2015 Spring Elder Law Institute: Developments in Elder Law Rules and Regulations

May 1, 2015

STATE BAR of NEW MEXICO
CENTER FOR LEGAL EDUCATION

2015 Spring Elder Law Institute: Developments in Elder Law Rules and Regulations

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Friday, May 1, 2015 • 1-4 p.m.
State Bar Center

Co-sponsor: *Elder Law Section*
Standard Fee: $125
Elder Law Section members, government and legal services attorneys, and Paralegal Division members $115
Webcast Fee: $135

Noon Lunch and annual section meeting (provided at the State Bar Center)
12:30 p.m. Registration
1 p.m. **VA Proposed Rules and Regulations- Changing the Face of Aid and Attendance**
Lori L. Millet, J.D., LL.M (Elder Law), ABQ Elder Law, PC
2 p.m. Break
2:10 p.m. **ABLE Act- New Tool for Saving for Individuals with Special Needs**
Margaret "Peggy" Graham, J.D., Of Counsel, Pregenzer Baysinger Wideman & Sale PC
3:10 p.m. Break
3:20 p.m. **Effects of the ACA's MAGI Calculation**
Sara R. Traub, J.D., CPA, Associate, Pregenzer Baysinger Wideman & Sale PC
4 p.m. Adjournment and Spring Fling Reception with the New Mexico Guardianship Association

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2015 Spring Elder Law Institute: Developments in Elder Law Rules and Regulations

Presenter Biography

Lori Millet is a sole practitioner in Albuquerque, where she practices in the area of estate planning, elder law, trusts, probate, and guardianship and conservatorship. She also provides Guardian ad Litem services. Additionally, Lori is a certified attorney with the VA. She received her B.S. degree in medical technology from the University of Central Florida and her J.D. degree from the University Of New Mexico School Of Law, where she received the Dean's Award and the Wall Street Journal Academic Achievement Award. Lori obtained her LL.M. (Master of Laws) in Elder Law through Stetson University College of Law. Lori is a member of the State Bar of New Mexico (Real Property, Probate and Trust Section and Elder Law Section), and the National Academy of Elder Law Attorneys. Lori also served on the board of directors for the New Mexico Guardianship Association for eight years and served as the president and the secretary of the New Mexico Chapter of the National Academy of Elder Law Attorneys.

Spring Elder Law Institute: Developments in Elder Law Rules and Regulations

Presenter Biography

Margaret "Peggy" Graham began her career in Topeka, Kansas where she practiced for 15 years before returning to Albuquerque. While practicing in Kansas, Peggy tried many cases to a jury verdict while an Assistant Attorney General, represented the State in numerous child and adult abuse cases, established guardianships and conservatorships for hundreds of vulnerable adults, and represented the State in Medicaid and welfare benefits appeals. For seven years Peggy served as an Administrative Law Judge where she presided over hearings for state agencies, boards and commissions, including the Kansas Department of Social and Rehabilitation Services, the Kansas Board of Pharmacy, the Kansas Department of Health and Environment, the Kansas Human Rights Commission, and the Kansas Department of Labor. She was also appointed by then Governor Kathleen Sebelius to oversee HIPAA compliance for all of Kansas' governmental entities. Since moving back to Albuquerque with her family in 2009, Peggy has continued to represent clients in litigation matters including professional liability and employment discrimination. She also routinely represents individuals and families in the appointment of guardians and conservators for the elderly or disabled as both the petitioning attorney and Guardian ad Litem. Peggy has a unique perspective on the representation of families who have members with developmental disabilities and special needs as she is the mother of a special needs child. Peggy also has experience in estate planning for clients with large and small estates.

Education

Washburn University School of Law, J.D., 1995
Saint Mary's College, B.B.A., 1992

Admissions to Practice

Licensed to practice law in Kansas, New Mexico and Texas
United States District Court for the Districts of Kansas and New Mexico
United States Tenth Circuit Court of Appeals
The Supreme Court of the United States

Memberships and Activities

American Bar Association
Albuquerque Bar Association
New Mexico Bar Association (Elder Law and Trial Practice Sections, Member)
New Mexico Defense Lawyers Association
New Mexico Women's Bar Association
New Mexico Guardianship Association, Board Member, 2014 to present
Cerebral Palsy Parents Association of Albuquerque, Member, 2007 to present
Ronald McDonald House Charities of New Mexico, Board Member, 2012 to present
Rotary Club of Albuquerque, Member
Albuquerque Rotary Foundation, Board Member

Spring Elder Law Institute: Developments in Elder Law Rules and Regulations

Presenter Biography

Sara R. Traub is an associate with the law firm of Pregenzer, Baysinger, Wideman & Sale, in Albuquerque. She is admitted to practice law in New Mexico and in U.S. Tax Court and is also a Certified Public Accountant licensed in New Mexico. Her law practice concentrates on tax, estate planning, probate, long-term care planning and adult guardianships. She is the past Chair of the Elder Law Section of the State Bar and the Secretary of the Real Property, Trust and Estate Section of the State Bar. She is a member of the National Academy of Elder Law Attorneys and the New Mexico Society of CPAs. Sara is a 2008 graduate of UNM Law School and represents the third generation of her family to become a New Mexico attorney. She enjoys hiking and whitewater rafting.

VA Proposed Rules and Regulations—Changing the Face of Aid & Attendance

[redacted]

A&A Amounts: Maximum Per Month

- Single veteran, no dependents
  - $1,788
- Veteran with one dependent
  - $2,120
- Surviving spouse
  - $1,149
- This is the MOST the VA will pay even if unreimbursed medical expenses exceed these amounts
  - No cap on what Medicaid will pay

Basic Eligibility Requirements for Pension

- Veteran must have been discharged under other than dishonorable conditions
- Available to wartime veterans only (**minimum of 90 days of active duty, 1 day of wartime service prior to 9-8-80, then 24 mos of active duty or full time called into active duty**) - if DC d due to medical or some other reason not have to fulfill 24 mos
- Must have limited income and assets
- Pension may be increased if there are additional medical needs of the veteran (known as a housebound or aid and attendance allowance)
- Available to surviving spouses of wartime veterans who meet the financial and medical criteria
- Permanently and totally disabled NOT due to veteran's own willful misconduct
  - Age 65 alone considered permanently and totally disabled
- Compensation and Pension cannot be paid concurrently

Periods of War

	Start	End
World War II	12/7/41	12/31/46
Korea	6/27/50	12/31/55
Vietnam	8/5/64 2/28/61 if in-country earlier	5/7/75
Gulf War	August 2, 1990	Date fixed by Congress (currently considered ongoing

Limited Income and Assets: Factors from CFR

- Amount of claimant's income
- Whether the property can be readily converted into cash at no substantial sacrifice. Not much guidance in definition of "substantial sacrifice." Income tax hit on IRA's doesn't matter to VA.
- Life expectancy of claimant. Has direct bearing on whether claimant should pay his own way.
- Number of dependents
- Potential rate of depletion. What are out of pocket medical expenses. VA ignores other expenses.
- If over $80,000 will most likely be denied. No rule, because of VA rep allows a claim with that much in assets they have to justify the decision and more paperwork.
- Unsecured debts do not decrease a claimant's net worth.

Transfers

- There are no penalties for transferring assets. Yet.
  - Must transfer to relative living outside of home
- **Transfer to a relative living in the home will not count**
  - They care about what assets can yet benefit from and what assets can yet benefit from. If living in home, yet will probably benefit from those assets.
- Transferor must relinquish all rights of ownership, including control and the right to receive income.
  - Big business to sell irrevocable trusts and annuities
    - Caution: watch for unintended consequence of jeopardizing future Medicaid qualification.
- No look back period. Yet.

No Ability to Plan for Qualification

- Currently can transfer to annuity or irrevocable trust
  - NOTE: this is a primary reason for the changes
    - VA feels veterans are being taken advantage of
- With no ability to transfer to annuity or trust or cure the transfer, planning very difficult
  - Immediate annuities very valuable planning tool for Medicaid

VA Proposed Rule Changes

- Net worth limit of $119,220
  - Max CSRA for CS under Medicaid rules
  - Would apply to single and married
  - Indexed for inflation
- Would include income in calculation
  - NOT like Medicaid
- Any increase in income and assets of nonveteran spouse causes loss of eligibility for veteran spouse
  - NOT like Medicaid
- No ability to divert veteran income to nonveteran spouse
  - Medicaid allows diversion of up to $2980.50 as CSMA
- Take away ability to adjust assets allowed to keep to allow for age or degree of care needed by claimant

Look Back and Penalty Period

- Begin 3 year look-back
  - Medicaid is 5 years
- Max penalty period of 10 years
  - Medicaid unlimited
- Penalty period can be "cured" if all assets returned to claimant within 30 days of filing pension claim
  - No partial cures
  - Claimant won't know about need for a cure until too late because of the timing of the application process
- Presumption that all transfers made to become eligible for pension
  - Cannot use annuities or trusts

Calculation of Penalty Period

- Harsher than calculation of Medicaid
  - Divide amount transferred by average cost of nursing home care, or $6,455 for 2015
  - Same rule for all applicants
- Proposed rule: divisor is the amount of the benefit being sought
  - A surviving spouse's divisor would be $1,149, resulting in a larger penalty period
  - Married couple divisor is $2,120, so shorter penalty period
  - Single veteran divisor is $1,786

Disabled Children

- Transfers to disabled children only if child became permanently unable to support himself prior to age 18 because of mental or physical defect
  - Excludes adult children disabled because of age, health or accident
  - Medicaid permits transfers w/o penalty to a trust for the sole benefit of a child who is under 21, blind or disabled as defined by Social Security

Exclusion of Home

- Home would be excluded even if claimant not residing there
  - Same as Medicaid
  - This is beneficial, VA rule unclear before, resulting in irrevocable trusts for homes
- reasonable lot area - defined as 2 acres
  - Medicaid allows exclusion of contiguous land
  - Claimant in rural area may have 2.5 acres and not be able to sell only 0.5 acres

Deductible Medical Expenses

- Room and board not allowed unless IL provides or contracts with third parties for custodial or medical care
  - Some veterans move to facilities for practical reasons, such as not being able to go to the grocery store
  - Limited mobility prevents exit in an emergency
  - Higher risk for falls or strokes so need help readily available
  - Will prevent ability to live in least restrictive environment
- Limit on hourly rate for HHC
  - Max of average hourly rate for home health aides published by MetLife Mature Market Institute Market Survey of Long Term Care Costs
    - Care is more expensive than that in certain parts of the country

Unanswered Questions

- What will the effective date of the new regs be?
  - Comment period expired Mar 24 but no deadline for final regs
- Will transfers before the effective date will be "grandfathered" in
- Uncertainty for current applications
  - Is it worth it to apply?
  - Application process more difficult and longer than for Medicaid

Maximum 2015 Pension Rates for Non-Service Connected Claims

	Maximum Annual Rate	Maximum Monthly Rate
Veteran:		
Independent, No Dependents	$12,868.00	$1,072.00
Independent, One Dependent	$16,851.00	$1,404.00
Housebound No Dependents	$15,725.00	$1,310.00
Housebound, One Dependent	$19,710.00	$1,642.00
Aid and Attendance, No Dependents	**$21,466.00**	**$1,788.00**
Aid and Attendance, One Dependent	**$25,448.00**	**$2,120.00**
WW1 Vet –add	$2,923.00	$243.00
Surviving Spouse:		
Independent, No Dependents	$8,630.00	$719.00
Independent, One Dependent	$11,296.00	$941.00
Housebound, No Dependents	$10,548.00	$878.00
Housebound, One Dependent	$13,209.00	$1,100.00
Aid and Attendance, No Dependents	**$13,794.00**	**$1,149.00**
Aid and Attendance, One Dependent	**$16,456.00**	**$1,371.00**
2 Vets Married to Each Other:		
Both Independent	$16,851.00	$1,404.00
One Housebound	$19,710.00	$1,642.00
Both Housebound	$22,566.00	$1,880.00
One Aid and Attendance, One Independent	$25,448.00	$2,120.00
One Aid and Attendance, One Housebound	$28,300.00	$2,358.00
Both Aid and Attendance	**$34,050.00**	**$2,837.00**
To the Above Add for Each Additional Child:	$2,198.00	$183.00
Typical Medicare Part B Monthly Premium:		$104.90

Total Annual Automatic VA Deduction Off Medical:

Single Veteran:	$643.00
Veteran with dependent:	$842.00
Veteran Married to Veteran (Both A&A):	$842.00
Surviving Spouse without Dependent:	$431.00
Surviving Spouse with Dependent:	$564.00

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NAELA
National Academy of Elder Law Attorneys, Inc.
Leading the Way in Special Needs and Elder Law

March 17, 2015

William F. Russo, Acting Director
Regulation Policy and Management (02REG)
Department of Veterans Affairs
810 Vermont Ave. NW, Room 1068
Washington, DC 20420

Subject: RIN 2900-AO73, Net Worth, Asset Transfers, and Income Exclusions for Needs-Based Benefits

Dear Acting Director Russo,

On behalf of the National Academy of Elder Law Attorneys (NAELA), please accept our comments regarding *RIN 2900-AO73, Net Worth, Asset Transfers, and Income Exclusions for Needs-Based Benefits, Proposed Changes to 38 C.F.R. Part 3, Department of Veterans Affairs.*

NAELA represents more than 4,500 attorneys who are experienced and trained to provide legal advocacy, guidance, and services to maintain the quality of the life of persons with disabilities and persons as they age. Many members are accredited by the Department of Veterans Affairs (VA) to assist Veterans in the preparation, presentation, and prosecution of claims. Collectively, we submit this public comment for consideration on behalf of Veterans across the nation.

