A level of care in any institution equivalent to that of nursing facility services; and
- Home and community-based services furnished under a waiver of section 1915 (c) or (d).

This disclosure requirement applies regardless of whether or not an annuity is irrevocable or is treated as an asset.

If the individual, spouse or representative refuses to disclose sufficient information related to any annuity the State must either:

- **Using the authority of new section 1917(e)(1) described above, deny or terminate coverage of long-term care services only; or**
- **Using existing Medicaid program authority, deny or terminate eligibility for Medicaid entirely based on the applicant's failure to cooperate.**

If the State wants to limit its action to denial of payment for long-term care services, it must still ensure that enough information regarding the income and/or resources related to an annuity has been collected and verified in order to establish Medicaid eligibility under existing rules. The DRA does not provide applicants an option to withhold information about annuities that may impact the computation of resources or income. If the State cannot collect enough information about an annuity to allow the

State to establish Medicaid eligibility, the State should deny eligibility entirely based on the applicant's failure to cooperate in accordance with the State's existing policies.

In cases where an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, the State should take appropriate steps to terminate payment for long-term care services as discussed above, including appropriate notice to the individual of adverse action. The State should also consider whether other steps should be taken including, if appropriate, possible civil and criminal charges, and potential recovery of benefits which were incorrectly paid.

B. Requirement to Name the State as a Remainder Beneficiary

Under new sections 1917(e)(1) and (2), all States must also include in the application for long-term care services, including the application for recertification, a statement that names the State as a remainder beneficiary on any annuity purchased on or after February 8, 2006 by virtue of the provision of medical assistance for institutional care. The State must also notify the issuer of any annuity disclosed for purposes of section 1917(c)(1)(F) of the State's rights as a preferred remainder beneficiary.

- The State may require the issuer to notify it regarding any changes in disbursement of income or principal from the annuity; and
- The issuer of an annuity may disclose information about the State's position as remainder beneficiary to others who have a remainder interest in the annuity.

C. Applications for Coverage of Long-Term Care Services in 1634 States

States that have entered into an agreement under section 1634 of the Social Security Act must ensure that any individual eligible for medical assistance under that agreement who wishes to receive coverage of long-term care services completes an application which includes the disclosure required under the new section 1917(e)(1) and the statement required under the new section 1917(e)(1) and (2). Failure to complete an application form that meets these requirements will not affect the individual's eligibility for Medicaid; however, the individual will not be eligible for coverage of long-term care services unless the appropriate form is completed and signed.

D. Consideration of Income and Resources from an Annuity

The State may take into consideration the income or resources derived from an annuity when determining eligibility for medical assistance or the extent of the State's obligations for such assistance. This means that even though an annuity is not penalized as a transfer for less than fair market value (see II. Evaluation and Treatment of Purchases of Annuities and Certain Transactions On or After February 8, 2006 below for further information about treating the purchase of an annuity as a transfer of assets), it must still be considered in determining eligibility, including spousal income and resources, and in the post-eligibility calculation, as appropriate. In other words, even if an annuity is not subject to penalty under the provisions of the DRA, this does not mean that it is excluded as income or resource.

II. Evaluation and Treatment of Purchases of Annuities and Certain Transactions Related to Annuities On or After February 8, 2006

A. Annuity-Related Transactions Other than Purchases

Section 6012(d) specifies that the provisions of the DRA apply to transactions, including purchases, which occur on or after the date of enactment. In addition to purchases, certain transactions which occur on or after that date would make an annuity, including one purchased before that date, subject to the provisions of the DRA. Such transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions taken by the individual on or after February 8, 2006. Such transactions result in all provisions of the DRA being applicable to the annuity.

For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after the effective date of enactment are not considered transactions that would subject the annuity to treatment under these provisions of the DRA. Routine changes could be notification of an address change or death or divorce of a remainder beneficiary, and other similar circumstances. Changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision, election or action to take effect are likewise not subject to the DRA.

For example, if an annuity purchased in June 2001 included terms which require distribution to begin five years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006 this will not be considered a transaction subject to the DRA, since no action was required, post-enactment, to initiate the change. Lastly, changes which are beyond the control of the individual, such as a change in law, a change in the policies of the issuer, or a change in the terms based on other factors, such as the issuer's economic conditions, are not considered transactions that cause the annuity to be subject to the terms of the DRA.

