

SENIOR BULLETIN: MEDICAID – INSTITUTIONAL/COPEs

The changes in the CSRA and their consequences

When a married person needs government help with long-term care, the person's spouse may be at risk of falling into – or further into – poverty. State law provides some protection against impoverishment for such spouses, but it is more limited than it used to be. In 2003, the Legislature acted to reduce the amount of non-exempt resources a married couple may have when one spouse applies for COPEs or Medicaid for nursing home care. The consequences of that action have been different from, and more complicated than, what some people expected.

The 2003 legislation, ESHB 2257, required the Department of Social & Health Services to lower what is called the "Community Spouse Resource Allocation" or "CSRA." Any individual, single or married, may have \$2,000 worth of non-exempt resources (for example, cash or savings in a bank) at the time of application for COPEs or Medicaid for nursing home care. The CSRA is the amount of non-exempt resources that a married couple may have, in addition to that \$2,000, when one spouse applies for COPEs or Medicaid for nursing home care. This additional resource allocation is intended to protect the "community spouse" from impoverishment. (The spouse of a nursing home resident or a COPEs recipient is sometimes referred to as a "community spouse.")

Before August 2003, the CSRA in Washington was \$90,660, the maximum permitted under Federal law. The Final Bill Report on ESHB 2257 summarized the primary effect of the legislation as follows: "The Department of Social and Health Services will disregard up to a maximum of \$40,000 in resources for the community spouse of persons institutionalized on or after August 1, 2003." This suggests an expectation that the legislation would simply reduce the CSRA from \$90,660 to \$40,000.

Federal law, however, does not permit Washington to set a maximum CSRA of \$40,000. It permits a state to set a CSRA at a minimum of \$40,000, but under certain circumstances it must be increased up to a maximum that was \$90,660 in 2003 and that will be \$92,760 in 2004. (The maximum increases annually in January.)

In amending its regulations to implement ESHB 2257, DSHS was obliged to adjust the Legislature's \$40,000 "maximum" to comply with Federal law requirements.¹ Under Federal law, if a state sets a minimum CSRA below the Federal maximum, then an applicant is entitled to an actual CSRA that is not less than half of the combined non-exempt resources of the husband and wife at the time the applicant began a continuous period of institutionalization in a hospital or nursing home, up to a maximum of \$90,660 in 2003 (\$92,760 in 2004).

If this seems a little complicated on first reading, that is because it *is* a little complicated. Community Spouse Resource Allocation determinations are often more complicated when a state establishes a minimum CSRA that is different from the Federal maximum. DSHS must now determine a couple's combined non-exempt resources at a time that may be many months earlier than the time of a Medicaid or COPES application. Eligibility determinations will now often be more complicated for the disabled individual and his or her spouse, and more time-consuming and expensive for the Department.

The following example shows how the new CSRA rule works. John is a married nursing home resident. He was eligible for Medicaid in December 2003 in all respects other than resources. He and his wife, Jane, had combined non-exempt resources of \$60,000 on December 1st. Was he resource eligible in December? Or to put it another way, what was the CSRA that would apply in his case?

To answer this question, the Department now needs to determine what the combined non-exempt resources of the couple were as of the first day of the month in which John's continuous period of institutionalization in a hospital or nursing home began. Let's assume that John entered a hospital in November and went from there to a nursing home (so his institutionalization has been continuous since November). And let's assume bank records show that as of November 1st the couple's combined non-exempt resources were \$120,000. Then the CSRA would be \$60,000 (that is, half of \$120,000). If they had only \$60,000 left on December 1st, John would be eligible for Medicaid in December, unless he is ineligible for some other reason.

Under the new CSRA rule, the CSRA will be \$40,000 only if the couple's combined resources were not more than \$80,000 (twice \$40,000) as of the first day of the month in which a continuous period of institutionalization in a hospital or nursing home began. Couples with combined non-exempt resources of more than \$80,000 when institutionalization began will get a larger CSRA – a CSRA that is half of the combined amount up to a limit of \$90,660 (\$92,760 in 2004). There is

nothing in the history of the legislation to suggest that legislators wanted to give a higher CSRA to couples with higher levels of non-exempt resources at the moment when institutionalization began, but that was one consequence of ESHB 2257.

The point of ESHB 2257 was to save State Medicaid funds. It was hoped that the change would delay Medicaid eligibility for many prospective married applicants. If they paid privately for their care for several additional months, that would mean several additional months in which they made no demands on the Medicaid program. And it is likely that in some cases such savings to the State will result, particularly in cases in which couples do not understand the options available to them. But, as the example of John and Jane illustrates, the prospect of savings is highly speculative.