NAELA welcomes the effort to try to make the eligibility criteria for pension and other benefits administered by VA objective and transparent, but we believe that these proposed regulations, if implemented, would cause substantial harm to wartime Veterans, their spouses, and dependents

and will not solve the serious issue of unscrupulous organizations taking advantage of potential beneficiaries by selling inappropriate annuities or trusts.

In addition, we express the serious concern that the proposed rule's 3-year look-back period and transfer of assets penalty exceed statutory authority, opening up VA to future litigation and causing additional uncertainty for Veterans and their families.

VA Lacks Statutory Authority to Create Look-Back and Penalty Periods

Proposed § 3.276 would create a 3-year look-back period for asset transfers with a maximum penalty period of 10 years related to those transfers. However, VA lacks the statutory authority to do so, putting the agency at risk of litigation and greater uncertainty for Veterans, if implemented.

VA regulations must be authorized by a congressional statute in order to be valid. A regulation that is "in excess of statutory jurisdiction, authority or limitations ... will be held unlawful by a reviewing court." 5 U.S.C. § 706(2)(C); 38 U.S.C. § 7261. This standard of judicial review was clarified by the U.S. Supreme Court in *Chevron USA, Inc. v. NRDC, Inc.*, 467 U.S. 837 (1984).

Under the *Chevron* standard, federal agency regulations that are *explicitly* authorized by a federal statute are called "legislative regulations" and are "given controlling weight unless they are arbitrary, capricious or manifestly contrary to the statute." *Supra* at 844.

A regulation is also valid if there is an *implicit* delegation by congressional statute. In such a case, the regulation is granted deference by courts. If the statute is "silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible interpretation of the statute." *Supra* at 843.

In *Chevron*, the court upheld an Environmental Protection Agency (EPA) regulation because it was a "reasonable accommodation of manifestly competing interests ... ."

By applying the *Chevron* analysis to the asset transfer and penalty period rules set forth in proposed § 3.276, they can be seen as exceeding statutory authority granted by Congress under the applicable statutes in 38 U.S.C. §§ 501(a)(1), 1522, 1543, and 1506(1).

Lack of Statutory Authority Under § 501(a)

First, the statutory authority granted to VA in 38 U.S.C. § 501(a) merely contains the usual, general, and "necessary and appropriate" standard given to any federal agency in charge of administering a program. That standard certainly is far too general to qualify as a legislative regulation since § 501(a) does not expressly mention a look-back period and transfer penalty. Nor does § 501(a) constitute implicit delegation of congressional statutory authority for which deference is required because it does not in any way hint at a look-back period and penalty period.

Lack of Statutory Authority Under §§ 1522, 1543, and 1506(1)

38 U.S.C. §§ 1522, 1543, and 1506(1) direct VA to deny, reduce, or discontinue the payment of a pension:

> [W]hen the corpus of the estate [net worth] ... is such that *under all the circumstances*, including ... the annual income of the veteran, the veteran's spouse, and the veteran's children, it is *reasonable* that some part of the corpus of such estates [net worth] be consumed for the veteran's [or spouse's or child's] maintenance. (emphasis added)

The Executive Summary of the proposed regulations on page 5 discusses these three statutes, but does not mention the important words "under all the circumstances, including ... the annual income." While we agree that these statutes are silent on when it is reasonable to require the claimant to consume some part of his or her net worth, that silence is not enough to implicitly authorize VA to create Medicaid-like look-back and penalty periods. Rather, it is the province of Congress to create such rules. Congress had the opportunity to do just that from 2012 to 2014 through the submission of S. 3270/ H.R. 6171 (2012) and S. 748/H.R. 2341 (2013), each of which died in session.

These three statutes neither provide explicit nor implicit authority for VA to go back 36 months in time to deny a claim or continue a denial for 10 years into the future. Rather, these statutes are present-oriented in their reach to force a Veteran, spouse, or child to spend down currently held available assets as a condition for pension qualification. There is no suggestion in these statutes that Congress intended any past or future restrictions.

The Summary section makes numerous comparisons between its proposed rule and Medicaid long-term-care rules. But Congress, not the federal agency in charge of the Medicaid program, enacted the look-back and penalty period rules for the Medicaid program in the Omnibus Budget Reconciliation Act of 1993 and Deficit Reduction Act of 2005 (DRA).

A recent example of a congressional statute that provides proper specific regulatory authority is subsection (g) of the Achieving a Better Life Experience (ABLE) Act of 2014:

> (g) Regulations—The Secretary shall prescribe such regulations or other guidance as the Secretary determines necessary or appropriate to carry out the purposes of this section, including regulations—
> (1) to enforce the 1 ABLE account per eligible individual limit,
> (2) providing for the information required to be presented to open an ABLE account,
> (3) to generally define qualified disability expenses,
> (4) developed in consultation with the Commissioner of Social Security, relating to disability certifications and determinations of disability, including those conditions deemed to meet the requirements of subsection (e)(1)(B)(ii),
> (5) to prevent fraud and abuse with respect to amounts claimed as qualified disability expenses,
> (6) under chapters 11, 12, and 13 of this title, and
> (7) to allow for transfers from one ABLE account to another ABLE account ....

Sections 1522, 1543, and 1506(1) do not provide similar specificity.

In applying the *Chevron* standard to the proposed look-back and penalty periods, it is true that there are gaps in applying §§ 1522, 1543, and 1506(1). However, VA has already adequately filled these gaps in adopting its existing regulations set forth in 38 C.F.R. §§ 3.275 and 3.276.

In particular, 38 C.F.R. § 3.275(d) provides a list of factors VA should consider when evaluating a claim, such as income, convertibility of property into cash, life expectancy, family membership, potential rate of asset depletion, and unusual medical expenses — and in doing so § 3.275(d) implements the "under all the circumstances" of 38 U.S.C. §§ 1522, 1543, and 1506(1).

By contrast, the look-back and penalty periods of proposed § 3.276 would swallow up the "under all the circumstances" mandate of the three cited statutes. Rather than the multifactor statutory mandate, there would be only two factors under the proposed regulations: whether there was a transfer within 36 months and whether the claimant's other assets are below the new bright-line Medicaid-related asset limit. Such a regulatory formulation clearly exceeds the authority granted in the three statutes.

Moreover, the look-back period, transfer penalty, and net worth rules of the proposed regulations provide no special protections for a Veteran's spouse — unlike the spousal asset and income allowances built into the Medicaid long term care (LTC) program. In the Medicaid LTC program, it is clear that Congress' intent, through these allowances, is to prevent the impoverishment of the community spouse when his or her institutionalized spouse qualifies for Medicaid LTC benefits. The spousal protections provided by the Medicaid LTC program include an exception for divestment of gifts made between spouses, a conversion of assets to provide extra income for the community spouse, a minimum income allowance, and a minimum asset allowance. The proposed regulation only provides one of these protections and falls detrimentally short of congressional intent.

Further evidence that VA does not have implicit authority to issue the look-back period and transfer penalty is provided in the relevant Government Accountability Office (GAO) report, GAO-12-540, May 15, 2012, wherein the GAO made the following specific recommendation:

> Congress should consider establishing a look-back and penalty period for pension claimants who transfer assets for less than fair market value prior to applying, similar to other federally supported means-tested programs.

The GAO report also comments on the role VA should have in this matter:

> VA should (1) request information about asset transfers and other assets and income sources on application forms, (2) verify financial information during the initial claims process, (3) strengthen coordination with the VA's fiduciary program, and (4) provide clearer guidance to claims processors assessing claimants' eligibility.

The final rule should strike the look-back period and transfer penalty from the proposed rule, given that it lacks the statutory authority to impose these measures pursuant to 5 U.S.C. § 706(2)(C); 38 U.S.C. § 7261; *Chevron USA, Inc. v. NRDC, Inc.*, 467 U.S. 837 (1984); and GAO-12-540. This authority rests solely with Congress.

Proposed § 3.276 Transfer Penalties Exception Is Too Narrow

Under the proposed rule, an applicant cannot rebut the presumption that all gifts and transfers were made for purposes other than VA pension eligibility, with one narrow exception. That exception is for fraud, misrepresentation, or unfair business practice "related to the sale or marketing of financial products or services for purposes of establishing entitlement to VA pension."

With this limited exception, Veterans and their surviving spouses will be unjustly penalized for prior transfers that had absolutely nothing to do with VA pension eligibility. Gifts to children at holidays and birthdays will be penalized. Donations to places of worship will be penalized. Contributions to charities will be penalized. All because there is a presumption that the transfer was made for the purpose of qualifying for VA pension and unless there was fraud, misrepresentation, or unfair business practice, the presumption cannot be rebutted. As a result, the Veteran or surviving spouse could be disqualified for VA pension benefits for up to 10 years.

The final rule should require that transfers only made for the sole purpose of qualifying for VA pension be penalized. If the claimant can show by a preponderance of the evidence or a prior pattern of gifts that a transfer was not made for the purpose of qualifying for VA pension but for a completely unrelated purpose, no penalty should be imposed.

Proposed § 3.276 Should Allow for Partial Cures

Proposed § 3.276(e)(5) only allows a penalty period to be "cured" if all assets are returned to the claimant within 30 days of filing a VA pension claim. This means that Veterans who gave an adult child a birthday gift for the past 3 years would be subject to the penalty unless they receive every cent back from the child. In addition, Veterans who made donations to the Wounded Warriors Project for the past 3 years would be penalized unless they demanded and received a return of all of those donations from the nonprofit.

A more equitable solution is to allow for a partial cure of a gift or transfer at any time that will reduce the penalty period according to the amount returned. For example, consider a Veteran who gifts $20,000 to his or her adult child and later applied for VA benefits. Upon notification from VA that the gift made the Veteran ineligible for a VA pension, the child returns $10,000. If the final rule allowed partial cures, the penalty period would be cut in half, which would be fair and equitable. Recalculating the penalty period upon partial cure will take no more time than confirming the cure itself. The final rule should allow a reduction in penalty period for partial returns of transfers.