B. Requirement to Name the State as a Remainder Beneficiary on Annuities

Section 6012(b) of the DRA adds a new section 1917(c)(1)(F) which provides that the purchase of an annuity shall be treated as a disposal of an asset for less than fair market value unless the State is named as a remainder beneficiary. Unlike the new section 1917(c)(1)(G) added by section 6012(c) of the DRA (discussed in detail below), section 1917(c)(1)(F) does not restrict application of its requirements only to an annuity purchased by or on behalf of an annuitant who has applied for medical assistance for nursing facility or other long term-care services. Therefore, we interpret section 1917(c)(1)(F) as applying to annuities purchased by an applicant or by a spouse, or to transactions made by the applicant or spouse.

Under the DRA an annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant, unless there is a community spouse and/or a minor or disabled child. A child is considered disabled if he or she meets the definition of disability found at section 1614(a)(3) of the Act. If there is a community spouse and/or any minor or disabled child, the State may be named in the next position after those individuals. If the State has been named after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State may then be named in the first position.

As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term care services and community services. Under the new section 1917(e) (see section I.B. above) the State must notify the issuer of the annuity of the State's right as the preferred remainder beneficiary. The State should require verification from the issuer that the State is named as a remainder beneficiary in the correct position. States should also require the issuer to notify the State if and when there is any change in the amount of income or principal being withdrawn.

If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. We interpret the statute to mean that the full purchase value of the annuity will be considered the amount transferred.

C. Annuities Purchased by or on Behalf of an Annuitant Who Applied for Medical Assistance

Section 6012(c) of the DRA amends section 1917(c)(1) by adding a new sub-paragraph (G) which provides that the purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services, shall be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria. Unlike the new section 1917(c)(1)(F) discussed above, this requirement does **not** apply to annuities for which the community spouse is the annuitant. **This requirement is in addition to those specified in 1917(c)(1)(F) pertaining to the State's position as a remainder beneficiary.** An annuity purchased by or on behalf of an annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions:

1. The annuity is considered either:
   - An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or
   - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC).

OR

2. The annuity is purchased with proceeds from one of the following:
   - A traditional IRA (IRC Sec. 408a); or
   - Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or
   - A simplified retirement account (IRC Sec. 408 §(p)); or
   - A simplified employee pension (IRC Sec. 408 §(k)); or
   - A Roth IRA (IRC Sec. 408A).

OR

3. The annuity meets all of the following requirements:
   - The annuity is irrevocable and non-assignable; and
   - The annuity is actuarially sound; and
   - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 1. and 2. above, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the institutionalized individual or his or her representative to produce this documentation. **Absent such documentation, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty.** We interpret the statute to mean that the full purchase value of the annuity will be considered the amount transferred.

When evaluating whether or not an annuity meets the conditions listed in 3. above, use the methodology for determining actuarial soundness that is found in the State Medicaid Manual Chapter III, Section 3258.9 B. However, do not use the actuarial life expectancy tables published in that section. Instead, use the *current* actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

Note that even if an annuity is determined to meet the requirements above, and the *purchase* is not treated as a transfer, if the annuity or the income stream from the annuity is transferred, except to a spouse or to another individual for the sole benefit of the spouse, child or trust as described in 1917(c)(2)(B), that transfer may be subject to penalty.

III. Effective Date

These provisions apply to purchases of annuities, and certain transactions related to annuities, that occur on or after the date of enactment of the DRA, February 8, 2006. States must take all reasonable steps to implement these provisions as soon as practicable. States should consider if pending applications need to be supplemented to collect information regarding annuities, or if this information is already specifically collected to determine income and resources. States should also consider how to best

notify applicants and recipients of the State's rights regarding annuities purchased after the date of enactment.

Enclosure

Section 6013

Application of the Spousal Impoverishment "Income-First" Rule Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6013

I. Background
II. New Provision

III. Effective Date

I. Background

Section 6013 of the Deficit Reduction Act of 2005 (DRA); P.L. 105-171 amends section 1924 of the Social Security Act (the Act) to require all States to follow the "income-first" method in calculating revisions to the community spouse resource allowance (CSRA) under section 1924(d).

Section 1924(d) of the Act requires States to set a monthly maintenance needs allowance (MMNA) for community spouses of institutionalized individuals applying for Medicaid. If the community spouse's own income is less than the MMNA, income of the institutionalized spouse may be paid to the community spouse to make up the difference or "shortfall." The State must also protect (i.e., not count in determining the institutionalized spouse's resource eligibility) for the community spouse a certain amount of the couple's resources, known as the community spouse resource allowance (CSRA). Protecting resources as part of the CSRA makes them available for transfer to the community spouse without counting as resources in determining the institutionalized spouse's initial Medicaid eligibility.

In calculating the community spouse's income, any interest, dividend, or other income generated by resources that are part of the CSRA, is included to the extent made available to the community spouse (see section 1924(d)(1)(B) of the Act). However, under section 1924(e)(2)(C) of the Act, the CSRA may be increased if an increase is necessary to raise the community spouse's income to the MMNA.

