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Financing Long-Term Care in Missouri: Limits and Changes in the Wake of the Deficit Reduction Act of 2005*

I. INTRODUCTION

The expense of long-term care, intensified by an aging population, has contributed to a nationwide financial strain on the Medicaid program, complicating the already difficult tasks of medical and fiscal planning for the elderly. Missouri's elderly population is substantial, the state having ranked 14th in the country for the number of residents over age 65 in 2000.¹ These senior citizens face the prospect of paying for long-term care, and many of them will rely on Medicaid for all or part of the cost. Medicaid is the primary taxpayer-funded program that finances long-term care. Current projections suggest that the cost of Medicaid "will continue to increase exponentially."² As a result of this projected increase, both the federal government and the state of Missouri have enacted legislation restricting the availability of Medicaid benefits for long-term care – limits that affect the financial planning of the baby boom generation, especially those in the middle-class.

Title XIX of the Social Security Act establishes the Medicaid program and provides federal funding to help states pay for medical assistance to individuals who cannot otherwise afford it.³ States also provide funding for the program and must implement it within federal guidelines.⁴ Since its creation

* The author would like to thank Reggie Turnbull for his assistance in writing this summary and Professor David English for reviewing it. Any errors are her own.

1. MEDICAID REFORM COMM'N, MEDICAID REFORM COMM'N REPORT 40 (2006), <http://www.senate.mo.gov/medicaidreform/MedicaidReformCommFinal-122205.pdf>. The report goes on to say: "By the year 2025, 19.8% of Missouri residents are projected to reach 65 years of age or older." *Id.*

2. *Id.* The Commission's report notes that "[t]he federally-funded Medicare program which provides healthcare to individuals aged 65 and older does not include a benefit that subsidizes extended long-term care for its participants, so Medicaid has become the sole source of publicly-supported financing for long-term care." *Id.*

3. 42 U.S.C. § 1396 (2000), amended by Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

4. See 42 U.S.C. § 1396a (2000) (setting out what states must do as participants in the federal program). See also 42 C.F.R. § 430.10 (2007) (noting that "[t]he State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program").

in 1965, Medicaid has been modified several times by Congress, most recently with the Deficit Reduction Act of 2005 (DRA).⁵ The Congressional Budget Office estimates that reductions in Medicaid outlays under the DRA would, while increasing direct spending by \$2.2 billion in 2006, ultimately diminish direct spending by \$4.7 billion from 2006-2010.⁶ Many of the cutbacks in spending will impact elderly people seeking Medicaid coverage for long-term care. The cutbacks result from provisions that discourage asset transfers, limit the usefulness of annuities in sheltering assets, and include home equity as a countable asset when determining Medicaid eligibility.⁷

In response to changes in federal law, Missouri immediately implemented the DRA as set forth in Section 208.010.7 of the Missouri Revised Statutes⁸ and enacted the Missouri Continuing Health Improvement Act of 2007 (MCHIA).⁹ Both Acts limit access to “Vendor Medicaid,”¹⁰ while ostensibly providing for alternative payment options, thwarting previous methods used by some middle-class Missourians to shelter their assets from long-term care costs. This summary examines provisions of the DRA and MCHIA that will most strongly impact elderly Missourians and addresses the considerations necessary for attorneys as they help clients plan for long-term care.

5. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (amending 42 U.S.C. § 1396p (2000)). See also ROBIN RUDOWITZ & ANDY SCHNEIDER, THE NUTS AND BOLTS OF MAKING MEDICAID POLICY CHANGES: AN OVERVIEW AND A LOOK AT THE DEFICIT REDUCTION ACT 5 (2006), <http://www.kff.org/medicaid/upload/7550.pdf> (last visited May 25, 2008) (noting that the DRA is a budget reconciliation bill, thus it is governed by special rules for debate time and only requires a majority to pass).

6. CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE, S. 1932, DEFICIT REDUCTION ACT OF 2005 34 (2006), available at <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>.

7. *Id.* at 34-38.

8. “Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.” MO. REV. STAT. § 208.010.7 (Supp. 2006).

9. MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007).

10. Vincent G. Rapp & Michael C. Weeks, *The Use of Personal Care Contracts in Light of Reed v. Dept. of Social Services*, 63 J. MO. B. 86, 86 (2007) (defining “Vendor Medicaid” as “Medicaid for individuals residing in skilled nursing facilities or eligible to receive in home care through the home and community based service programs” and noting that “[o]ther Medicaid programs have different rules regarding asset transfers”).

II. LEGAL BACKGROUND

A. Federal Medicaid under the Social Security Act

Title XIX gives states with approved Medicaid plans a right to “federal matching funds at a specified rate for all allowable expenditures.”¹¹ Predictably, the incentives provided by federal funding influence state Medicaid programs and the Medicaid planning options available under them. Of these combined state and federal Medicaid funds, a large portion is spent on long-term care for the elderly. Long-term care includes medical and personal assistance provided to individuals with chronic illnesses or disabilities, among them residents of long-term care facilities.¹² In 2005, 34% of Medicaid spending was on long-term care services,¹³ due in part to the opportunities for Medicaid planning available under existing laws. Planning tactics relating to asset transfers, look-back periods, and other methods such as annuities permitted the elderly to shelter assets from Medicaid eligibility requirements.

Prior to the enactment of the DRA on February 8, 2006, restrictions on asset transfers were relatively broad. These restrictions allowed for reasonably straightforward Medicaid planning, mainly because the date that the penalty period began to run was the date of asset transfer.¹⁴ The penalty period was the number of months an institutionalized individual was ineligible for Medicaid payments, calculated by taking the total value of gifts made on or after the look-back date, which was thirty-six months prior to application for Medicaid, and dividing by the average monthly cost of nursing home care in the state.¹⁵ The resulting number indicated the number of months of ineligibility for Medicaid funding.¹⁶ Because the penalty period prior to February 8,

11. RUDOWITZ & SCHNEIDER, *supra* note 5, at 4.

12. MO. REV. STAT. § 344.010(2) (Supp. 2006) (defining “[l]ong-term care facility” as “any residential care facility, assisted living facility, intermediate care facility or skilled nursing facility, as defined in section 198.006, RSMo, or similar facility licensed by states other than Missouri”). Long-term care services can be provided at home, in the community, or in long-term care facilities. *See* first quotation *infra* note 67.