Time Allowed to Cure Transfers Should Be Expanded

The proposed time constraints for curing a gift make it nearly impossible to do so. The proposed rules require that all gifts be returned to the claimant within 30 days of filing a VA pension claim. However, many claimants, without the benefit of an attorney or without knowledge of the regulations, will have no idea that they have done something to disqualify them from benefits until they receive a denial letter — which is, on average, 9 months or later from the filing date. It will be too late at that time for a claimant to return any transferred money and get a penalty removed. Furthermore, 30 days is an extremely limited period of time to track transfers and

recoup them from the prior 3-year period, especially for a claimant who may be suffering from serious medical issues. Moreover, persons with dementia may need a guardian or conservator appointed in order to recover a transfer, which could take a significant amount of time to arrange and process through the court system.

Instead, the final rule should allow a claimant 90 days from *the date of the denial letter* to return a disqualifying transfer and receive a total or partial cure of the penalty period. This would better allow sufficient time for a claimant to trace transferred funds and attempt to recover those funds, if possible.

Use Comparable Federal Laws for Transfers to a Trust for a Child Incapable of Self-Support

Under proposed 38 C.F.R. § 3.276(d), a Veteran, the Veteran's spouse, or the Veteran's surviving spouse could make a transfer to a trust for a disabled child only if that child became permanently incapable of self-support prior to age 18 because of a mental or physical defect, pursuant to 38 C.F.R. § 3.356. This strict standard excludes adult children who become permanently disabled later in life due to an accident, health reasons, age, or other reasons and thereby become dependent again on a Veteran parent. It is inequitable to treat a child who becomes permanently disabled later in life differently from a child who becomes permanently disabled prior to age 18.

The final rule should adopt the same standard as the federal Medicaid law. Under 42 U.S.C. § 1396p(c)(2), an applicant can transfer any asset without penalty to a trust for the sole benefit of a child who is under 21, blind, or disabled as defined in 42 U.S.C. § 1382(c). This will allow a Veteran, the Veteran's spouse, or the Veteran's surviving spouse to ensure that any child who is blind or disabled is taken care of properly, regardless of the age the disability began.

Proposed § 3.276 Disproportionately Harms Surviving Spouses of Veterans

When calculating the transfer of assets penalty, the proposed rule would use the maximum annual pension rate, plus the aid and attendance supplement, divided by 12, based on the type of

applicant. A married Veteran's rate would be $2,120 per month, a single Veteran's rate $1,788 per month, and a surviving spouse's rate $1,149 per month.

By comparison, 42 U.S.C. § 1382b(c), pertaining to Supplementary Security Income (SSI), the penalty devisor for transferring assets is the SSI monthly rate, which is the same for *all* SSI recipients, currently $733 per month. For nursing home Medicaid recipients, the penalty divisor is the average monthly nursing home rate for all applicants in a region. For example, the average nursing home rate per month in Georgia is $5,825, as determined annually by the Georgia Department of Community Health. Thus, all Georgia residents applying for nursing home Medicaid are subject to the same penalty divisor. When a married applicant transfers $100,000, a 17.16-month penalty is assessed ($100,000 divided by $5,825). Likewise, when a single applicant transfers $100,000, the penalty period is 17.16 months.

In the proposed rule, married Veterans, single Veterans and surviving spouses have different penalty periods based on the maximum annual pension rate (MAPR) with Aid and Attendance (A&A) instead of based on the actual dollar amount transferred. In addition, the proposed rule does not specify how gifts or other transfers made by one spouse who then passes away before an application is filed would be treated, which the final rule should clarify.

Examples of Proposed Rule's Disproportionate Transfer Penalties

- Married Veteran transfers $10,000 – penalty = 4.71 months ($10,000/$2,120)
- Single Veteran transfers $10,000 – penalty = 5.59 months ($10,000/$1,788)
- Surviving spouse transfers $10,000 – penalty = 8.70 months ($10,000/$1,149)

Surviving spouses are most often women and historically have lower lifetime earnings than their partners. Many served as caregivers to their Veteran spouses. Yet the proposed rule would apply a more stringent penalty on them, almost double, for transferring the same amount of money.

The final rule should use one figure as the penalty divisor for *all* transfers regardless of the type of applicant, which should be the MAPR with A&A for a married veteran — $2,120. This would be consistent and equitable to all applicants and easier for VA to administer.

Proposed Definition of "Transfer for Less Than Fair Market Value" and Its Application Related to Annuities and Trusts Are in Conflict

Proposed § 3.276(a)(4) defines "fair market value" as the price at which an asset would change hands between a willing buyer and willing seller who are under no compulsion to buy or sell and who have reasonable knowledge of relevant facts.

The proposed rule also defines "transfer for less than fair market value" as the selling, conveying, gifting, or exchanging of an asset for an amount less than the asset's fair market value, including "any financial instrument or investment that reduces net worth and would not be in the claimant's financial interest were it not for the claimant's attempt to qualify for VA pension by transferring assets to or purchasing such instruments or investments — two examples of such being annuities and trusts."

The proposed rule defines "annuity" as "a financial instrument that provides income over a defined period of time for an initial payment of principal." The proposed rule defines "trust" as "a legal arrangement by which an individual (the grantor) transfers property to an individual or an entity (the trustee), who manages the property according to the terms of the trust, whether for the grantor's own benefit or for the benefit of another individual."

The first issue is that the proposed rule does not recognize or acknowledge, through its definitions, the different types of annuities or trusts, thereby treating all of them the same, which would improperly impose transfer of assets penalties.

Certain Annuities Comply With the Intent of the VA Pension Program

Certain annuities comply with the intent of the VA pension program, are in the best financial interest of the claimant, and are exempt by other, similarly situated needs-based programs such

as Medicaid, to which VA has referenced consistently as its guide when proposing changes to the regulations.

By law, VA must consider whether it is reasonable, under all the circumstances, for the claimant to "consume some" of his or her estate for maintenance. An annuity as defined by VA, "a financial instrument that provides income over a defined period of time for an initial payment of principal," does exactly that.

For example, consider a claimant who converts $100,000 from a savings account into a single premium immediate annuity. The annuity is annuitized over the claimant's life expectancy, which means that the entire principal amount of $100,000, plus interest, will be paid back to the claimant by the expiration of the claimant's life expectancy. The guaranteed monthly income is being spent on medical expenses and living expenses. This monthly income is also countable toward the income/net worth limit.

For Medicaid eligibility, Congress decided that these specific types of annuities were to be exempt under the DRA. These annuities are often solid retirement, financial, and estate planning mechanisms. For example, consider a claimant who has $3,000 in monthly income. His/her assisted living facility costs $6,500 per month, leaving him/her with a shortfall of $3,500 per month. With his/her VA pension of $1,788, his shortfall is $1,712 per month. Assuming his/her life expectancy is 3 more years, he/she could convert $60,000 into a single premium immediate annuity (SPIA), which would produce the extra $1,712 per month he/she needs for the rest of his life. His/her other assets would be necessary and used to cover increases in health care costs and daily living expenses.

Certain annuities are in conflict with the intent and integrity of VA pension program and should be treated as either resources or transfers of assets for less than fair market value. Examples of such annuities are (1) revocable annuities, which can be cashed in for the initial premium minus any early withdrawal penalties, and (2) deferred annuities, wherein an initial lump sum is paid but income is deferred until later. This too is consistent with the Medicaid laws enacted by Congress.

The final rule should treat a nonrefundable, nonassignable SPIA, which is actuarially sound as an income stream only, not as a covered asset or as a transfer of assets for less than fair market value. Revocable deferred annuities should be treated as countable toward net worth. Irrevocable deferred annuities should be treated as a covered asset subject to the look-back period and as transfers for less than fair market value.

Final Rule Should Differentiate Between Revocable and Irrevocable Trusts

There are two main types of trusts — revocable and irrevocable. VA has a history of issuing Office of General Counsel opinions on how assets should be treated when they are transferred to a trust.

Revocable Living Trusts

Revocable living trusts are legal instruments wherein the grantor retains all rights of ownership and control. These trusts are a common estate planning tool for (1) easing the transition into incompetency and disability and (2) avoiding probate.

The proposed rule would treat all transfers of assets into this type of trust as transfers for less than fair market value and impose a penalty. This is contrary to all laws, in addition to Board of Veterans Appeals Decision, Citation 9712649, April 11, 1997, wherein the court accurately and appropriately held that the income from the trust was countable toward income for VA purposes. It follows that the assets inside the trust would be countable for net worth purposes.

Irrevocable Living Trusts

Irrevocable living trusts are legal instruments wherein the assets inside the trust are not available to the grantor of the trust; however, on occasion, the grantor may have reserved the right to receive income from the trust. VA's long-standing Office of General Counsel opinions regarding irrevocable living trusts include VAOPGCPREC 64-91 (held that only such portion of the trust property as made available for the veteran's use is countable for income and net worth purposes) and VAOPGCPREC 73-91 (held that assets placed into an irrevocable living trust for the benefit of grandchildren is not countable toward the veteran's net worth). VA also issued

VAOPGCPREC 33-97, specific to first-party special needs trusts, which held (arguably in error based on federal special needs trust laws) that the assets are countable.

Final Rule Should Treat Revocable and Irrevocable Trusts Differently

VA should maintain the current long-standing history of

1. Treating assets in a revocable living trust as countable toward income and net worth standards.
2. Treating assets transferred to an irrevocable living trust as exempt from net worth standards. However, if it is found that VA has the authority to impose a look-back period and transfer of assets penalty without the approval of Congress, a penalty should be assessed on the covered assets transferred to the irrevocable living trust.
3. Overturning the erroneous VAOPGCPREC 33-97 decision to conform to the special needs trust laws at 42 U.S.C. § 1396(p), Social Security Act §§ 1917(d)(4)(A) and 1917(d)(4)(C), exempting a transfer of assets penalty when assets are transferred to a special needs trust for the benefit of the grantor or another individual with disabilities.

Proposed § 3.275(3) Arbitrarily Excludes Lot Sizes Larger Than 2 Acres

When determining assets for the purpose of net worth, the proposed rule continues to exclude personal residences but creates a new limitation by excluding lots larger than 2 acres.

As stated in VAOPGCPREC 64-91, it is the "apparent congressional objective of assuring that an incompetent veteran is not rendered homeless by operation of statute by excluding the value of the veteran's home from the veteran's estate." *See*, by analogy, Sen. Rep. No. 98-604, 98th Cong., 2d Sess., reprinted in 1984 U.S.C. Cong. & Admin. News 4479, 4518 (concerning home exclusion under 38 U.S.C. § 3203(b) (now § 5503(b)). We also note the definition of "corpus of estate" for pension purposes as excluding the claimant's dwelling but "including a reasonable lot area." 38 C.F.R. §§ 3.263(b), 3.275(b). *See also* 123 Cong. Rec. S19754 (daily ed. Dec. 15, 1977) (statement of Sen. Alan Cranston).

Current policy defines "reasonable lot area" as "the degree to which the property is connected to the dwelling and *the typical size of lots in the immediate area*" and "[c]ontiguous land which is

closely connected to the dwelling in terms of use, and *which does not greatly exceed the customary size of lots in the immediate area* ... ." (emphasis added) M21-1MR, Part V, Subpart iii, Chapter 1, § J, 71.d.

When limiting the lot size to 2 acres, the proposed rule does not offer any commentary on why it was necessary to further refine this definition. This proposed criteria is arbitrary and capricious. The standard the proposed rule used to substantiate limiting the lot size to 2 acres was based on new home sales in 2010. First, those figures are outdated by 5 years. Second, Veterans seeking the pension benefit, many of them elderly, have owned their homes for decades and purchased them without the ultimate goal of filing for VA pension years later.

These proposed changes will have a dramatically negative effect on rural Veterans who have homes on lots similar to the norm in their communities. According to the National Center for Veterans Analysis and Statistics, Veterans as a group tend to live in more rural areas than the general population. In addition, seniors often move to more rural areas in retirement age due to lower costs of living.

Maintain Immediate Area Analysis or Alternatively Exempt Lot When for Sale

The final rule should maintain the current intent of Congress, laws, and VA policy by excluding for net worth purposes the personal residence and "reasonable lot area" as defined by the VA as "the typical size of lots in the immediate area."