Remember that in November John and Jane had \$120,000, but by December 1st they had only \$60,000, which corresponded to their CSRA. What might have happened to the other \$60,000? If they had given away \$60,000 in November, the Department would have calculated a resulting period of Medicaid or COPES disqualification that would have lasted close to a year. But there are a number of other choices permitted to the couple. To understand the significance of the CSRA, it is necessary to know what some of those choices are and to consider why a couple might feel considerable pressure to exercise one or more of them.

Of course, the money might have been spent on medical care. Or, it might have been used, for example, to pay off a debt, to make repairs on the couple's house or apartment, or to purchase an exempt resource, such as a household appliance. Another option is the purchase of an annuity in the name of the community spouse. The annuity income would be counted as income to the community spouse, but the couple's resources would be decreased by the amount used to purchase the annuity. (There is controversy about whether this annuity option should be retained or curtailed.²)

The motivation for many informed couples in modest circumstances³ to consider ways to preserve resources in one form or another for the community spouse is intense, in light of their reasonable fears about the community spouse's financial security. It was such reasonable fears that Congress responded to by establishing the Federal formula for the CSRA in 1988, and that our Legislature responded to by keeping Washington's CSRA at the Federal maximum until 2003.

A typical spouse of a nursing home resident must face the prospect of losing his or her spouse before many years pass. At that point, many

surviving spouses will rely, primarily, on one Social Security check averaging around \$820 a month.⁴ The CSRA represents a potential additional source of future income. Savings of \$90,000 at 6% would provide around \$5,400 in additional income annually, or \$450 monthly. Added to \$820 of Social Security, this would leave the surviving spouse with \$1,270 a month. Savings of \$40,000 would add less than half as much – \$200 a month – leaving the surviving spouse with \$1,020 a month.

As the CSRA is decreased, an increasing number of community spouses face the prospect of being unable to remain in even a modest private apartment or home, when only their own income is available to meet housing, food, clothing and uncovered medical expenses. This prospect is likely to move many couples to explore estate planning options that may improve the financial security of the community spouse.

Endnotes:

¹ The amendment was made in WAC 388-513-1350. The governing Federal statute is 42 U.S.C. § 1396r-5. The operation of the CSRA is explained in more detail in the Columbia Legal Services pamphlets entitled “Questions and Answers on Medicaid for Nursing Home Residents” and “Questions and Answers on the COPES Program.” Both are posted on the Northwest Justice Project web site at http://www.nwjustice.org/law_center/seniors.html.

² An October 2003 report by the Annuities Work Group of the National Association of Medicaid Directors recommended, among other things, that the Federal Centers for Medicare and Medicaid Services (CMS) allow states to treat annuities as devices similar to trusts, giving states greater authority to limit the use of annuities for Medicaid planning purposes. (The report acknowledged the difficulty in distinguishing between annuities “purchased in order to qualify for Medicaid” and annuities “purchased as part of a legitimate retirement plan.” It did not suggest that *income* protections for individuals who receive retirement income in the form of annuity payments ought to be less favorable than those for individuals who receive retirement income in other forms.) “The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies,” American Public Human Services Association. The Department of Social & Health Services recently used its authority to limit the use of trusts for Medicaid planning. Washington couples had been able to achieve Medicaid resource eligibility by funding a trust for the sole benefit of the community spouse. They can no longer do so with trusts established after July 2003 under the current regulation, WAC 388-561-0100(5)(e). This development has resulted in an increased interest in analogous uses of annuities, which remain an option to the extent to which they satisfy the requirements of WAC 388-561-0200(5). Policy objections to the use of annuities to achieve Medicaid resource eligibility parallel objections to the corresponding use of sole benefit trusts, but state authority to limit annuity use is more limited.

³ According to a survey conducted by the National Academy of Elder Law Attorneys this year, “Medicaid estate planning (defined as ‘use of permissible legal or financial means

to preserve or shelter assets while securing Medicaid eligibility for a client') is typically employed only for relatively small estates." NSCLC Washington Weekly, July 25, 2003.

⁴ According to data published by the Social Security Administration's Office of Research, Evaluation and Statistics, the average Social Security payment for all widows and widowers in Washington State was \$820 a month in December 2001. To appreciate the full significance of this point one must consider the likely circumstances of the community spouse a year or so after the initial Medicaid application. Assume, for example, that John (who has gone into a nursing home) has Social Security of \$850 a month and Jane (John's wife who has remained in the apartment previously shared by the couple) has \$750 in Social Security. While John is on Medicaid in a nursing home, most of his Social Security will go to Jane under Medicaid rules that give her what is called a "spousal allowance." Until April of 2004, enough of John's Social Security would be allocated to Jane, as a spousal allowance, to bring her total income up to at least \$1,515. (The number will increase in April of each year.) However, in the likely event that John should die before Jane, she would then be left with income of only \$850 a month from Social Security.