13. THE KAISER COMM’N ON MEDICAID & THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE 2 fig.4 (2007), <http://www.kff.org/medicaid/upload/7235-02.pdf>. *See generally* Memorandum from Cong. Budget Office on Additional Info. on CBO’s Estimate for the Medicaid Provisions in the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005 (Jan. 27, 2006), <http://www.cbo.gov/ftpdocs/70xx/doc7030/s1932updat.pdf> [hereinafter *Additional Information*].

14. 42 U.S.C. § 1396p(c)(1)(D)(i) (2000), *amended by* Deficit Reduction Act of 2005, Pub. L. No. 109-171, sec. 6011, 120 Stat. 4, 61 (2006).

15. 42 U.S.C. § 1396p(c)(1)(E)(i)(I)-(II), *amended by* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 61 (2006).

16. “With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a num-

2006 began running on the date of an asset transfer, individuals were able to engage in “half-a-loaf” planning, calculating how long they would be ineligible for Medicaid benefits after a transfer and reserving enough personal assets to pay for their care until the penalty period had run.¹⁷

Also prior to the DRA, Title XIX imposed a thirty-six month look-back period for asset transfers when property was disposed of for less than fair market value.¹⁸ That is, in determining the penalty period, the government would look back at gifts given or assets transferred for less than fair market value for thirty-six months on or before the date that an individual became institutionalized and applied for state medical assistance.¹⁹ Applying the penalty period equation to transfers in these thirty-six months, fractional penalty periods would often result. Because Title XIX was silent on the treatment of fractional periods, states had the discretion to round down to the nearest whole month of ineligibility.²⁰ The consequence of rounding down was that individuals could “stagger transfers”²¹ by giving away more than the monthly cost of care²² but less than the amount that would trigger two months

ber equal to-- (I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by (II) the 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) at the time of application.” 42 U.S.C.A. § 1396p(c)(1)(E)(ii), *amended by Deficit Reduction Act of 2005*, Pub. L. No. 109-171, 120 Stat. 61 (2006).

17. Andrew H. Hook, *Durable Powers of Attorney: They Are Not Forms!*, 2000 NAT'L ACAD. OF ELDER LAW ATTORNEYS SYMPOSIUM 26-1 n.42 (“Half a loaf [sic] gifting is a Medicaid planning strategy by which a potential Medicaid recipient makes a gift of a portion of his assets while retaining sufficient assets to pay for his nursing home care during the period of ineligibility that results from the gifts.”).

18. 42 U.S.C. § 1396p(c)(1)(B)(i), *amended by Deficit Reduction Act of 2005*, Pub. L. No. 109-171, 120 Stat. 61 (2006). “The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section, 60 months) before the date specified in clause (ii).” *Id.*

19. 42 U.S.C. § 1396p(c)(1)(B)(i), *amended by Deficit Reduction Act of 2005*, Pub. L. No. 109-171, 120 Stat. 61 (2006). 42 U.S.C. § 1396p(c)(1)(B)(ii) applies to noninstitutionalized individuals when the individual “applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.”

20. *Id.* § 1396p(c)(1)(E), *amended by Deficit Reduction Act of 2005*, Pub. L. No. 109-171, 120 Stat. 61 (2006).

21. Gene V. Coffey et al., *Analysis of Changes to Federal Medicaid Laws under the Deficit Reduction Act of 2005*, 2 NAELA J. 189, 236 (2006).

22. The monthly cost of care is known as the “divestment penalty divisor” and is the average monthly cost of nursing facility services for a private patient in the state. *See infra* Part II.B.

of ineligibility. Thus the amount transferred resulting in the fractional period of ineligibility was, in effect, not a countable asset.²³

Similar to calculated asset transfers, annuities were another method through which individuals could disqualify assets from consideration in determining Medicaid eligibility because annuities were assessed only under the test of actuarial soundness.²⁴ Title XIX treated annuities as countable assets when determining Medicaid eligibility “to such extent and in such manner as the Secretary [of Health and Human Services] specific[d].”²⁵ The Secretary interpreted this provision to mean that an annuity is actuarially sound if the life expectancy of the individual is commensurate with the life of the annuity.²⁶ Thus, people could shelter assets by purchasing annuities that met the Secretary’s definition.

Like annuities, other exempt assets provided investment options through which long-term care applicants could shelter funds, thereby making it easier to qualify for Medicaid benefits. Among these, investing in homes was an option, as home equity was not included in assets when determining Medicaid eligibility.²⁷ Similarly, money used to purchase life estates was not considered a countable asset because the purchase of life estates was not mentioned in Title XIX prior to the DRA.²⁸

23. Coffey et al., *supra* note 21, at 235-36.

24. See 42 U.S.C. § 1396p, amended by Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 61 (2006); see also Coffey et al., *supra* note 21, at 208 (noting that Section 3258.9(B) of the State Medicaid Manual prior to the enactment of the DRA relies entirely on actuarial soundness in determining whether an annuity should result in a penalty).

25. 42 U.S.C. § 1396p(d)(6), amended by Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 61 (2006); see also RUDOWITZ & SCHNEIDER, *supra* note 5, at 2.

26. U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE MEDICAID MANUAL, ELIGIBILITY § 3258.9.B (2005), available at <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927>. The Secretary emphasized that annuities can be used to shelter assets; however, they were also a valid retirement planning tool. *Id.* Therefore, the Secretary had to determine the “ultimate purpose of the annuity,” and this determination hinged on whether the annuity was “actuarially sound.” *Id.* Determination of life expectancy was based on “life expectancy tables, compiled from information published by the Office of the Actuary of the Social Security Administration.” *Id.* Thus, “[i]f the individual [was] not reasonably expected to live longer than the guarantee period of the annuity, the individual [would] not receive fair market value for the annuity based on the projected return,” and the annuity was considered a transfer of assets for less than fair market value. *Id.*

27. 42 U.S.C. § 1396p(c)(2)(A), amended by Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 61 (2006).