Additionally, if it is determined that limiting the lot size does not run afoul of congressional intent and a lot size of not more than 2 acres is exempt from net worth standards, the excess property should be exempt, as well as any other real property, as long as it is for sale at current market value. This is consistent with laws and policy in that the convertibility of an asset into cash is an element that is to be considered when determining net worth. Obviously, if the property is listed for sale but is not yet sold, it is not an asset that can be consumed for living expenses or care until actually sold. This is also consistent with Medicaid regulations, to which VA consistently refers as similar to VA pension program. In addition, if the 2-acre rule is implemented, the final rule should provide for a six-month period with which to purchase a new

personal residence. Under the proposed rules, the claimant/recipient of benefits has until December 31st to reinvest the proceeds into a new residence. This disproportionately harms claimants who sell their homes during the second half of the year, especially those who sell in the month of December. Whereas, those who sell during January have an entire year to reinvest in a new home. Changing the regulations to provide all claimants/recipients a six-month period to reinvest would equitably treat all claimants the same regardless of when the house sells.

VA Should Continue With a Factor Analysis for Net Worth Limits

Proposed § 3.274 seeks to create a test that combines the assets and income of a beneficiary into a single net worth test aligned with the community spousal resource allowance in Medicaid. But the VA already has a process, which can be administered consistently without variation or discretion on behalf of the individual adjudicator. At present, § 3.275(d) requires VA to consider the (1) claimant's income, (2) liquidity of property, (3) life expectancy of the claimant, (4) number of family members, and (5) rate of depletion of assets.

Proposed Net Worth Limits Are Harsher Than Medicaid's Limits

While the Medicaid program is analogous to VA's pension program, in that they are both needs-based programs, adopting the Medicaid asset limitation for VA purposes, in the way the proposed rule intends to do so, is much more limiting and impoverishing in nature than the Medicaid system.

First, the proposed rule includes both income and assets of the claimant and any family member toward the bright-line figure. Medicaid considers only the assets of the claimant and spouse, not the income.

Second, the proposed rule does not incorporate Medicaid's protections to prevent the impoverishment of the healthy spouse (the community spouse). One of the Medicaid spousal protections the proposed rule neglects to incorporate is that the community spouse is permitted to acquire assets in excess of his or her asset allowance after the noncommunity spouse's Medicaid eligibility is established without disqualifying the noncommunity spouse from eligibility. This is

not the case under the proposed rule, wherein any increase in income and assets of the nonveteran spouse can cause the veteran spouse to lose eligibility.

Third, in addition to preserving a certain asset limit for the community spouse to prevent further impoverishment, Medicaid does not consider the community spouse's income when determining eligibility. The proposed rule, on the other hand, requires that *all* income, from both the Veteran and the spouse, be completely consumed by medical expenses before the claimant meets the income eligibility for the maximum annual pension rate, leaving absolutely no available income for non-medical living expense.

Fourth, Medicaid covers as much as 100 percent of the costs for care (i.e., room and care in a nursing home), including all medication, for the Medicaid recipient. Moreover, Medicaid allows the Medicaid recipient to divert up to as much as $2,980.50 (2015 Maximum Monthly Community Spouse Maintenance Allowance) to the community spouse for nonmedical living expenses. Veterans' pensions merely provide for a small offset of costs. Thus, the VA claimant will continue to rapidly deplete assets to maintain access to long-term care. By contrast, Medicaid will protect a recipient's assets from the daily costs of care.

Fifth, the bright-line asset/income limit does not take into account the age or degree of care needed by the claimant. A 68-year-old claimant who suffered a stroke and needs 24/7 care will presumably need much more in assets and income than a claimant who is 98 with colon cancer.

Use Age as a Factor When Determining Financial Need

The final rule should continue to use age analysis already outlined in M21-1MR, Part V, Subpart iii, Chapter 1, § J:

> No specific dollar amount can be designated as excessive net worth. What constitutes excessive net worth is a question of fact for resolution after considering the facts and circumstances in each case. A number of variables must be taken into consideration when making a net worth determination.

Factors to consider include

- income from other sources
- family expenses
- claimant's life expectancy, and
- convertibility into cash of the assets involved.

Note: In general, the older an individual is, the smaller estate the individual requires to meet his/her financial needs.

The VA life expectancy table is located at M21-1MR, Part V, Subpart iii, Chapter 1, § J, 72, Exhibit 1: Life Expectancy Table for Net Worth Determinations. The final rule could develop a fairly simple formula for determining net worth based on age.

As VA recognizes, the current net worth limit covers between 1 and 2 years of care in a nursing home. But these limits are harsh, particularly for younger Veterans with disabilities who must receive care over a substantial number of years.

Example Net Worth Limits Using Age as a Factor

Step 1: (income x life expectancy) + total liquid assets = net worth

Step 2: net worth – (medical expenses x life expectancy) = net worth for VA purposes

- If the net worth for VA purposes is positive, the claimant is ineligible and denied benefits.
- If the net worth for VA purposes is negative, the claimant is approved for benefits.

Example 1

$35,000 annual income x 6 years' life expectancy = $210,000 + $130,000

liquid assets = $340,000 net worth

$78,000 annual medical expenses x 6 years' life expectancy = $468,000 medical expenses

$340,000 net worth minus $468,000 medical expenses = negative amount = approved

Example 2

$65,000 annual income x 3 years' life expectancy = $195,000 + $90,000 liquid assets = $285,000 net worth

$78,000 annual medical expenses x 3 years' life expectancy = $234,000 medical expenses

$285,000 net worth minus $234,000 medical expenses = $51,000. Net worth for VA purposes: the claim would be denied for excessive net worth.

Creating a Single Bright-Line Test Because of Delays Is Unwarranted

The need to impose a bright-line net worth test for all claimants due to VA's concern that current rules require collection of additional information that is not solicited in the initial application, thus delaying processing times, is unwarranted. Instead, the initial application could solicit the required information from the outset. VA already has a form for soliciting the information subsequent to the application, VA Form 21-8049, Request for Details of Expenses.

VA should modify the current application forms (VA Forms 21-526EZ and 21-534EZ) to include or incorporate the necessary information solicited in VA Form 21-8049. The formula for net worth would then be as follows:

> Step 1: (income x life expectancy) + total liquid assets = net worth
> Step 2: net worth – [(medical expenses x life expectancy) + (nonmedical living expenses x life expectancy)] = net worth for VA purposes

The basic issue in evaluating net worth is to determine whether the claimant's financial resources are sufficient to meet the claimant's basic needs (both medical and nonmedical) without assistance from the VA. M21-1MR, Part V, Subpart iii, Chapter 1, § J, 67.g. Using the formula above satisfies the current laws without making changes to the net worth standard.

Proposed § 3.278 Limiting Deductible Medical Expenses Violates Statutory Authority and Harms Those Seeking Less Restrictive Environments

The proposed rule goes too far in limiting medically necessary expenses for the health and welfare of Veterans, particularly senior Veterans and their spouses who are beginning to show

signs of advanced aging and/or dementia. The proposed cap on fees paid to caregivers would limit Veterans' choices to providers that charge at or below the national average. This is unduly burdensome on families, particularly those in higher cost areas of the country. More importantly, restricting the ability to deduct medical expenses, specifically the hourly amount of home health care provider rates to $21 per hour exceeds statutory authority under 38 U.S.C. § 1503(8). Those provisions allow for "amounts equal to amounts paid...for unreimbursed medical expenses." Thus, the provisions only allow for regulations to define what constitutes a medical expense as exclusions of income. These provisions do not allow for monetary limitations on those medical expenses, but instead deem "amounts equal to amounts paid" as exclusions of income for qualification purposes.

Remove the Licensure Requirements

Proposed § 3.278(b)(8) removes the facility's licensure requirement and the requirement that it be staffed with custodial care providers 24 hours per day or, in the alternative, the requirement that the facility be staffed 24 hours per day even if the primary duty of the staff present at certain times (such as overnight) are providing direct custodial care or serve as emergency responders. Proposed § 3.278(d)(2) should be expanded to either remove or significantly increase the limitation on payments to an in-home attendant. Proposed § 3.278(d)(2)(i) should be amended to include medication management as an activity of daily living.

Proposed § 3.278(b)(8) Definition of "Custodial Care" Effectively Eliminates the Ability of Any Person Who Is Rated as Housebound but Does Not Have a Mental Disorder to Deduct Facility Fees as Medical Expenses

Veterans who are eligible to receive a VA pension qualify for the pension at the Housebound rate if they have a single permanent disability that is rated at 100 percent by a schedular evaluation and either have at least one additional disability independently rated at 60 percent or more per 38 C.F.R. § 3.351(d)(1) or are permanently housebound by reason of their disabilities per 38 C.F.R. § 3.351(d)(2).

Some Veterans move to independent living facilities when living in their private dwellings no longer meets their needs due to the following: (1) not having transportation to medical

appointments or to places for meeting other basic living needs, such as the grocery store; (2) not being able to safely exit the house in the event of a fire because of limited mobility (e.g., having a fall risk, being in a wheelchair); or (3) being identified as having a high risk for strokes, heart attacks, or other medical ailments based on their medical history. These individuals no longer drive; are essentially confined to their homes, as defined in 38 C.F.R. § 3.351; and are in need of a safer environment due to their medical conditions. Nevertheless, under proposed § 3.278, their facility fees would not be deductible because they do not meet the proposed requirement for receiving custodial care resulting from their not having mental disorders that require supervision or not needing the assistance with two activities of daily living. As defined, custodial care would require the "regular assistance with two or more activities of daily living or regular supervision because an individual with a mental disorder is unsafe if left alone due to the mental disorder."

Not allowing the deduction of independent living fees as medical expenses will prevent many seniors from living functionally in the least restrictive environment possible. While independent living facilities are usually significantly less expensive than assisted living facilities and nursing homes, they are almost exclusively considered "private pay" and are the first step in the dramatic increase in health care and living expenses as health declines.

The final rule should permit Veterans and other appropriate claimants to deduct facility fees, including fees for independent living facilities and assisted living facilities, as long as a licensed physician certifies that they have a medical condition requiring such level of care. This is consistent with current laws and policy, specifically M21-1MR, Part V, Subpart iii, Chapter 1, § G, 43.h.

Activities of Daily Living Should Include Medication Management

Although medication administration is usually defined as an activity of daily living, without proper medication management, a person's health declines much more rapidly, increasing the cost of care and accelerating the need for higher levels of care, including skilled nursing facilities. A person with memory loss who cannot remember to take medication, or the right dosage at the proper time, and a person with a physical disability who needs assistance reading or opening medication dispensers, should be treated the same as a person who needs assistance

putting on a shirt or taking a bath. Treating medication management as one of the two necessary activities of daily living under the custodial care definition is consistent with the question asked on VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, "Does claimant require medication management?"

The proposed rule makes an exception to the activities of daily living by permitting the deduction of medically necessary travel expenses. It follows that VA make an exception by regarding medication management as an activity of daily living and a medical expense, given that taking medication is directly related to a person's medical condition and, the need for medication management is, therefore, directly related to the medical condition and treatment of that condition.

The final rule should include medication administration as one of the two ADLs necessary to meet the need for Aid & Attendance level of care.

Proposed § 3.278(d)(2) Limits the Rate of Payment That Will Be Deductible for In-Home Health Care Providers Regardless of Whether They Work With an Agency or Their Actual Skill Levels

Limiting the deductible in-home health care provider fee will only limit an individual's ability to assess and access quality care. The changes to the laws are capricious for two primary reasons.

First, Proposed § 3.278(d)(2) is based on the average rate for in-home health care across the county. This is unduly burdensome on claimants who live in higher cost areas (with costs generally higher on the coasts than in the Midwest) and on claimants who live in urban areas as opposed to rural areas (with costs generally lower in rural areas). The proposed regulation, by using the average rate of in-home health care as a benchmark, would mean half of all in-home health care would be provided at a rate higher than the proposed rule would allow.