Prior to enactment of the DRA, generally States could use one of two methods in determining whether to increase the CSRA in order to increase the community spouse's income. States using an "income-first" method assume that all income of the institutionalized spouse that could be made available to the community spouse to bring the spouse up to the MMNA will be made available. Only if there would still be a remaining income "shortfall" would the CSRA be increased to the amount necessary to make up for the "shortfall" in income. In other States, using a "resources first" method, the increased CSRA is calculated based on comparing the community spouse's income to the MMNA without assuming that any allocation of income from the institutionalized spouse will be made.

II. New Provision

The DRA makes use of the "income first" method mandatory for all States. Thus, all States are required to attribute or allocate the maximum available income of the institutionalized spouse to the community spouse before granting an increase in the CSRA under section 1924(e)(2)(C) of the Act.

In cases where a community spouse is seeking an increased CSRA on the basis that additional resources are needed to generate the monthly maintenance needs allowance (MMNA), States may now follow the following steps:

1. Determine the MMNA for the community spouse in the same manner that you currently use pursuant to sections 1924(d)(3), (4), and (5) of the Act;

2. Determine the community spouse's total gross monthly income, including income from income-producing assets retained by the community spouse;

3. Subtract the community spouse's total monthly gross income from the MMNA. If there is a deficit, this is the amount of the income "shortfall" for the community spouse;

4. Determine the institutionalized spouse's total gross monthly income. Deduct the personal needs allowance. Allocate sufficient income from the remainder of the institutionalized spouse's income to meet the "shortfall" amount for the community spouse.

5. If, after Step 4 above, there is still some "shortfall" remaining for the community spouse, determine the amount of increased resources needed to generate that amount of income for the community spouse. In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income, including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income, attributing a rate of return based on a presumed available rate of interest, or other methods.

The above steps are offered for illustrative purposes, and do not preclude States from applying the income-first methodology in a different manner or sequence.

III. Effective Date

The effective date of this change is the date of enactment of DRA, February 8, 2006. However, this provision applies only to determinations of the CSRA made on or after the effective date, and only when the institutionalized spouse became institutionalized on or after the effective date. Couples who have had increased CSRAs calculated under a resources first methodology prior to the enactment of DRA will not be affected.

Enclosure

Section 6014

Disqualification for Long-Term Care Coverage for Individuals with Substantial Home Equity Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6014

I. New Provision
II. Methodology

III. Limitations

IV. Increases in Limits

V. Undue Hardship

VI. Effective Date

I. New Provision

Section 6014 of the DRA amends section 1917 of the Social Security Act (the Act) to provide that in determining the eligibility of an individual to receive medical assistance payment for nursing facility services or other long-term care services, States must deny payment if the individual's equity interest in his or her home exceeds $500,000. States have the option to substitute an amount exceeding $500,000, but not in excess of $750,000. States that choose to use a higher amount than the $500,000 need not use the higher amount on a statewide basis. Also, States need not apply their higher amount to all eligibility groups.

For purposes of this provision, "other long-term care services" include:

- A level of care in any institution equivalent to nursing facility services;
- Home or community-based services furnished under a waiver under sections 1915(c) or (d) of the Act; and
- Services provided to a noninstitutionalized individual that are described in paragraph (7), (22), or (24) of section 1905(a) of the Act, and, if a State has elected to apply section 1917(c) to other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care, those services.

NOTE: This is not a change in the general rule that excludes a home of any value for purposes of determining eligibility for Medicaid. It applies only to medical assistance payment for nursing facility services, or other long-term care services as defined above.

II. Methodology

In determining the value of home equity, States should follow the basic policies of the Supplemental Security Income (SSI) program. The equity value of a resource is the current market value minus any encumbrance on it. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in the particular geographic area involved. An encumbrance is a legally binding debt against the resource. This can be a mortgage, reverse mortgage, home equity loan, or other debt that is secured by the home. States should follow their existing policies to determine current market value. States should also apply their usual verification procedures if an encumbrance is alleged.

If the home is held in any form of shared ownership, e.g., joint tenancy, tenancy in common, or other arrangement, only the fractional interest of the applicant for medical assistance for nursing facility or other long-term care services should be considered. For example, if the home is owned in joint tenancy by an applicant and a sibling, one-half of the home's current market value should be used in calculating the equity value of the individual, unless the individual can rebut the presumption that he or she has equal ownership interest in the property.

III. Limitations

The limitations on home equity do not apply if the spouse of the individual, the individual's child under 21, or the individual's blind or disabled child is residing in the home. A child is considered disabled if he or she meets the definition of disability in section 1614(a)(3) of the Act. In Guam, Puerto Rico, and the Virgin Islands, instead of using the section 1614(a)(3) definition of disability, the child must be permanently and totally disabled (as defined for purposes of the State plan

program under title XVI of the Social Security Act) for the exemption to apply.