28. See *id.* § 1396p, amended by Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 61 (2006).

B. Missouri Medicaid

Pursuant to Missouri Revised Statute Section 208.010.7, through which Missouri automatically implements all federal changes to Medicaid law, Missouri Medicaid has followed federal guidelines as provided in Title XIX.²⁹ As a joint federal and state program, however, Medicaid is open to narrow state interpretation. Missouri has exercised its discretion in implementing optional Medicaid provisions, generally maintaining the most stringent requirements available.³⁰ This exacting approach is based in part on the disbursement of nearly a quarter of the state's Medicaid assets to the elderly, even though they comprise only 8.2% of the state's Medicaid-eligible population.³¹

Historically, Missouri has been one of the strictest states in providing access to state and federal Medicaid funds to the elderly.³² One way Missouri restricted Medicaid access was by implementing the lowest countable resource allowance, the amount to which an individual must spend down his or her assets to qualify for Medicaid coverage.³³ While most states use Social Security Income rules to determine eligibility, setting their resource allowance at \$2,000, Missouri has set the personal allowance at \$999.99.³⁴

Reflecting the narrowness of Medicaid accessibility in Missouri relative to other states,³⁵ Missouri tightened Medicaid availability with the passage of Senate Bill 539³⁶ in 2005. The bill anticipated changes that would later be adopted by Congress with the DRA. Moreover, it further limited financial planning options previously available to the elderly by shifting from a resource-first to an income-first rule³⁷ and strengthening limitations on transfers of assets through annuity purchases.³⁸

29. MO. REV. STAT. § 208.010.7 (Supp. 2006) (Federal laws are automatically implemented “[b]eginning July 1, 1989.”).

30. Reginald H. Turnbull, *Missouri: The Meanest State to Nursing Home Residents* (May 18, 2007) (on file with author).

31. MEDICAID REFORM COMM’N, *supra* note 1, at 40. *See also* DEP’T OF SOCIAL SERVS., QUICK FACTS ABOUT DSS IN MISSOURI (2006), *available at* <http://dss.mo.gov/mis/cqfacts/moqfct06.pdf> (noting that of the \$5,176.3 million spent in 2006 on Missouri Medicaid, \$785.4 million was spent on Medicaid nursing home services alone, not including other services available to elderly individuals).

32. Turnbull, *supra* note 30.

33. *Id.*

34. *Id.*

35. *Id.*

36. MO. LEG. S.B. 539, 93d Gen. Assem., 1st Reg. Sess. (Mo. 2005).

37. *Id.* (“An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse to raise the community spouse’s income to the level of the minimum monthly needs allowance, as described in 42 U.S.C. Section 1396r-5. Such diversion of income shall occur before the community spouse is

The income-first and resource-first methods of asset allocation are relevant when a married individual enters a long-term care facility and his or her spouse remains at home. The income-first method is less forgiving than the resource-first approach.³⁹ Under the income-first method, as the name suggests, income from the institutional spouse is used first to generate enough money for the non-institutionalized, or community, spouse to live,⁴⁰ known as the “monthly maintenance needs allowance” (MMNA).⁴¹ Under the resource-first method, the community spouse receives resources from the institutionalized spouse that can be used to generate income,⁴² thereby providing the spouse’s MMNA.⁴³ The practical effect of this difference is that the resource-first method allows the community spouse to live off income from investments even after the institutionalized spouse dies. Conversely, the income-first method requires the institutionalized spouse to spend down income-generating resources in order to qualify for Medicaid, thereby leaving his or her spouse with few or no income-generating assets and threatening the financial security of the surviving spouse.⁴⁴

Like asset allocation, annuities were also treated more harshly under Senate Bill 539, as codified in Missouri Revised Statute Section 208.212.1. This statute added two limitations to the treatment of Title XIX annuities, which were already required to be actuarially sound.⁴⁵ First, the statute required that the annuity provide equal or nearly equal payments throughout its life, thereby forbidding balloon payments.⁴⁶ Second, the statute mandated that the annuitant make the state of Missouri the “secondary or contingent beneficiary” for amounts paid by the state for the individual’s care,⁴⁷ marking “a large departure from the previous policy of Missouri.”⁴⁸ These require-

allowed to retain assets in excess of the community spouse protected amount described in 42 U.S.C. Section 1396-r.”).

38. *Id.*

39. David G. Lupo, *Medicaid -- Long-Term Care in Missouri: An Update Since OBRA 1993*, 62 J. MO. B. 188, 189 (2006).

40. *Id.*

41. Turnbull, *supra* note 30. The MMNA may be increased upon a showing of the community spouse’s additional need. 42 U.S.C. § 1396r-5(e)(2)(B) (2000).

42. See Lawrence A. Frolik, *Medicaid: Paying for Long-Term Care*, SL071 A.L.I.-A.B.A. CONTINUING LEGAL EDUC. 331, 340 (2006).

43. Turnbull, *supra* note 30.

44. *Id.*

45. MO. REV. STAT. § 208.212.1(1)-(3) (Supp. 2006), *amended by* MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007).

46. *Id.* § 208.212.1(2). Balloon payment is defined as “[a] final loan payment that is [usually] much larger than the preceding regular payments and that discharges the principal balance of the loan.” BLACK’S LAW DICTIONARY 1165 (8th ed. 2004).

47. MO. REV. STAT. § 208.212.1(3). The statute also provided for a sixty month look-back period at all annuity purchases by applicants for Medicaid benefits. *Id.* § 208.212.2.

48. Lupo, *supra* note 39, at 190.

ments would be paralleled in the DRA's annuity provisions that were enacted a year later.

III. RECENT DEVELOPMENTS

A. *The Deficit Reduction Act of 2005*

The DRA is an extensive federal law intended to reduce the costs of government social spending, including Medicare and Medicaid, which are "straining budgets at both the State and Federal level."⁴⁹ While the bill's goal, a reduction in spending, results from a variety of changes that do not affect senior citizens,⁵⁰ the bill nevertheless forecloses many Medicaid planning methods previously available to elderly Americans and makes others more difficult. As President Bush put it, "[t]he bill tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits."⁵¹ By restricting asset transfer rules, requiring use of the income-first method of asset allocation, limiting the usefulness of annuities and life estates as a way to shelter assets, and including home equity as a countable asset, the DRA severely curtails previously available Medicaid planning options.