Second, it is unjust to cap expenses without any regard for the needs of the individual claimant and without verifiable abuses. All in-home health care providers are not of an equal skill level, and depending on state licensing requirements, it is frequently required under state law to have a

health care provider with more advanced skills perform certain activities such as injecting insulin, changing colostomy bags/tubes, and providing services for an individual who uses a feeding tube. These providers, because of their skill levels, are often able to command a significantly higher rate of pay than more traditional in-home health care providers. The cap on expenses does not take situations such as these into account; therefore, this proposal will be unduly burdensome on claimants who need higher levels of care. This runs contrary to the stated intent of the proposed rule to ensure Veterans access to the highest level of care possible.

The final rule should provide no specific cap or limitation on fees for care providers.

Establish an Effective Date That Provides Appropriate Notice Due Process That Is Fair to Claimants and Makes Implementation Feasible

Proposed rule changes should be no less than one year from when the rules become final. Implementing a 3-year look-back period would bring an unfamiliar process to VA, requiring an estimated 70 additional adjudicators at the cost of $100,000 each to process the applications, according to the Congressional Budget Office in a November 12, 2013, report on S.944, *Veterans Health and Benefits Improvement Act of 2013*.

The proposed rule does not state when an effective date would occur after the rule becomes final. But, imposing an immediate effective date, or going back to when the rule changes were proposed, will subject VA to an unattainable goal, will violate notice and due process laws, and harm applicants through delays in processing. Additional staff will need to be hired and adequately trained to review complicated financial statements with applications. Moreover, applicants, including those with dementia or a severe physical disability, will suddenly need to obtain and submit 3 years' worth of financial information, which they may not have readily available and will need to order, incurring additional time and fees.

Applications for Medicaid take several months to cull through documents related to financial transactions. The individual state-specific Medicaid agencies process the applications, wherein they are knowledgeable about specific financial entities in their state. By contrast, VA adjudicators would need to possess knowledge on a national basis regarding financial entities

and variances in statements. Those hired to administer the new system should be experienced in reviewing financial data and fully trained before the consideration of any claims. Reviews of claims made before the enactment of the new rules, indeed, before the placement of the properly trained adjudicators, would further bog down the pension system and create an even larger backlog.

Medicaid agencies had approximately 20 years of experience with calculating a three-year look-back prior to Congress extending it to a 5-year look-back under The Deficit Reduction Act of 2005. When implementing an effective date, it's therefore critical that the final rule provide enough time to attain any new funding required for the 70 new staff CBO estimates is required and properly train them to avoid further delays when implemented.

Previous Legislation Recognizes the Need for a Delayed Effective Date

Recent legislation introduced in both the Senate and House of Representatives recognizes the need to delay the effective date of a look-back and penalty period. For instance, S. 3270/ H. R. 6171 (112th Congress) required that the changes "shall take effect on the date that is one year after the date of the enactment of this Act and shall apply with respect to payments of pension and increased pension applied for after such date and to payments of pension and increased pension for which eligibility is re-determined after such date."

A year later, S. 748/ H.R. 2341 (113th Congress) included similar provisions, but added a caveat: shall take effect on the date that is one year after the date of the enactment of this Act and shall apply with respect to payments of pension and increased pension applied for after such date and to payments of pension and increased pension for which eligibility is re-determined after such date, *except that no reduction in pension shall be made under such subsections because of any disposal of covered resources made before such date.* (emphasis added)

This caveat would be critical to allow the care for pension recipients to continue uninterrupted if the final rule implemented a hard effective date. Members of Congress recognized that potential beneficiaries would be unfairly blind-sided if they were otherwise qualified at the time of their application, but were terminated due to a change in the law.

Grandfather in Transfers Prior to the Enactment Date of the Final Rule

To ensure a fair and efficient rollout of the new regulations, VA should not subject claims made prior to the enactment date to the look-back period or transfer penalties. Less than one percent (1%) of applicants make transfers to become eligible for benefits, according to VA. Thus, the overwhelming majority of claimants who made gifts or other transfers prior to the effective date will have done so without knowingly taking into account the new rules and should not be denied benefits that are helping them pay for care.

Using Medicaid as a reference, the effective date of the Deficit Reduction Act of 2005 (DRA) was February 8, 2006. Any applications for Medicaid submitted after that date, but that identified transfers of assets prior to that date, were subject to the transfer rules prior to the effective date, which had a three-year penalty. For example, a claimant made a gift of $20,000 in January 2005, but applied for Medicaid in March 2006. This claimant was subject to the prior three-year look back, even though his application was filed after the effective date of DRA because his/her transfer of assets was before the effective date. In contrast, a claimant who transferred assets on February 15, 2006, who then applied for Medicaid on March 1, 2006, would be subject to the five-year look back rules because the transfer was made after DRA effective date.

In its justification, the proposed rule expresses the desire to retain the "spirit of Medicaid regulations." Yet, unlike Medicaid, it would subject prior claimants to the same penalties as claimants after the proposed regulations are adopted. If enacted, this would be a violation of these claimants' due process rights. As stated earlier, in the Medicaid legislation that expanded the look-back period, Congress grandfathered in actions taken by applicants prior to the enactment date.

The final rule should set a specific effective date of no less than one year from the adoption of the final rules and grandfather all transfers made prior to the effective date, penalizing only transfers made after the effective date.

Cost to Implement a Look-Back Period Will Outweigh Its Benefits

A 3-Year Look-Back Period Will Result in a Net Loss to Taxpayers According to the Congressional Budget Office

The Congressional Budget Office (CBO) estimated in a November 12, 2013, report that if a 3-year look-back period was implemented, VA would need to hire 70 new employees, at an expense of $100,000 per person, to handle the increased workload of reviewing and processing applications because of the additional financial information to be analyzed. This equaled a total cost of $7 million per year over the look-back period once the look-back period was fully implemented.

By contrast, CBO estimated that once fully implemented, the look-back period would only save $5 million per year (scaling up from $2 million in the first year, with an additional million saved each year until it plateaued at $5 million). *Thus, even after full implementation, a look-back period would result in a net loss to taxpayers of $2 million per year.*

Following CBO's estimates, the purported benefit to limit VA's estimated 1 percent of beneficiaries who transfer assets for the purposes of qualifying do not outweigh costs to the government in ensuring the stated goal of program integrity that the proposed rule intends to achieve.

The regulatory impact analysis for the proposed rule estimates a different cost without reference to or disagreement with why the CBO is flawed in its analysis. For instance, it estimates that with the 3-year look-back period, the VA will save $36.7 million in 2020 alone, a number over 7 times greater than the $5 million savings per year in the CBO estimate and a full 19 times the difference in the overall cost estimate, which shows a $2 million dollar loss. In addition, the regulatory impact analysis does not appear to include the stated costs of the increased need for hiring new administrators and the substantial training that will be required. Rather it states that it assumes the administrative efficiencies gained would be minimal.

Assessing 3 Years of Financial Transactions Will Lead to Further Delays

Presently, we estimate that Veterans pension claims take anywhere from 6 months to 2 years to

approve, averaging around 9 months. However, many benefits are denied quickly and those who likely do qualify often must wait longer than the average time. This time period is already a concern, given both the high costs of long-term care and the unfortunate fact that the life expectancy of many potential beneficiaries is often very short. It's an unfortunate fact that, even now, NAELA members work with Veterans who pass away before their benefits are ever approved due to these delays.

In addition, long-term care can come at a high price. For instance, 9 months in a nursing home costs $58,500, using the semi-private room cost estimate discussed in the proposed rule. A 2-year wait time in a nursing home would cost an estimated $156,000, which is above the total net worth amount allowed under the proposed rule. We fear that requiring claims adjudicators to review 3 years of financial documentation will likely result in more claims getting approved at the 2-year mark or worse, further impoverishing Veterans and their spouses paying for the high costs of long-term care as a result.

Make Wartime Veterans and Their Families More Aware of These Benefits

The proposed rule focuses on reducing the number of wartime Veterans and their surviving spouses with conditions such as Alzheimer's and ALS from receiving long-term-care support due to their financial positions. But regardless of the new limitations that could get imposed, too few Veterans with these conditions and their families know, understand, and access this benefit than could.

In 2011, the GAO concluded in its report VA Enhanced Monthly Benefits that *elderly veterans and their family members are the primary recipients of enhanced monthly benefits, but that many potential recipients are unaware of the benefits.*

In 2004, only 22 percent of eligible pension recipients actually received a benefit. A study estimated that in 2010, between 565,000 and 925,000 Veterans and between 940,000 and 1.38 million surviving family members would be eligible for, but would not receive, VA pension benefits. The study further concluded that VA should be doing more to create awareness of these benefits.

VA should continue with efforts to advertise these benefits to Veterans and their families regardless of the outcome of the final rule. Veterans' pensions offer a critical long-term-care lifeline for some of our wartime Veterans who are most in need and their surviving spouses, particularly given the crushing costs of long-term care. It's unfortunate to see so many Veterans struggle to pay for long-term care while unaware of benefits that can alleviate some of the burden of these costs.

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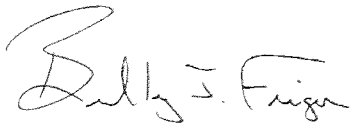
Thank you for your consideration of our comments. If you have any questions, please contact David Goldfarb, NAELA's Public Policy Manager, at 703-942-5711 #232 or dgoldfarb@naela.org.

Sincerely,



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The ABLE Act

Another Option for Enhancing Lives

The ABLE Act

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Understanding the ABLE Act

1. History and Overview of the ABLE Act
2. Analysis of ABLE Accounts
3. State's Role and Incorporating ABLE Accounts into Your Practice
4. Questions

Achieving a Better Life Experience (ABLE)

- HISTORY AND OVERVIEW
  - The Act was passed by Congress in the fall of 2014
  - Cosponsored by 380 members of the House and 74 members of the Senate
  - Supported by more than organizations and health care professionals including: American Association of People with Disabilities, the Autism Society of America, Autism Speaks, the Brain Injury Association of America, Easter Seals, the National Association of Councils on Developmental Disabilities, the National Disability Institute, the National Downs Syndrome Society, the National Federation of the Blind, and The ARC.

Achieving a Better Life Experience (ABLE)

- This Legislation was repeatedly introduced for over 6 years and has been revised several times. It has now become Federal Law and must be enacted in each state (or the state must contract with an enacting state) in order for residents of the state to take advantage of the new law.
- The Act has very specific applications and it is important to understand when it will be the right tool and when other options may be more appropriate.
- The Act focuses on the need for sustainable funding and options for all persons with disabilities.

Achieving a Better Life Experience (ABLE)

SSI Eligibility Lost if Exceed $100k	SSI Eligibility Lost if Exceed $100k
Medicaid Eligibility Continues if Exceed $100k	Medicaid Eligibility Continues if Exceed $100k
Only One ABLE Account Per Person	Only One ABLE Account Per Person
No Limitation on Age of Beneficiary	Disability MUST be Established Before Age 26
Contributions Capped at 529 Limits	Annual Contribution Limit of $14,000
GAO Estimated Cost: $19 B over 10 years	GAO Estimated Cost: 2 B over 10 years

Achieving a Better Life Experience (ABLE)

- Starting in 2015, State now have the OPTION to establish and ABLE program under which eligible individuals with disabilities can start an ABLE account.
- These accounts are modeled after Section 529 savings plans
- To be eligible, the participant must have become disabled BEFORE TURNING AGE 26, based upon marked and severe functional limitations or be the recipient of benefits under the SSI or Disability Insurance programs.

Achieving a Better Life Experience (ABLE)

Analysis of ABLE Accounts

Achieving a Better Life Experience (ABLE)

- Key Features of the Act:
  - The participant is limited to ONE account;
  - The TOTAL contributions cannot exceed the gift tax limit ($14,000 currently) each year;
  - Aggregate contributions are limited;
  - For participants under age 19, they must establish the disability under the Social Security Act definitions;
  - For participants over age 19, they must establish the disability under the Social Security Act definitions AND that the disability occurred prior to age 26; and
  - Growth in the account accrues with income tax exemption.

