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Speaker:
Mary Alice Jackson, Esq.

Author Contact Information:
Mary Alice Jackson, Esq.
Mary Alice Jackson, P.C.
Austin, TX

maj@majackson.com
512-499-0049

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With the election of Donald Trump and a Republican-controlled Congress, there has been a shift in policy that will have a significant impact on our practice. The over 65 population has increased over 30% over the past decade.[1] In 2015, there were 47.8 million Americans over the age of 65, and this number is expected to double by the year 2060.[2] With the increase in the over 65 population, a need for caregiving and additional services increases. This will be met by an ever-growing cost of long term care and expected cuts in Medicaid funding. This paper will discuss how changes in federal law will affect seniors and individual with disabilities, in particular the House bill of the ACHA and its effect on Medicaid funding, the new federal nursing home regulations, and updates on other federal legislation such as the Special Needs Trust Fairness Act and the ABLE Act.

I. The 115th Congress and Medicaid – as of 07/07/2017

Congress is on the warpath with respect to controlling funding of the Medicaid program to reduce federal expenditures. Two fundamental elements of the long-time program have been targeted: (1) the federal/state funding mechanism[3] and (2) program eligibility requirements.[4] The House Bill, also known as the American Health Care Act (AHCA), passed by a 217-213 margin on May 4, 2017. The Senate's version is called the "Better Care Reconciliation Act" (BCRA) was expected to be less draconian then the House version, but surprisingly turned out to be as mean-spirited as the AHCA when it was finally released on June 29, 2017. Early Congressional Budget Office projections predicted that the House bill would result in cuts to Medicaid of up to 800 billion dollars over ten years.[5] How will our advocacy change during that time? Are we riding a dead horse but don't know that it's time to get off?[6] Let's examine the primary changes which *are likely* to become a reality when this legislation passes (some things seem too mean-spirited to be true, but sadly, these are projected changes):

- Change the federal/state financial participation in Medicaid by "cost-shifting" - having the federal government give states a fixed dollar amount per beneficiary starting in 2020: known as the "per capita cap" system, caps will vary by state and by beneficiary designation (elderly, blind and disabled, children), and provide for growth by medical inflation;

- Repeal retroactive Medicaid eligibility for long term care services; eligibility would begin from the month of application;

- Eliminating higher home equity limit options for states which chose the original $750,000 limit; only the $500,000 equity limitation (as now adjusted by inflation) will be available;

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[1] "A Profile of Older Americans" Administration of Aging - U.S. Department of Health and Human Services. https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2016-Profile.pdf.
[2] *Id*.
[3] 42 U.S.C. 1396a(a)(2).
[4] 42 U.S.C. Title XVI, Sec. 1601 et seq.
[5] https://www.cbo.gov/publication/52752
[6] With thanks to elder law guru Charlie Robinson of Florida

- Providing that inheritances of "lump sum income" shall be treated as income over a period of months rather than in the month of receipt; with calculation of income per month being dependent upon the amount inherited;

- Providing that the ten "essential health benefits" required by the ACA may be implemented at the option of the states; the ten benefits included coverage for substance abuse, prescription drugs and certain therapies, among other things;

- Effectively weakens coverage for persons with pre-existing conditions by calling for insurers to offer plans but making the premium and other costs prohibitively expensive;

- Per capita cap amounts will vary both by state and by beneficiary designation (elderly, blind and disabled, children), even for medically complex children and individuals with disabilities;

- Establishes "Medicaid Flexibility Program" starting in FY 2020 to allow states to apply to operate portions of their Medicaid program under a block grant program;

- Imposes a new age rating so that people ages 50 to 64 could pay 5x more than younger adults for insurance; and

- Permits states to impose work requirements for certain Medicaid recipients.

Health care reform proposals aren't the only pieces of federal legislation of concern to elder law practitioners. NAELA led a successful fight against a bill which would have required states to attribute ½ of the income from an annuity purchased by a community spouse to the institutionalized spouse. As for the ABLE Act, three bills which would improve the law are pending:

- Proposed changes to increase the age of individuals who can participate in ABLE programs from 26 to 46 remain in play;[7]

- Amendment to the IRC allow: (1) an ABLE account beneficiary to make additional contributions to an ABLE account equal to the lesser of such beneficiary's compensation or an amount equal to the federal poverty line for a one-person household, and (2) a retirement savings tax credit for contributions to an ABLE account;[8] and

- Amendment to the IRC to allow tax-free rollovers of amounts in qualified tuition programs (529 plans) to qualified ABLE programs.[9]

[7] ABLE Age Adjustment Act
S.817 & H.R. 1894—115th Congress (2017-2018)
[8] ABLE to Work Act of 2017
S.817 & H.R. 1896 —115th Congress (2017-2018)
[9] ABLE Financial Planning Act
S. 816 & H.R. 1897-—115th Congress (2017-2018)

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