Under the DRA, the date on which the penalty period for asset transfers begins is the date of application for Medicaid, and the look-back period is increased from three to five years.⁵² The change in the starting date for asset transfer penalties is arguably the DRA's most significant amendment to Medicaid affecting the elderly.⁵³ The Act requires that an individual be eligible

49. Remarks on Signing the Deficit Reduction Act of 2005, WEEKLY COMP. PRES. DOC. 213, 214 (Feb. 8, 2006).

50. CONGRESSIONAL BUDGET OFFICE, *supra* note 6, at 1-3 (noting that "[t]he largest budgetary effects of S. 1392 over the next five years would stem from changes in federal student loan programs").

51. Remarks on Signing the Deficit Reduction Act of 2005, *supra* note 49, at 214.

52. Deficit Reduction Act of 2005, Pub. L. No. 109-171, sec. 6011, 120 Stat. 4, 61 (2006) (amending 42 U.S.C. § 1396p (2000)). See also *New Medicaid Asset Transfer Rules Under the Deficit Reduction Act of 2005*, 181 ELDER L. ADVISORY 1, 1 (2006) ("The 'look-back period' is the period of time within which Medicaid is permitted to review a Medicaid applicant's financial transactions to determine whether any of those actions would result in Medicaid disqualification. It begins with the date of application and goes backwards in time. Transactions outside of the look-back period are not part of the application process, and, thus, cannot be a basis for Medicaid disqualification.").

53. Sec. 6011, 120 Stat. 4, 61-62 (2006) (amending 42 U.S.C. § 1396p(c)(1)(D)) (For assets transferred after the enactment of the DRA, the date the penalty period begins "is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional

for Medicaid to start the running of the penalty period and that the individual be eligible at the time he or she applies for Medicaid benefits.⁵⁴ Whereas prior to the DRA, individuals could determine the penalty period at the time of an asset transfer and retain enough money to get them through the period of ineligibility,⁵⁵ now such planning is foreclosed.⁵⁶ According to the Congressional Budget Office's estimate, the practical effect of these changes is an average delay of three months in Medicaid eligibility.⁵⁷

Significantly, the DRA allows states to accumulate multiple transfers into one penalty period.⁵⁸ When an individual makes multiple "fractional transfers" for less than fair market value during the look-back period, states may determine the penalty period based on the total uncompensated value of all assets transferred during the period.⁵⁹ The decision of whether to accumulate gifts is left to the discretion of the states.⁶⁰

Moreover, in narrowing the asset transfer rules, the DRA prohibits states from "round[ing] down, or otherwise disregard[ing] any fractional period of ineligibility."⁶¹ Therefore, states are required to impose a "partial month

level care . . . but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection." See also *Additional Information*, *supra* note 13, at 1.

(Under pre-DRA law, "very few applicants for Medicaid incur penalties for prohibited asset transfers." However, delays in eligibility "would occur because individuals would either incur a penalty for prohibited transfers or refrain from making such transfers and instead pay for some nursing home care themselves.").

54. Sec. 6011, 120 Stat. at 61-62. See also Coffey et al., *supra* note 21, at 198.

55. The Centers for Medicare & Medicaid Services (CMS) noted this planning strategy, saying "individuals [were] 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 . . . until the expiration of that time period." CTRS. FOR MEDICARE & MEDICAID SERVS., SECTIONS 6011 & 6016, NEW MEDICAID TRANSFER OF ASSET RULES UNDER THE DEFICIT REDUCTION ACT OF 2005, pt. II(A) (2006), available at <http://www.cms.hhs.gov/smdl/downloads/TOAEnclosure.pdf>.

56. *Id.* Offsetting the impact of the penalty period, the DRA expands the "undue hardship" provision, permitting an institution to file an undue hardship application on behalf of a resident if the asset transfer rule 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." *Id.* at pt. V(A).

57. *Additional Information*, *supra* note 13, at 2 (noting that the average delay of three months is for the year 2006 and would decrease to 2 months by 2015).

58. Sec. 6016, 120 Stat. at 67 (amending 42 U.S.C. § 1396p(c)(1)).

59. *Id.*

60. In Missouri, Senate Bill 577 does not expressly mandate an accumulation of asset transfers in determining the penalty period. MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007).

61. Sec. 6016, 120 Stat. at 66 (amending 42 U.S.C. § 1396p(c)(1)(E)). See generally CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 55, for the CMS's interpretation of "rounding down."

disqualification” where the period of ineligibility would be less than one-month.⁶² Like the increased look-back period, prohibition of rounding down increases the amount of time an individual must wait before he or she is eligible for Medicaid benefits.

Just as limiting asset transfers causes longer periods of ineligibility, the DRA’s mandate that states use the income-first method of allocating assets lengthens the time before Medicaid becomes available to applicants.⁶³ Under this method the community spouse’s income includes both his or her income available at the time of a fair hearing and any anticipated post-eligibility transfers from the institutionalized spouse pursuant to 42 U.S.C. § 1396r-5(d)(1)(B).⁶⁴ By including present and imputing future income to the community spouse, this method virtually ensures that the community spouse’s monthly maintenance needs allowance will be met without requiring the institutionalized spouse to transfer additional assets. Therefore, the income-first method forces both spouses to expend more resources so that the institutionalized spouse may become eligible for Medicaid.⁶⁵

Another significant limitation to Medicaid eligibility by the DRA is the treatment of annuities, which were previously a tool through which Medicaid applicants could shelter assets.⁶⁶ Whereas prior to the enactment of the DRA, disclosure of annuity interests of applicants or community spouses was not required, Section 6012(a) of the DRA now requires such disclosure when individuals apply for long-term care services.⁶⁷ Failure or refusal to disclose information about annuities is *per se* grounds for denial of Medicaid bene-

62. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 55, at pt. II(B).

63. Keith Bradoc Gallant, *Long Term Care Insurance: Planning and Paying for “Long Term Care,”* SL071 A.L.I.-A.B.A. CONTINUING LEGAL EDUC. 345, 357 (2006). The requirement of the income-first method was mandated in Missouri by Senate Bill 539. MO. LEG. S.B. 539, 93d Gen. Assem., 1st Reg. Sess. (Mo. 2005).

64. *See* Wis. Dep’t of Health & Family Servs. v. Blumer, 534 U.S. 473, 484 (2002).