Achieving a Better Life Experience (ABLE)

- Participant Maintains Eligibility for Means Based Programs:
  - For SSI, the first $100,000 in account balances are EXCLUDED from counting as resources, as are most account withdrawals.
    - Over $100,000 and lose SSI payments until back below $100,000
  - ABLE Account balances and withdrawals are COMPLETELY EXCLUDED for purposes of Medicaid and other benefit programs.
    - But, participant gets to keep his or her Medicaid eligibility!!

Achieving a Better Life Experience (ABLE)

- But, there's always a catch . . . Medicaid Payback
  - In the event the qualified beneficiary does with remaining assets in the ABLE account, the assets remaining in the account are first distributed to any State Medicaid Plan that provided medical assistance to the designated beneficiary - like a (d)(4)(a) trust.
  - The amount of the Medicaid payback is calculated based upon amounts paid by Medicaid AFTER THE CREATION of the ABLE account.
  - It's like a 529 plan with a lien for any Medicaid used by the beneficiary from the time the account was created.
  - To avoid payback, we must still consider a Third Party SNT - or maybe both!

Achieving a Better Life Experience (ABLE)

- Permitted Contributions:
  - The Act requires that "a program shall not be treated as a qualified ABLE program unless it provides tat no contribution will be accepted:
    - (a) unless it is in cash, or
    - (b) except in the case of contributions under subsection (c)(1)(C), (rollovers) to another beneficiary who is a family member of the designated beneficiary, of an ABLE account to another disabled beneficiary if such contribution to an ABLE account would result in aggregate contributions from all contributors to the ABLE account for the tax-able year exceeding the amount in effect under section 2503(b), for the calendar year in which the tax-able year begins.
- What Does That Mean???
  - If the total amount of contributions to an ABLE Account exceed the annual gift tax exclusion, the annual gift-tax exemption amount (which is currently $14,000), then the account could no longer be counted as an ABLE Account and would be a countable resource.

Achieving a Better Life Experience (ABLE)

- What are Considered Qualified Disability Expenses? What can we spend the money on?
  - Any expenses made for the designated beneficiary related tot heir disability including"
    - Education
    - Housing
    - Transportation
    - Employment training and support
    - Assistive technology and personal support services
    - Health, prevention and wellness
    - Financial management and administrative services
    - Legal fees
    - Expenses for oversight care and monitoring
    - Funeral and burial expenses

Achieving a Better Life Experience (ABLE)

- Separate Accountings Required
  - A program shall not be treated as an ABLE account unless it provides separate accounting for each designated beneficiary
  - This is presumably because of the payback requirement that all Medicaid used by the beneficiary from the time the account was established be paid back upon the death of the beneficiary.
- Limited Investment Direction
  - These accounts would be administered on a voluntary basis by the State in a manner similar to 529 college savings accounts.
  - As with 529 accounts, the range of investment options available for ALBE accounts would be determined by the States.

Achieving a Better Life Experience (ABLE)

- What are the Tax Issues with ABLE Accounts
  - Contributions are in after-tax dollars, and earnings grow tax-free just like 529 college savings accounts (ROTH style).
  - Withdrawals must be for qualified expenses or else the earning portion would be subject to regular income tax and a 10% penalty (state penalties could also apply.
  - Example: Over 10 years, Susan saves $50,000 in her ABLE Account and earns $10,000 in interest over those years, for a total account balance of $60,000. If she uses some or all of the balance for a down payment on a house, she incurs no tax liability. If, however, she uses some of the balance for a trip to Sea World, the $10,000 would become taxable and she would incur a 10% penalty (and possibly a state imposed penalty as well).
  - It is CRITICAL to ensure that the funds are spent on Qualified Disability Expenses!!

Achieving a Better Life Experience (ABLE)

- ABLE Accounts MUST be opened in the State in which the beneficiary resides.
  - That means Grandma and Grandpa who live in Nebraska cannot open an account there for their disabled grandchild who lives in New Mexico
  - However, if the state where the intended beneficiary lives does not have an ABLE account program but instead contracts with another state for such program, the intended beneficiary's account must be opened in the contracting state
    - For example, if New Mexico contracts with Texas to provide ABLE accounts to New Mexico residents, Grandma and Grandpa in Nebraska would be required to open an ABLE account in Texas for their disabled grandchild living in New Mexico.
    - This is different from 529 College Savings accounts
- An ABLE account beneficiary can only have ONE account.
  - That means if mom and dad open an account, Grandma and Grandpa cannot open another one
  - This is also different from 529 College Savings accounts

Achieving a Better Life Experience (ABLE)

- What About Gift Taxes??
  - The Act States that "any contribution to a qualified ABLE program on behalf of any designated beneficiary ... (i) shall be treated as a completed gift to such designated beneficiary which is not a future interest in property, and (ii) shall not be treated as a qualified transfer under section 2503(b)."
  - Gifts to a Special Needs Trust is, by nature, not considered a completed gift.
  - So, if you gift funds to your child's special needs trust you cannot use your $14,000 federal gift exclusion because it is not a completed gift. Instead you need to use part of your $5.4 million lifetime exclusion.
  - But, you can use the federal gift tax exclusion for a gift to an ABLE account (but always keep in mind the annual limits to these accounts!)
  - This can get complicated for folks so encourage them to also discuss their gifting plans with their accountant or financial advisor.

Achieving a Better Life Experience (ABLE)

- ABLE Accounts can be rolled over .....
  - But, unlike 529 college savings accounts that can be rolled over to any family member,
  - ABLE accounts can only be rolled over to another family member with a qualifying disability

Achieving a Better Life Experience (ABLE)

The State's Role and Incorporating ABLE Accounts into your Practice

Achieving a Better Life Experience (ABLE)

- States have the OPTION to participate by enacting their own legislation
  - States not wanting to participate directly can contract with states which have an ABLE plan
- The Qualified Able Program (QAP) is maintained by a state agency or instrumentality thereof
  - Must keep a separate accounting for ABLE accounts in the state program
  - Must maintain safeguards to prevent excess contributions
  - If more than one account is established, only the first account qualifies
  - Contributions from a parent/grandparent are protected from bankruptcy if made 365 days in advance
  - Contributors may NOT directly or indirectly direct the investment of the contribution
  - May not be used a collateral for loans

Achieving a Better Life Experience (ABLE)

- The Feds will be putting out Regulations, including:
  - Information needed to open ABLE accounts;
  - To generally define qualified disability expenses;
  - Relating to disability certifications;
  - To allow for interstate transfers if the beneficiary moves
- The State designated Trustee must submit notice to the Secretary of HHS upon establishment of an ABLE account.
  - Must contain the name and state of residence of the beneficiary.
- The Trustee must also submit monthly electronic accounting of distributions and account balances to the SSA.

Achieving a Better Life Experience (ABLE)

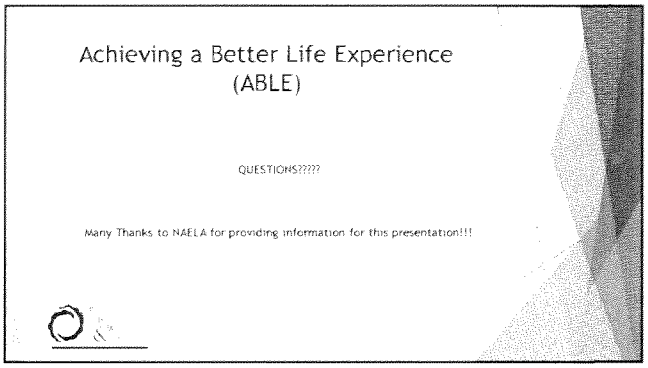
- Client Pitfalls:
  - Payback!!!!!
  - Establishing more than one account;
  - Overfunding the account;
  - Paying for things not considered a QDE;
  - Failing to make reports to the State;
  - Loss of SSI relationship to Medicaid;
  - Uneducated choice between alternatives;
  - Confusion between SNT and ABLE rules - especially for distribution;
  - Protection from fraud, undue influence, exploitation;
  - Impact on child support???

Achieving a Better Life Experience (ABLE)

- When Might an ABLE Account be a good fit?
  - Mix and Match SNT's, ABLE, First Party/ Self-Settled Trust, Pooled Trust
  - One size does not fit all, and more than one type of trust may be appropriate
  - Does the beneficiary have a job and need a place for earning to grow and be protected?
  - Are the funds small and an SNT too complicated?
  - A good savings plan for a low income beneficiary.
  - Not quite ready to spend down (ie waiting for a new van to be made)

Achieving a Better Life Experience (ABLE)

- What's Up with New Mexico??
  - A bill to adopt an ABLE account was introduced in the both the House and Senate in 2015. They were consolidated into the House Bill.
  - The Bill passed the House Health Subcommittee unanimously, but died in the House Ways and Means Committee.
  - The Bill initially put the plan under the State Investment Council, but they refused so was moved to the Treasure's Office where they were willing to accept it.
  - According to the Committee Chair, Rep. Jason Harper, there were still too many questions about investing the funds, reciprocal contracting with other states, and identifying a investment company to take on the plan.
  - Harper says it will be worked by interim committees in the spring and summer.
  - But, next session is a short one for the budget so .....???????
  - That means, for now, ABLE is not an option for New Mexico residents.


Achieving a Better Life Experience
(ABLE)
QUESTIONS?????
Many Thanks to NAELA for providing information for this presentation!!!

The Affordable Care Act and Modified Adjusted Gross Income

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What the ACA Does Do

- Reforms health insurance coverage
- Expands coverage to those excluded from health insurance
- Mandates health insurance coverage for everyone
- Expands Medicaid health coverage

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Reforms Health Insurance Coverage

- No exclusion for pre existing conditions
- No lifetime caps of coverage
- No annual caps of coverage
- No rescinding coverage
- Monitoring increases in premiums by health insurance companies
- Closing the "donut hole" in Medicare

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Expansion of Coverage to Those Excluded from Health Insurance

- Health insurers are prohibited from denying coverage to children with pre-existing conditions
- Children over the age of 19 can be covered under family policies until age 26

Mandate of Health Insurance Coverage for Everyone

- As of 2014, everyone in the United States is required to have health insurance coverage
- Health insurance exchanges
- Surtax on people with income over $200,000
- Employers with more than 50 employees will be penalized if they do not provide health insurance to their full time employees

Expansion of Medicaid Coverage

- Based on Modified Adjusted Gross Income (MAGI) of household only
- 138% of Federal Poverty Level: 2015 Household of 1 $16,243; Household of 4 $33,465
- No resource criteria
- No other health insurance coverage
- Persons age 19 up to 65
- No health condition requirement

Essential Health Benefits

- Hospitalization
- Prescription drug coverage
- Rehabilitation
- Mental Health Services
- Substance Abuse Treatment
- Preventative and Wellness Health Coverage
- Chronic Disease Management
- Pediatric Coverage (inc dental and vision)
- Maternity Coverage

Health Insurance Exchanges

- Available for applications October 15 to December 7
- Apply on line, by phone or in person
- One application for all purposes
- Four levels of plans
- Limit on premium of 8% of MAGI
- Federal subsidies for premiums if low income

MAGI

- Modified Adjusted Gross Income
- Not new a new concept, just a new application
- New method for determining income for most Medicaid, CHIP and tax credits
- What is it?
  - Adjusted Gross Income (AGI) plus certain income previously excluded from AGI, reduced by certain deductions

AGI – What is it?

- Adjusted Gross Income
- Wages, salaries, taxable interest and dividends, taxable retirement benefits, business income, capital gain, rental income, income from corporations, partnerships and trusts, unemployment, alimony received, other
- Reduced by certain self-employment expenses, student loan interest, tuition and fees, education expenses, IRA deduction, moving expenses, health savings account, alimony paid, other

MAGI – What is it?