IV. Increases in Limits

Beginning in the year 2011, the $500,000 and $750,000 limits on home equity will increase each year. The increase will be based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000. However, States will continue to have the option under the State plan to elect a home equity limit that is greater than $500,000 as adjusted by inflation, but that does not exceed $750,000, as adjusted by inflation.

V. Undue Hardship

In addition, the Secretary of Health and Human Services is directed to establish a process to waive the application of the home equity limit in the case of a demonstrated hardship. Pending publication of a process specific to the home equity limit, States may use their existing procedures for determining the existence of undue hardship as currently required under section 1917(c)(2)(D) (transfers of assets for less than fair market value), or newer procedures developed for transfer of assets undue hardship waivers under section 6011 of the DRA.

Effective Date

The changes made by this section apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on applications filed on or after January 1, 2006.

Enclosure

Section 6015

Rules Pertaining to the Treatment of Continuing Care Retirement Community (CCRC) Entrance Fees Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6015

I. General Discussion
II. Effective Date

I. General Discussion

This enclosure concerns provisions of the Deficit Reduction Act of 2005 (DRA); P.L. 109-171, applicable to cases where entrance fees have been paid to continuing care retirement communities (CCRCs), or life care communities. The changes modify portions of the Federal Medicaid statute, specifically section 1919(c)(5) of the Social Security Act (the Act) and section 1917 of the Act.

The Federal Medicaid statute does not define what constitutes a CCRC or life care community. However, as a general rule CCRCs or life care communities provide a range of living arrangements, from independent living through skilled nursing care. Regulation, licensing or certification of such facilities is a function of the States. Some CCRCs include Medicaid certified nursing facilities and others do not participate in Medicaid. In many cases, potential residents must provide extensive information about their finances, including their resources and income, before being accepted for admission. In addition, they frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

The amendments to section 1919(c)(5) of the Act provide that contracts for admission to a State licensed, registered, certified, or equivalent CCRC or life care community may require residents to spend on their care the resources that were declared by the resident for the purpose of admission to the CCRC prior to applying for Medicaid. However, the provisions of the entrance contract are subject to the rules relating to the prevention of impoverishment of a community spouse under subsections 1924(c) and (d) of the Act. Therefore, any contractual provision requiring the expenditure of resident entrance deposits must take into account the required allocation of resources or income to the community spouse before determining the amount of resources that a resident must spend on his or her own care.

In addition, the DRA and added a new subsection (G) to section 1917(c)(1) of the Act. The new subsection (G) defines when an entrance fee paid to a CCRC or life care community would be treated as a resource to an individual for purposes of determining Medicaid eligibility. The following three conditions must all be met in order for the entrance fee to be considered an available resource:

- The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient; and
- The entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract and leaves the CCRC or life care community; and
- The entrance fee does not confer an ownership interest in the community.

States should note that in order to meet the first condition listed above, it is not necessary for CCRCs or life care communities to provide a full, lump-sum refund of the entrance fee to the resident. If portions of the fee can be refunded or applied to pay for care as required, this condition would be met.

Also, in order to meet the second condition listed above, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This condition is met as long as the resident could receive a refund were the contract to be terminated, or if the resident dies.

II. Effective Date

The provisions related to entrance deposits made to CCRCs and life care communities became effective upon the date of enactment of the DRA, February 8, 2006.

_____ _____ Life Beneficiary Designation form

Contract # _____

Letter of Instructions regarding Contingent Beneficiary:

The Primary beneficiary is named on Page 1 (Louis Palermo, spouse) of the Beneficiary Designation Form.

The Contingent Beneficiary is named as follows:
State of New York c/o Suffolk County Department of Social Services

Percentage of benefit to be paid in the event the primary beneficiary is deceased shall be: in an amount equal to the Medicaid benefits actually paid on behalf of _____ at the time of her death. In no event shall the State of New York be entitled to receive the full amount of this contract unless it can be proven by the State of New York that the benefit paid on behalf of Tana Palermo equals or exceeds the death benefit of the Contract herein.

In the event the State of New York is paid a partial benefit under this Contract upon the death of _____ and there are funds remaining, the beneficiaries of such remaining funds shall be paid out equally to the following persons:

1. _____, daughter of _____
   Address:
   DOB: SS#

2. _____, son of _____
   Address:
   DOB: SS#

3. _____, grandson of _____
   Address:
   DOB: SS#

Signature:_____ Date:_____

Duly sworn before me this
day of _____, 2018

_____
Notary Public