65. *Id.*

66. *See generally* Coffey et al., *supra* note 21.

67. Long-term care services include “[n]ursing facility services; [a] level of care in any institution equivalent to that of nursing facility services; and [h]ome and community-based services.” *See* CTRS. FOR MEDICARE & MEDICAID SERVS., SECTION 6012, CHANGES IN MEDICAID ANNUITY RULES UNDER THE DEFICIT REDUCTION ACT OF 2005, pt. I(A) (2006), available at <http://www.cms.hhs.gov/smdl/downloads/TOAEnclosure.pdf>. *See also* Harry S. Margolis, *Treatment of Annuities Under the Deficit Reduction Act of 2005*, SM054 A.L.I.-A.B.A. CONTINUING LEGAL EDUC. 669, 676-77 (2006) (“While the disclosure provisions are rather convoluted, the clearest way to read them is to impose notice requirements to annuities in which the state is in fact named as a remainder beneficiary under the transfer provisions described above.”). The article also notes that disclosure is only required for annuities purchased after the date of enactment of the DRA, February 8, 2006. *Id.* at 673.

fits,⁶⁸ therefore, a strong incentive exists to reveal annuities, whether or not these annuities may or will be treated as assets.⁶⁹

More specifically, the DRA sets out three scenarios in which annuities will not be considered transfers for less than fair market value and thus will not increase the penalty period for Medicaid applicants.⁷⁰ First, if the state is named as the primary beneficiary or the secondary beneficiary after the community spouse, or minor or disabled child, then the annuity is not a countable asset.⁷¹ Second, if the long-term care applicant purchases retirement annuities pursuant to 42 U.S.C. § 1396p(c)(1)(G)(i), as amended by Pub. L. No. 109-171, § 6012, 120 Stat. at 63-64, the annuities are not included in assets for Medicaid eligibility purposes.⁷² Third, if an annuity is irrevocable, non-assignable, and actuarially sound, and provides for equal payments with no deferral or balloon payments, then the transfer of assets does not apply to the determination of Medicaid eligibility.⁷³ By making the state a beneficiary and foreclosing balloon payments, the DRA reflects provisions already enacted in Missouri by Senate Bill 539.

The purchase of life estates is also limited by the enactment of the DRA. The Act redefines the term “asset” to include “the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least one year after the date of the purchase.”⁷⁴ It is important to note that living in the transferor’s home for one year does not automatically take the purchase out of the realm of “assets” for Medicaid eligibility purposes.⁷⁵ The next step in the analysis is to determine whether the

68. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 67, at pt. I(A).

69. *Id.*

70. Coffey et al., *supra* note 21, at 211-212.

71. *Id.*

72. *Id.* As amended, 42 U.S.C. § 1396p(c)(1)(G)(i) states: “For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes an annuity purchased 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 under this title unless (i) the annuity is (I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or (II) purchased with proceeds from (aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code; (bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or (cc) a Roth IRA described in section 408A of such Code” Deficit Reduction Act of 2005, Pub. L. No. 109-171, sec. 6012, 120 Stat. 4, 63-64 (2006) (amending 42 U.S.C. § 1396p(c)(1)(G)(i) (2000)).

73. Coffey et al., *supra* note 21, at 211-12; sec. 6012, 120 Stat. at 63-64 (amending 42 U.S.C. § 1396p(c)(1)(G)(i) (2000)). This language parallels section 208.212.1 of the Missouri Revised Statutes. MO. REV. STAT. § 208.212.1 (Supp. 2006).

74. Sec. 6016, 120 Stat. at 67 (amending 42 U.S.C. § 1396p(c)(1) (2000)).

75. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 55, at pt. IV.

transfer complies with existing provisions of Title XIX regarding Medicaid eligibility and asset transfers.⁷⁶

By including home equity as a countable asset, the DRA further curtails Medicaid planning options. The law makes individuals with more than \$500,000 in home equity assets who do not have a spouse, or minor or disabled child living in their home ineligible for Medicaid benefits.⁷⁷ Under the DRA, states can raise the home equity requirement to \$750,000 at their discretion.⁷⁸ Home equity was previously excluded from assets in the determination of eligibility for Medicaid benefits; therefore, the inclusion of home equity marks a manifest change in Medicaid eligibility requirements.⁷⁹ In reality, this change will “have a negligible effect on the treatment of the homes of married individuals” and would affect only about 2,000 Medicaid applicants annually by 2010.⁸⁰

The DRA mitigates the limits placed on Medicaid by making the creation of Long-Term Care (LTC) partnership programs an option available to the states.⁸¹ Previously, these programs were available in only four states.⁸² Under LTC partnership programs, people who use some of the benefits of private long-term care insurance policies may qualify for Medicaid benefits without meeting all of the eligibility requirements otherwise necessary.⁸³ The

76. *Id.* (noting that states should continue to follow CMS instructions for determining the value of life estates. It follows, as CMS states, that transfers of life estates for more than fair market value fall outside this rule and the amount transferred above fair market value is a countable asset. Similarly, gifts of life estates fall outside of this rule and the fair market value of the life estate is a countable asset). This rule does not apply to the sale of a life estate by a Medicaid applicant. *Id.* (“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 or assets has occurred and in calculating the period of ineligibility.”).

77. Sec. 6014, 120 Stat. at 64-65 (amending 42 U.S.C. § 1396p (2000)).

78. *Id.* at 65.

79. *Additional Information, supra* note 13, at 1-2.

80. *Id.* at 2.

81. Sec. 6021, 120 Stat. at 71-72 (amending 42 U.S.C. § 1396p(b)(1)(C)). *See generally* JOEL FERBER & JAMES FROST, MO HEALTHNET AND SB 577: A PRELIMINARY ANALYSIS OF REVISIONS TO THE MISSOURI MEDICAID PROGRAM 19 (2007),

<http://www.lsmo.org/Home/PublicWeb/Library/Documents/1185806991.02/SB%20577%20Overview%20Final%20Bill%20June%2011%20revised.pdf>.

82. New York, Connecticut, California, and Indiana were the first four states permitted to implement LTC partnership programs. Keith Bradoc Gallant, *Long-Term Care Insurance: Planning and Paying for “Long Term Care,”* SM061 A.L.I.-A.B.A. CONTINUING LEGAL EDUC. 71, 81 n.32 (2007).