- Adjusted Gross Income
- Plus: nontaxable Social Security, tax-exempt interest, and foreign earned income
- Minus: scholarships and certain American Indian and Alaska Native income
- Requires a filed tax return or sufficient evidence of income

Effects of MAGI on Planning

- Affects premium subsidy and tax credits for health insurance
- Used to determine eligibility for expanded Medicaid and Children's Health Insurance Program (CHIP)
- Includes trust income allocated to a beneficiary

What the Affordable Care Act Means for the Elderly and Persons with Disabilities

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The Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act" or "ACA") embodies many reforms of the health insurance industry in the United States. This act is referred to commonly as "health care reform" and "Obamacare," and there are several provisions that do in fact address improvements in the delivery of health care services. But we should be clear that the ACA is a reform of how we access health insurance in the United States. The principal objective of the ACA is to ensure access to health insurance for everyone. As of 2014, almost everyone in the United States is required to have health insurance. The corollary is that no one may be denied coverage by health insurance companies, regardless of age, pre-existing conditions, or the amount of coverage that may be subsequently needed. The rationale for these reforms is that if all American citizens are members of the insured pool, the risks for insurance companies will be spread across a larger group of persons so that the cost of private insurance coverage should be less. We are already seeing, however, that health insurance

companies are raising premiums dramatically. Be that as it may, the ACA presents new opportunities for people with disabilities that have not existed before.

The ACA does not radically change the delivery of health care services in the United States, nor does it fundamentally change the health insurance system. The ACA is a reform of the health insurance industry, but it is not introducing concepts that we have no experience with. In fact, the rationale for the ACA is in some respects similar to the rationale for employer-based health insurance. Employer-based health insurance remains a bulwark of access to health insurance. Sixty-one percent of all companies in the United States offered health insurance benefits to their employees according to a survey reported in September, 2012. The health insurer providing the insurance spreads the risk across the entire work force of the company, insuring healthy workers along with not as healthy workers. Similarly, Medicare spreads the risk, because it insures everyone who is eligible for the program, regardless of health status. The ACA incorporates the notion of spreading the risk by expanding the pool of the insured to every eligible American. The ACA is not socialism, universal health care, nor a single payor system. However, we are not unfamiliar even with these concepts in the American health system. Veterans Affairs ("VA") provides universal health care for all veterans who qualify. That health care system is paid for and provided by the United States government, but we do not describe the VA as a socialist entity. Medicare is a health insurance system run by the federal government, which is funded by a tax imposed on everyone who earns wages.[1] Although everyone who works, no matter what their ages, pays the Medicare tax, Medicare provides health insurance coverage only for individuals

[1] The tax is 2.9% on wages of the *worker* with 1.45% paid by the worker and 1.45% paid by the employer. In 2013, there will be an additional surtax of .9% on earned income over $200,000 for individuals, and 3.8% on unearned income over $200,000.

who are over age 65 and who have also worked or been married to a worker, and disabled workers who have received Social Security Disability Insurance benefits for two years or more. So a very large pool of healthy workers pays into insurance that they can access later if they live until age 65, or become disabled at an earlier age. Additionally, under Medicare, there are no exclusions for pre-existing conditions, degree of health need, or age after 65. Everyone who is eligible is required to participate in Medicare. If a person refuses to participate, there is a penalty for late enrollment. The pool of the insured under Medicare includes those who are healthy and those who are not, thus spreading the risk among as large a group as possible. The ACA does not call for either a government run and provided health care system such as the VA, nor a single payor system into which all must pay, such as Medicare. It is a reform of the private health insurance industry.

The ACA contains an array of reforms that are rolled out over several years. It amends the Public Health Services Act, the Internal Revenue Code, and the Social Security Act, among others. This smorgasbord of changes and the time spans involved have made it very difficult for many people to get a handle on what to expect. Most have found it very difficult to piece together a clear and meaningful picture of what the ACA provides. My goal is to present the information to you in such a way that you can have a sense of confidence about what the primary reforms are and how they affect you and your clients. For those of you who would like to have an office reference for the ACA itself, I recommend the two volume Commerce Clearing House's Law, Explanation and Analysis of the Patient Protection and Affordable Health Care Act.[2]

[2] CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act, Wolters Kluwer publisher, 2010, Two volumes.

Timelines vary for certain measures. Major changes occurred in 2014. Some others, which went into effect in 2010, were stop gap measures, which ended in 2014. Some reforms will occur gradually, with completion targeted as far off as 2020. Some of the dates have changed over time. However, simply giving you a time line of reforms for each year does not give you a coherent picture of the ACA. Instead, I have found that describing the provisions of the ACA as parts of a system of reforms has helped people get a grip on what the ACA might mean for them. It is important for all advisors to understand these fundamentals, because the ACA will cause a shift in how we need to think about our practices and the services that we provide to our clients.

Four Reforms of the Health Insurance System

I will focus on four areas that the ACA addresses:

1. Reforms of existing health insurance coverage;

2. Expansion of coverage to those who have been excluded from health insurance coverage;

3. Mandate of health insurance coverage for everyone; and

4. Expansion of Medicaid coverage.

In each area, I will describe specific programs to look for, the timeline for each of those programs, and what problems each program is designed to solve.

1. Reforms of Existing Health Insurance Coverage

Effective on September 23, 2010, health insurers were banned from setting lifetime or annual caps on the dollar amount of existing coverage[3] and from rescinding

[3] 42 U.S.C. § 300gg-11(a)(2)

existing coverage.[4] Furthermore, states were provided funds to begin monitoring increases in premiums set by health insurance companies. Health insurance premiums have doubled on average in the U.S. in the past 10 years. Increases in health insurance premiums are currently easily outpacing raises and inflation. For example, immediately following the passage of the ACA, in April, 2010, Blue Cross Blue Shield of New Mexico raised its rates by 18 to 25%. In June, 2012, another rate increase of 6.9% was approved, as reported in the Santa Fe New Mexican on May 29, 2012.

Another reform closes the so-called "donut hole" in Medicare.[5] In 2005, prescription drug coverage was made available for the first time to people who had Medicare coverage. However, the devil is in the details, and among other things, it was found that each year, after spending one's deductible and paying the co-pay for a certain amount of dollars,[6] one enters the "donut hole," meaning that the Medicare insured person pays 100% of the costs of prescriptions until reaching another dollar threshold.[7] At the end of the donut hole, Medicare pays almost the entire bill. Many people routinely enter the donut hole in November and never get out before the calendar year ends, and then they start the cycle again in January. Folks with very large drug expenses enter the donut hole much sooner in the year. In 2010, every Medicare insured person who entered the donut hole received a one-time check for $250.00. In 2013, drug manufacturers provided a 52.5% discount for brand-name drugs purchased during the donut hole, and

[4] 42 U.S.C. § 300gg-12
[5] 42 U.S.C. § 1395w-114A
[6] Out of pocket payments of the $325 deductible plus 25% copay reaching a total of $2,970 in 2013
[7] $4,750 in 2013

consumers received a 21% discount for generic drugs.[8] This federal subsidy will gradually increase each year until the donut hole is entirely closed in 2020.[9]

2. **Expansion of Coverage for those Excluded from Health Insurance Coverage**

Effective on September 23, 2010, health insurers were prohibited from denying coverage to children with pre-existing conditions whose parents have health insurance.[10] As of 2014, no one can be denied health insurance because of a pre-existing condition. Health and Human Services released an analysis in January, 2011, that reported that 129 million non-elderly Americans have some type of pre-existing condition and could be denied health insurance coverage.[11] Because the ACA eliminates the option for health insurance companies to deny coverage for a pre-existing condition, new health insurance options will open up for persons with permanent injuries and disabilities. In 2009, I met with a mother whose 6 year old son was born with a chromosomal defect. The family was an honest hard working family. Dad worked in construction and mom had recently taken a part-time job as a home health aide. Neither parent had health insurance. Their two children qualified for children's Medicaid in New Mexico because of the family's low income. The son had had several surgeries since birth and was seen regularly by specialists in the Presbyterian Health Care system in Albuquerque. When this family filed their 2008 annual income tax returns, Medicaid ruled that the part-time income of mom resulted in the family having too much income for Medicaid coverage for the children. So they applied for coverage under the Children's Health Insurance Program

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[8] 42 U.S.C. § 1395w-114A
[9] 42 U.S.C. § 1395w-114a(b)(i)(c)(ii)
[10] 42 U.S.C. § 300gg-3; see 26 CFR 54.9815-2704T(b)(2)
[11] News Release January 18, 2011, U.S. Department of Health & Human Services www.hhs.gov/news/press/2011pres/01/20110118a

("CHIP") for New Mexico, available to low income families who have too much income for Medicaid. The healthier child was insured, but Presbyterian Health Care denied coverage for the son, because he had a pre-existing condition. The denial was sustained on an appeal, even though the lack of coverage may have been life threatening. If the parents had had health insurance, the ACA would have prohibited this from happening. As of 2014, the parents will have health insurance, and this child will have coverage.

Another group who are receiving coverage because of the ACA are children over the age of 19. As of September 23, 2010, health insurers must extend coverage for children under family policies up to age 26.[12] Parents who have health insurance in place can now add a disabled child to their coverage and can enroll a child up to age 26 as a dependent on the parent's health plan, even though the child may not be a dependent or live at home with the parents.

A temporary reform that expanded health insurance coverage to people who had been unable to obtain health insurance was the Pre-Existing Coverage Insurance Plans ("PCIP"). This was a federally subsidized health insurance program for anyone who has been turned down for health insurance, had not had health insurance six months prior, and who is a U.S. citizen or legal resident.[13] This program suspended taking new applications on February 16, 2013, and expired in 2014. Beginning on January 1, 2014, health insurance companies are prohibited from denying coverage to anyone with a pre-existing condition.[14]

Finally, the ACA provided a temporary reinsurance program, Early Retirement Reinsurance Program ("EERP") for employers that provide health insurance to retired

[12] 42 U.S.C. § 300gg-14
[13] 42 U.S.C. § 18001(c)
[14] 42 U.S.C. § 300gg- 2704

employees who were over the age of 55 who retired before the age of 65.[15] In 2010, the federal government reimbursed up to 80% of the claims made. As of August 31, 2010, nearly 2000 employers had enrolled. This program expired in 2014, when everyone will be required to have health insurance.

3. Mandate of Health Insurance Coverage for Everyone

As of 2014, almost everyone in the United States is required to have health insurance coverage.[16] For those who do not have coverage through Medicare, Medicaid, Veterans Affairs or employer benefits, health insurance can be obtained through health insurance exchanges or Marketplaces. Health insurance companies are able to offer basic coverage through exchanges or marketplaces.[17] The Act describes two types of exchanges: the American Health Benefit Exchange and the Small Business Health Options Programs or "SHOP" exchange. The health insurance exchanges provide a marketplace in which to compare plans. The four types of plans that are available are labeled Bronze, Silver, Gold and Platinum.[18] All health insurance companies that intend to participate in the exchanges must offer at least one Silver and one Gold plan.[19]

Each plan must provide hospitalization, prescription drug coverage, rehabilitation, mental health services, substance abuse treatment, preventative and wellness health coverage, chronic disease management, pediatric coverage (including dental and vision for children) and maternity coverage.[20] These services are known collectively as "essential health benefits." The Bronze plan will pay 60% of the costs, the Silver 70%,

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[15] 42 U.S.C. § 18002
[16] 42 U.S.C. § 18091; 26 U.S.C. § 5000A
[17] 42 U.S.C. § 13031(b)
[18] 42 U.S.C. § 18022(d)
[19] 42 U.S.C. § 18021(a)(1)(C)(ii)
[20] 42 U.S.C. § 18022(b)

the Gold 80% and the Platinum 90%. The Bronze plan will have a limit of $5,950 per year for out of pocket expenses by the insured. Small businesses will be able to access health insurance for their employees through the SHOP exchange. As stated earlier, health insurance companies cannot exclude anyone from coverage for a pre-existing condition, or set a cap for the amount of coverage regardless of an illness.