83. JULIE STONE-AXELRAD, CRS REPORT FOR CONGRESS, MEDICAID’S LONG-TERM CARE PARTNERSHIP PROGRAM 3 (2005), <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3261001212005.pdf>.

goal of these programs is to “[e]ncourage the purchase of long term care insurance by providing that for every dollar of insurance benefit paid, the insured’s Medicaid exempt assets will increase by the same amount.”⁸⁴

B. *The Missouri Continuing Health Improvement Act*

Missouri anticipated and implemented a few provisions of the DRA with Senate Bill 539 and thereafter immediately put into practice the rest of the Act.⁸⁵ Still, the state went beyond these laws by enacting the Missouri Continuing Health Improvement Act of 2007 (MCHIA). The MCHIA changes the name of the state Medicaid program to “MO HealthNet”⁸⁶ and modifies the provisions of Missouri Medicaid by adopting some of the discretionary provisions made available to the states through the DRA.⁸⁷ Missouri implements DRA provisions in a restrictive manner by using a low divestment penalty divisor, choosing the lower threshold for home equity, and imposing stricter annuity rules. Moreover, the MCHIA limits the usefulness of personal care contracts previously available under Missouri common law, while slightly alleviating the burdens of the new law by creating a LTC partnership program as provided by the DRA.

Because the asset transfer rules of the DRA lengthen the period of ineligibility for Medicaid benefits, it is important to acknowledge the consequences for Missouri residents given the low divestment penalty divisor in this state.⁸⁸ The divestment penalty divisor is “the average monthly cost to a private patient of nursing facility services in the State . . . at the time of application.”⁸⁹ Title XIX requires that the penalty period be determined using this divisor.⁹⁰ In Missouri, the Family Support Division (FSD) of the Department of Social Services initially implemented this federal requirement by con-

84. Gallant, *supra* note 82, at 81.

85. MO. REV. STAT. § 208.010.7 (Supp. 2006).

86. MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007). This provision more broadly changes the name of “the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq.” to “MO HealthNet.” *Id.*

87. Senate Bill 577 does not expressly adopt the option to accumulate asset transfers in determining the penalty period which is left to the discretion of the states by the DRA; however, because Missouri automatically implements all changes to 42 U.S.C. §1396p and tends toward more restrictive measures, it is reasonable to expect the rule of accumulation of partial-month asset transfers will be adopted in Missouri. *Id.* See also RUDOWITZ & SCHNEIDER, *supra* note 5, at 9 (explaining that states are required to amend their Medicaid plans in order to comply with changes in federal laws).

88. See Turnbull, *supra* note 30.

89. 42 U.S.C. § 1396p(c)(1)(E)(i)(II) (2000).

90. *Id.*

ducting a survey of nursing homes throughout the state.⁹¹ But in an effort to “save the time and expense” of conducting the same survey annually, the FSD has since used the change in the U.S. Department of Labor Consumer Price Index to calculate the average private pay rate for nursing home care.⁹² The resulting divisor is much lower than the true average cost of nursing home care in the state, making the penalty period longer than it would be if the divisor accurately reflected nursing home costs.⁹³

In keeping with Missouri’s strict Medicaid requirements as reflected by the low divestment penalty divisor applied in recent years, the state chose to adopt the more stringent federal guidelines for Medicaid eligibility. Complying with the home equity requirement of the DRA, MO HealthNet forecloses long-term care services for individuals with more than \$500,000 in home equity.⁹⁴ Missouri opted not to raise the threshold for eligibility to \$750,000,⁹⁵ which is permissible under the DRA, thereby making certain homeowners less likely to be eligible for Medicaid benefits.

Just as home equity is no longer immune from consideration when determining Medicaid eligibility, MO HealthNet has implemented requirements that make annuities a less attractive financial planning option.⁹⁶ With the enactment of the MCHIA came the additional requirement that excludable annuities must “[n]ame and pay the MO HealthNet claimant as the primary beneficiary.”⁹⁷ In addition to the DRA, which mandates that the state be named primary beneficiary under an annuity upon the annuitant’s death, Missouri requires that a “community spouse, investing in an annuity, must also name the state of Missouri as the primary beneficiary upon the death of the annuitant, payee.”⁹⁸

Not only does the MCHIA limit the interpretation of Medicaid eligibility under federal law, but it also codifies and restricts the common law option of forming a personal care contract as part of Medicaid planning. In *Reed v. Missouri Department of Social Services*⁹⁹ the Missouri Court of Appeals for

91. Letter from Janel R. Luck, Dir. of the Family Support Div. of the Mo. Dep’t of Soc. Servs., to Rudy D. Beck, Rudy D. Beck & Assocs., P.C. (Mar. 28, 2007) (on file with author).

92. *Id.*

93. Letter from Mary R. McCormick, President of the Mo. Chapter of the Nat’l Acad. of Elder Law Attorneys, to Janel R. Luck, Dir. of the Family Support Div. of the Mo. Dep’t of Soc. Servs. (Feb. 20, 2007) (on file with author). As this article was being prepared for publication, the FSD increased the divestment penalty divisor in Missouri pursuant to the request of the Missouri Chapter of the National Academy of Elder Law Attorneys; however, it is unknown whether the FSD will continue to use the Consumer Price Index to calculate the divestment penalty divisor in the future.

94. MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007).

95. *See id.*

96. *Id.*

97. *Id.*

98. Lupo, *supra* note 39, at 190.

99. 193 S.W.3d 839 (Mo. App. E.D. 2006).

the Eastern District of Missouri upheld a personal care contract for medical and other services provided by a daughter for her institutionalized mother.¹⁰⁰ The daughter, Teson, provided meals, served as a communication link to medical staff, and noted medication errors when the nursing home staff was unavailable to care for her mother, Reed.¹⁰¹ The court, emphasizing that Teson's care exceeded that given by the nursing home staff, held that Teson's actions constituted valuable consideration for the payments made by Reed.¹⁰²

The MCHIA recognizes the holding of *Reed* but reduces its scope by requiring that the services provided do not duplicate those for which another party is being paid.¹⁰³ Moreover, that the MCHIA requires services to be "essential to avoid institutionalization" indicates a stricter standard than the one set out in *Reed*, as Reed was institutionalized at the time of the contract.¹⁰⁴ The MCHIA has three additional requirements: first, that the recipient of services have a "documented need" for the services given; second, that the services are paid for at the time of performance or within two months thereof; and third, that "[t]he fair market value of the services provided prior to the month of institutionalization is equal to the fair market value of the assets exchanged for the services."¹⁰⁵

Providing another opportunity to offset Medicaid restrictions, the MCHIA establishes the Missouri Long-Term Care Partnership Program, under which an individual may qualify for long-term care coverage without substantially spending down his or her resources.¹⁰⁶ In determining whether an individual qualifies for MO HealthNet benefits, Missouri "provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy."¹⁰⁷

100. *Id.* As its name suggests, a personal care contract is a contract that sets out duties of a "Care Provider" in exchange for payment by the "Care Recipient." *Id.* at 840. The court in *Reed* listed some of the duties of the care provider (Teson), including "preparation of nutritious, appropriate meals, house cleaning and laundry; assistance with grooming, bathing, dressing, and personal shopping . . . monitoring of Reed's physical and mental condition and nutritional needs in cooperation with health care providers; arranging for transportation to health care providers and to the physician of Reed's choice, . . . assisting Reed in carrying out the instructions and directives of Reed's health care providers; arranging for social services by social service personnel as needed; visiting at least weekly and encouraging social interaction; arranging for outings and walks . . . and interacting with and/or assisting any agent of Reed in interacting with [various] professionals." *Id.* at 840-41.

101. *Id.* at 843.

102. *Id.*

103. MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007).

104. *Id.*; *Reed*, 193 S.W.3d at 840.

105. MO. LEG. S.B. 577.

106. *Id.*

107. *Id.*

IV. DISCUSSION

The DRA and comparable provisions in MO HealthNet curtail planning opportunities previously available to the elderly in Missouri. Because Missouri has adopted among the strictest eligibility requirements for Medicaid (and HealthNet) benefits, “America’s middle class seniors” who have heretofore relied on Medicaid to pay for long-term care may be forced to seek other options.¹⁰⁸

Missouri has already implemented the asset transfer provision of the DRA. Thus, practitioners involved in Medicaid planning must be prepared to find alternative methods for asset transfers after February 8, 2006 and to explore alternative methods of funding long-term care if their clients are otherwise ineligible for Medicaid benefits. Most strategies regarding the timing and amount of asset transfers are foreclosed. Furthermore, planning opportunities seemingly available on the face of new laws, such as purchasing life estates, provide little practical opportunity for Medicaid planning. Still, limited Medicaid planning is available through the purchase of permissible annuities, the reduction of home equity to an amount below \$500,000, the formation of personal care contracts within the strict provision of Missouri law, and investment in long-term care insurance.

Prior to Congress narrowing the statutory definition of the term “assets” for Medicaid eligibility purposes, Missourians could shelter assets through the purchase of a life estate in another person’s home, thereby transforming “countable resources (cash) into a non-countable resource (the life estate).”¹⁰⁹ The purchaser of the life estate who was engaged in Medicaid planning need not live in or “[derive] any benefit from” the home to shelter his or her assets.¹¹⁰ The DRA radically changed this planning opportunity by requiring that the purchaser live in the home for one year, leaving little opportunity for an individual facing immediate long-term care to shelter countable assets from the Medicaid penalty equation.¹¹¹ Because of CMS’s strict interpretation of this provision, the opportunity to use life estates for Medicaid planning seems to be effectively foreclosed.

Annuity purchases are slightly more effective than investing in life estates; although they are less useful than they were prior to the DRA and MCHIA. Because certain features take annuity purchases out of the realm of impermissible asset transfers, such purchases are not completely precluded by recent changes.¹¹² These features include investments in retirement annuities

108. Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can It Be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 WM. MITCHELL L. REV. 111, 121 (2002).

109. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 55, at pt. IV.

110. *Id.*

111. Deficit Reduction Act of 2005, Pub. L. No. 109-171, sec. 6016, 120 Stat. 4, 67 (2006).

112. Lupo, *supra* note 39, at 190-91.

after entering a nursing home, annuities purchased with IRAs, retirement accounts, or employee pensions, or annuities that are non-assignable, actuarially sound, and provide for equal payments.¹¹³ Absent these features, however, annuities purchased are countable assets.¹¹⁴ Practitioners and applicants for Medicaid should be aware that even in the unlikely circumstance that an annuity is not subject to penalty under the transfer rules of the DRA, income derived from the annuity may be considered “in determining eligibility, including spousal income and resources, and in the post-eligibility calculation, as appropriate.”¹¹⁵

Like annuities, Missouri’s requirement that home equity over \$500,000 be considered a countable asset offers few planning opportunities. Although Missouri has chosen to adopt the lowest threshold available for home equity disqualification, this rule is still, as a practical matter, unlikely to “affect the majority of individuals who are worried about Medicaid benefits because of the relatively high equity cap.”¹¹⁶ Thus, only a small number of Missouri Medicaid applicants are now effectively unable to shelter assets in home equity.

Nevertheless, Missouri Medicaid applicants may be able “to obtain a reverse mortgage or home equity loan to reduce equity” to an amount below \$500,000.¹¹⁷ Reverse mortgages allow seniors “to borrow money against the equity of their home and receive cash payments” if the individual is “at least sixty-two years old” and owns and “[uses] the property as a primary residence.”¹¹⁸ The cash received from the reverse mortgage is still considered an asset for Medicaid eligibility purposes and must be used to pay healthcare

113. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 67, at pt. II(C). CMS notes that “[t]he 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/table_4c6.html.” CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 55, at pt. III.

114. See generally Thomas D. Begley, Jr. & Andrew H. Hook, *Medicaid Planning After Reform*, SM061 A.L.I.-A.B.A. CONTINUING LEGAL EDUC. 359, 368 (2007) (The authors recommend that practitioners make sure “the form of annuity contract has been approved by the State Department of Insurance. Otherwise, Medicaid can make the argument that the right to assign the annuity, to change the payee and to change the beneficiary are important consumer rights. Therefore, the annuity is void.”).

115. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 67, at pt. I(D).

116. Slyvius H. von Saucken, The Garretson Firm, The DRA of 2005 – What Havoc Has Congress Wrought? 27 (Mar. 27, 2007), http://www.garretsonfirm.com/pdf/TGLF_DRA_and_Settlements_03_07.pdf.

117. *Id.*

118. Robert C. Christopherson, Note, *Missing the Forest for the Trees: The Illusory Half-Policy of Senior Citizen Property Tax Relief*, 13 ELDER L.J. 195, 221-22 (2005).

costs or spent down to qualify for Medicaid.¹¹⁹ Both reverse mortgages and home equity loans are “condoned” by the DRA,¹²⁰ however, they trigger a number of complicated planning issues which are beyond the scope of this summary.

Another way to avoid the more stringent asset transfer rules enacted by the DRA is the formation of a personal care contract, an option that was upheld in *Reed* and codified in limited form by the MCHIA. Forming a personal care contract for assistance provided to a Medicaid applicant can take asset transfers out of the realm of non-fair market value conveyances.¹²¹ A number of contractual elements are required for the formation of a legally sound personal care contract, including identifying the parties, recognizing the specific duties of the care provider, establishing the duration of the contract and the compensation to be paid, and providing signatures and a date.¹²² The obvious practical difficulty with personal care contracts is that the recipient of funds must provide actual services for fair market value if the contract is to withstand legal scrutiny.

Advising clients to purchase long-term care insurance is another option to protect the elderly from Medicaid ineligibility. While the creation of the Missouri Long-Term Care Partnership Program expands the number of seniors who will receive Medicaid (or MO HealthNet) benefits, long-term care insurance is not a viable option for all Missourians facing institutionalization.¹²³ Certainly, it is difficult to qualify for long-term care insurance.¹²⁴ Furthermore, the DRA does not require that insurers partnering with states provide insurance to everyone.¹²⁵ Individuals with pre-existing or uninsurable conditions such as Alzheimer’s, dementia, diabetes, schizophrenia, or memory loss will not be able to obtain long-term care insurance.¹²⁶ In fact, “[n]ot a single state in the country has a long-term care insurance high risk pool that makes coverage available to those who are unable to obtain it in the

119. Tracy Speck Neisent, *Planning with the Residence Post DRA 2005*, 2006 NAELA INST. 2-1, pt. (1)(B).

120. *Id.* See generally Nat’l Acad. of Elder Law Attorneys, *Using a Reverse Mortgage to Pay for Health Care*, 17 FALL EXPERIENCE 19 (2006).

121. Rapp & Weeks, *supra* note 10, at 87.

122. *Id.* at 87-88.

123. See A. Kimberley Dayton, *Caveat Elder: Long-Term Care Insurance Partnership Policies Under the DRA*, 197 ELDER LAW ADVISORY 1, 3-4 (2007).

124. *Id.* (“[U]nderwriting standards preclude the sale of LTCI policies to persons with even the most minor of disabilities. This is not simply a matter of setting higher premiums for those who have an identifiable condition that could result in a need for long-term care at some future date. Rather, companies simply *will not insure* disabled persons. Most older persons who require institutional-level long-term care have one of three conditions: Alzheimer’s disease, diabetes, or disabilities resulting from a stroke.”).

125. *Id.* at 3.

126. *Id.* at 4.

private market.”¹²⁷

Moreover, long-term care insurance is expensive and is not affordable for many middle-class Americans – the same Americans who would otherwise be ineligible for Medicaid benefits, particularly after implementation of the DRA.¹²⁸ Monthly investments in a policy that might never be necessary can be an unreasonable financial burden or, at least, an imprudent investment, for middle-class individuals.¹²⁹ Making long-term care insurance a somewhat more attractive option, Missouri has an income tax deduction for long-term care insurance premiums.¹³⁰ Still, partnership policies do not affect income restrictions on Medicaid. Thus, practitioners should advise clients with high incomes that they may still have to spend down assets over the amount of their policy’s benefits to become eligible for Medicaid payments.¹³¹

One potential use of long-term care insurance is to offset the newly-enacted five-year look-back period.¹³² Under this strategy, “[h]ealthy clients could buy long-term care insurance for a period of five years. If they need long-term care in the future, they could transfer their assets at that time and wait out the five-year look-back through the use of long-term care insurance.”¹³³ To some extent, purchasing long-term care to alleviate the potential of ineligibility for Medicaid benefits minimizes other problems with long-term care, namely, the expense.

127. *Id.*

128. *Id.*

129. *Id.* at 4-5. Dayton also notes that

Implementation of a LTCIP program enables policyholders to protect assets--it does not affect in any way, shape, or form a state's income restrictions on medical assistance eligibility. Due to the high cost of LTCI, the majority of those who buy it are upper middle class individuals who are very unlikely to qualify for medical assistance due to their monthly incomes. This appears to explain why so few of all long-term care recipients in the four pilot states were actually able to obtain medical assistance after they had exhausted their long-term care insurance benefit.

Id. at 5.

130. See MO. LEG. S.B. 577, 94th Gen. Assem., 1st Reg. Sess. (Mo. 2007) (amending MO. REV. STAT. § 135.096.1 (2000)). The Medicaid Reform Commission, created by MO. REV. STAT. § 208.014 (repealed) to make the recommendations that shaped the development of Missouri HealthNet, was hopeful about the potential of long-term care insurance and recommended “efforts to educate consumers,” especially young consumers, about long-term care insurance. MEDICAID REFORM COMM’N REPORT, *supra* note 1, at 43. It is yet to be seen whether the Commission’s hopefulness was misguided.

131. MEDICAID REFORM COMM’N REPORT, *supra* note 1, at 42.

132. Begley, Jr. & Hook, *supra* note 114, at 362.

133. *Id.*

V. CONCLUSION

An increasing number of Missourians are facing the challenge of financing long-term care, a challenge made more difficult because the DRA and MCHIA limit access to Medicaid funds. The legislative desire to close so-called loopholes creates a tension between governmental and individual goals. Missourians affected by recent changes likely will look for permissible planning opportunities within the new framework to finance long-term care, exacerbating the tension that already exists amid the varying goals of Medicaid.

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