There is a uniform enrollment form for health coverage through the exchanges. The exchanges are a clearing house to determine eligibility for Medicaid, CHIP or premium credits using a uniform enrollment form. Moreover, the exchanges can screen for families that may be exempt from tax penalties.

States create insurance exchanges under the ACA or opted to do nothing, in which case the federal government created the exchange for the states. The ACA provided federal funding to the states for the design and implementation of the exchanges. As of September 16, 2013, seventeen states and the District of Columbia had enacted authority to create state-based exchanges ("SBE"), and twenty-seven states had opted out of state-based exchanges.[21] The initial enrollment period for the exchanges began on October 1, 2013 and continued until March 31, 2014. For subsequent years, it will open on October 15 and close on December 7, just like Medicare.

There has been political turmoil created over the creation of the exchanges. For example, New Mexico received $34,279,483 from the federal government to plan the implementation of an exchange for the state.[22] A bill to create the exchange was passed by the Legislature in 2011 but vetoed by Republican Governor Susana Martinez. A bill was introduced in the 2012 Legislature, but it did not pass. On November 15, 2012,

[21] National Journal "State-Based ACA Exchanges Getting More Attention from the Public" by Sophie Novack citing Pew Poll
[22] http://www.healthcare.gov/news/factsheets/2011/05/exchanges/nm.html

Governor Martinez announced that New Mexico intended to establish a state-based exchange. It was estimated that over 300,000 New Mexicans did not have health insurance.

As of 2014, all individuals in the United States who refuse or fail to obtain health insurance coverage will pay a "shared responsibility payment." On June 28, 2012, the United States Supreme Court held that this payment was a tax and was constitutional.[23] The shared responsibility payment in 2014 was the greater of $95 or 1% of the taxpayer's annual taxable income. In 2015, the payment is $325 or 2% of taxable income, and in 2016, $695 or 2.5% up to a maximum of $2,085.[24] If a person's income is too low, there is an exemption from the penalty. For those with low income who obtain health insurance, there is a sliding scale of assistance and premium credits to make health insurance affordable. The term "affordable" means that the premiums shall not exceed 8% of the family's annual income. For example, an individual with an annual income of $44,680 in 2012 would qualify for a tax credit to purchase health insurance.[25]

For individuals who earn more than $200,000 per year, and couples who earn more than $250,000 per year, the ACA imposes a surtax of .9% on earned income. For example, if an individual's total earned income is $250,000, he or she would pay a surtax of $450, which is, .9% of $50,000, the amount of earned income over $200,000. The ACA also imposes a 3.8% "Medicare tax on investments" on unearned income of individuals who have an adjusted gross income ("AGI") over $200,000, and couples over $250,000. For example, if the AGI of an individual exceeds the $200,000 base amount, and $10,000 of that excess is unearned income, the additional Medicare tax would be

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[23] *National Federation of Independent Business, et al v. Sebelius*, 567 U.S. ___ (June 28, 2012)
[24] 26 U.S.C. § 5000A(c)(1)
[25] AARP Bulletin, September, 2012

$380. The surtax will also be assessed on trusts and estates with taxable income over $11,950 in 2013.

As of 2014, employers with more than 50 employees are required to provide health insurance coverage to employees, or the employer will be penalized.[26] The penalty is $2,000 per year per full-time employee. The penalty is nondeductible.[27] By October 1, 2013, all employers were required to provide notice to their employees of their options under the ACA for health insurance.[28]

4. **Expansion of Long Term Care Coverage.**

Although the ACA will significantly improve access to health insurance, it does not expand the services available for the long term care needs of people with disabilities or long term chronic diseases. It is still the case that those types of services are available only through private resources or Medicaid. The ACA does provide for improvements, however, in the delivery of these services under Medicaid.

One concept promoted by the ACA is "health homes." Health homes are a method of delivering health care services to patients who have chronic and multiple symptom conditions, such as diabetes, asthma, heart disease, obesity, mental conditions or chronic substance abuse.[29] Services are provided in a patient-centered environment by a multidisciplinary staff, which also links to community based services that will promote healing rather than acute care oriented care. A state may apply for a state plan amendment ("SPA") to the Centers for Medicare and Medicaid Services ("CMS") if it

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[26] 26 U.S.C. § 4980H(a)
[27] *Id.*
[28] OMB No. 1210-0149
[29] Kaiser Family Foundation publication #8136 "Medicaid's New 'Health Home' Option," www.kff.org

wishes to implement health homes. States will receive 90% federal matching funds for the first two years to implement health homes.

In October, 2011, the ACA provided for the implementation of the Community First Choice Option for home and community based services through additional funding to state Medicaid programs.[30] A proposed rule to implement this program was issued by CMS on February 25, 2011.[31] This program is available for those who have functional needs that would otherwise require institutional care and whose incomes are no more than 300% of the Supplemental Security Income threshold, i.e., $34,470 per year in 2013. One's age or diagnosis is not a determining factor for eligibility. The services include assistance with activities of daily living ("ADLs"), transition costs such as bedding or rent, training in management of assistants, backup safety devices, and assistance with health related tasks. The program does not cover room and board (such as in an assisted living facility), medical equipment, home modifications or special education services. The federal Medicaid funding available to states increases by 6% for those states that adopt this program. States that implement the Community First Choice Option are not allowed to have waiting lists. This is not a "waiver" program. California was the first state to adopt Community First Choice Option in the summer of 2012, and will receive an estimated $258 million in the first year and $315 million in the second year from the federal government.[32] Eight states have elected to adopt this plan.[33]

As of 2014, 100% federal funding is available for state Medicaid programs to provide overall medical services to every adult under age 65 whose income is below

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[30] 42 U.S.C. § 1396n(k) et. seq.
[31] Federal Register http://www.federalregister.gov/articles/2011/02/25/2011-3946/medicaid-program-community-first-choice-option#p-3
[32] The ARC Capitol Insider, September 4, 2012
[33] http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/

138% of the federal poverty level ($33,465 per year for a family of 4 in 2015) and who is not otherwise insured. Eligibility for the benefit will be based on modified adjusted gross income MAGI only, without a resource analysis.[34] The governor of New Mexico determined in December, 2012, that this would be good for New Mexico. According to the September 28, 2012, issue of the Albuquerque Journal, 170,000 New Mexicans could obtain health coverage under this program. Lee Reynes, director of the University of New Mexico Bureau of Business and Economic Research, estimated conservatively that New Mexico would receive $3.9 billion from the federal government from 2014 to 2020 under this program. The analysis projected 1500 new jobs being created in New Mexico in 2014, with a total of 5000 new jobs by 2020. The Legislative Finance Committee estimated increased revenue generated by income taxes to the state from these jobs would be $98.5 million per year through 2019.[35] The federal funding to the states will decrease in 2017 from 100% to 95%, to 94% in 2018, to 93% in 2019 and to 90% from 2020 on. In the *National Federation of Independent Business* decision, the U.S. Supreme Court it was held that this provision of the ACA is optional with the states. So far 29 states have opted to expand Medicaid coverage to low income citizens regardless of resources and health status, for ages 19 through 64.[36]

Challenges to the Affordable Care Act

There have been many challenges made to the Affordable Care Act. During the months in which it was being debated in Congress, the forces opposed to these reforms launched a vituperative campaign that included gun toting seniors at town hall meetings,

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[34] Modified Adjusted Gross Income is described at IRC §36B(d)(2)(B)
[35] Albuquerque Journal, September 28, 2012
[36] http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap

terrifying television ads, and the introduction of phrases such as "death panels," "socialistic health care," and of course "Obamacare." The Affordable Care Act is not socialized medicine, universal health care, nor is it a single payor system. It is not like Canada. It is very much like Massachusetts. Some members of Congress and other elected officials made it a goal to either repeal the Affordable Care Act, to break it apart, piece by piece, to attack its components at the state level, and most recently to block funding by shutting down the federal government entirely.

It might be helpful to put this acrimony into an historical perspective. The United States government first mandated that sailors buy health insurance in 1798.[37] In the twentieth century, the first serious attempt was in California. In 1945, then Governor Earl Warren of California, who was elected as a conservative, proposed a universal health insurance system for the state. As you may recall, Earl Warren went on to become the Chief Justice of the United States Supreme Court, who, as the author of *Brown v. Board of Education* striking down racial segregation in public schools, became one of the most hated liberal Justices in American history. Governor Warren had suffered from a serious kidney infection in the fall of 1944. Although he could afford the health care he needed, through that experience he realized the catastrophic effects that sudden illness could have on a family without health insurance. He consulted with the California Medical Association, which initially did not object to the idea. However, once the bill was introduced into the California legislature, the doctors retained a team of political publicists, Leone Baxter and Clem Whitaker, for $25,000, to campaign against the governor's plan. Using techniques that are commonplace today, such as creating false

[37] http://blogs.smithsonianmag.com/smartnews/2012/06/a-little-perspective-congress-first-mandated-health-care-in-1798/

enemies, sending hysterical mass mailings, providing editorial materials disguised as news to news outlets, and creative use of graphics and slogans, this team defeated the plan in California.[38] Subsequently, in 1948, newly elected President Harry Truman proposed a federal health insurance program funded by a payroll tax. The American Medical Association responded by retaining Baker and Whitaker, and assessed its members an extra $25.00 per month to fund the campaign, which ultimately cost the AMA nearly $5 million over three years. Describing the plan as socialism and inspired by the Soviets, the team found an enthusiastic audience in the post World War II, pre cold war environment. And so, a mystified President Truman saw the demise of his plan in 1952. The point here is that the ACA is not new. And organized opposition to this reform is also now new.

Effect of the Affordable Care Act on Advisors and Trustees

The ACA contains many provisions discussed above that are prima facie benefits to people with disabilities. The most significant provision that causes us to refocus our thinking, in my opinion, is the prohibition of excluding a person with a pre-existing condition from health insurance coverage. The ACA puts a new focus on the planning that we do with disabled adults and families who have children who are faced with long term injury or illness. For example, a child who has suffered an injury but who is not disabled and therefore not eligible for Supplemental Security Income ("SSI") benefits, or whose family income is high enough to be excluded from SSI and Medicaid eligibility, can now anticipate health insurance coverage, even with the injury. Until the ACA, advisors and trustees working with children or adults who had suffered a disabling injury were forced to think in terms of applying for Medicaid, because it was a foregone

[38] "The Lie Factory" by Jill Lepore, The New Yorker, September 24, 2012

conclusion that the injured person would not be able to obtain health insurance. Special needs trusts were considered to be the only option for that purpose, because means-based benefits were the only option due to the pre-existing condition.

As advisors and trustees, we need to be knowledgeable about the expansion of Medicaid benefits to all poor adults in our states. We should advocate for our states to adopt the Community First Choice Option so that we can move away from the institutional bias of Medicaid that sends so many of our clients into nursing homes who would rather remain at home.

We need to work even harder with our colleagues in the trial bar so that we can offer a more comprehensive analysis for the long term care needs of injured plaintiffs for whom special needs trusts may have been the only solution when we presumed that they would never be eligible for health insurance as a result of their injuries. We should be getting involved in personal injury cases as early as possible as health coverage advisors and trustees need to consider all possible options for health coverage not limited to Medicaid.

We will need to get involved in the health insurance exchanges in our states, learn the procedures being used to determine eligibility, know the income tax provisions and reporting requirements for our clients to determine eligibility for subsidies or other tax effects of the ACA, and know the eligibility guidelines for federal poverty limits for health coverage.

Conclusion

In summary, the ACA reforms the health insurance industry. This paper focuses on four ways that access to health insurance has been reformed: reforms of existing

health insurance coverage; expansion of coverage to those who have been excluded from health insurance coverage; the mandate of health insurance coverage for everyone; and the expansion of Medicaid coverage. I have suggested some ideas about how the ACA affects our practices. We need to inform and educate our colleagues, other professionals, and our clients about the elements of the Affordable Care Act that will affect them. In addition to the cites in the footnotes I have provided, you can obtain basic information and stay abreast of developments at www.healthcare.gov.

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