Stiller Law Offices

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FUNDAMENTALS OF MEDICAID PLANNING

One of the greatest fears of older Americans is that they may end up in a nursing home. You, or someone you know, may have this fear. This not only means a great loss of personal autonomy, but also a tremendous financial price. Even without going into a nursing home, the costs can be staggering. According to 2013 figures, nineteen percent (19%) of nursing home and home health care bills are paid by individuals, 51% by Medicaid, 21% by other public funding, and only about 8% by private insurance, including long-term care insurance. At some point in their stay, almost two-thirds of Ohio's nursing home patients are covered by Medicaid. A 2012 report found that 46 percent of people die with virtually no assets, often because they had inadequate resources to pay for unanticipated expenses related to their health care.

Some people are not interested in qualifying for government assistance to provide for their long term health care, if and when they need it. Others lack the resources to be able to take that stance. This article is just a brief overview of the complex and intensely personal area of estate planning devoted to planning for those people.

Most people end up paying for nursing home care out of their savings and other assets until they run out. In 2016, the median annual cost for private nursing facility care

You Should Know

Based on figures from 2012, a woman has a 52% chance of going into a nursing home while a man has only a 33% chance of needing such care. Women are more likely to go into a nursing home because they live longer and they are more likely to become feeble. They are also more likely to require such care because their spouse, if any, has passed away and there is no longer someone at home to provide long-term care. Depending on location and level of care, nursing homes cost between $40,000 and $180,000 a year.

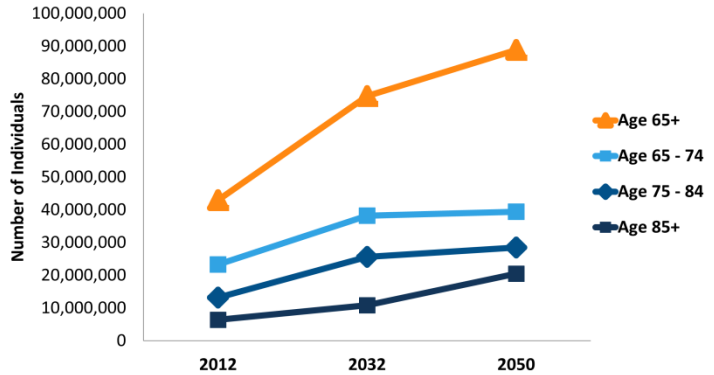
was $92,378 and the median cost for one year of home health aide services (at $20/hour, 44 hours/week) was $46,332 and adult day care (at $68/day, 5 days/week) totaled almost $18,000. At such rates, it is easy to see how quickly a lifetime of savings can be depleted. Once they are, then clients can qualify for Medicaid to pick up the cost. The advantages of paying privately are that you are more likely to get into a better quality facility and doing so eliminates or postpones dealing with Ohio's welfare bureaucracy--an often demeaning and time-consuming process. The disadvantage is that it is expensive. Careful planning, whether in advance or in response to an unanticipated need for care, can help protect your estate, whether for your spouse or for your children.

This can be done by purchasing long-term care insurance or by making sure you receive the benefits to which you are entitled under the Medicare and Medicaid programs. Veterans may also seek benefits from the Veterans Administration.

Those who are not in immediate need of long-term care may have the luxury of distributing or protecting their assets in advance. This way, when they do need long-term care, they will quickly qualify for Medicaid benefits. Giving general rules for so-called "Medicaid planning" is difficult because every client's case is different. Some have more savings or income than others. Some are married, others are single. Some have family support, others do not. Some own their own homes, some rent. Still, a number of basic strategies and tools are typically used in Medicaid planning, including converting non-exempt assets to exempt assets, converting assets to income, the use of irrevocable trusts, promissory notes, caregiver contracts, annuity planning and other spend down planning.

Figure 1

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

WHAT IS MEDICAID

Medicaid is a joint federal-state program that provides health insurance coverage to low-income children, seniors, and people with disabilities. In addition, it covers care in a nursing home for those who qualify.

In the absence of any other public program covering long-term care, **Medicaid** has become the default nursing home insurance of the middle class. Lacking access to alternatives such as paying privately or being covered by a long-term care insurance policy, most people pay out of their own pockets for long-term care until they become eligible for **Medicaid**.

As for home care, **Medicaid** has traditionally offered very little. Recognizing that home care generally costs far less than nursing home care, more and more states, including Ohio, are providing **Medicaid**-covered services to those who remain in their homes.

Although their names are confusingly similar, **Medicaid** and Medicare are vastly different programs. All retirees who receive Social Security benefits also receive Medicare as their health insurance. Medicare is an "entitlement" program. **Medicaid**, on the other hand, is a "needs-based" program. So to be eligible for **Medicaid**, you must become "impoverished" under the program's guidelines. There is both a resource component (although there are some assets that are exempt and not counted as available resources) and an income component for **Medicaid** qualification.

Unlike Medicare, which is a federal program, **Medicaid** is a joint federal-state program. Each state operates its own **Medicaid** system, but this system must conform to federal guidelines in order for the state to receive federal money, which pays for about half the state's **Medicaid** costs while the state pays the remainder. This complicates matters, since the **Medicaid** eligibility rules are somewhat different from state to state and they keep changing. In 2016, Ohio enacted sweeping changes to its Medicaid laws that significantly changed the rules governing the treatment of income, real estate, and asset transfers by nursing home residents. To be certain of your rights, call me, or another attorney familiar with these matters, with your questions.

Numbers for 2017

For a spouse at home (community spouse), the numbers are:

***Community Spouse Resource Allowance** (CSRA):*

Minimum: $24,180

Maximum: $120,900

***Monthly Maintenance Needs Allowance** (MMNA):*

Minimum: $2,003

Maximum: $3,023

For the nursing home resident, the numbers are:

***Monthly Personal Needs Allowance**: $50*

***Resource Allowance for an Individual**: $2,000*

An attorney can guide you through the complicated rules of the different programs and help you plan ahead.

Many older Americans mistakenly believe that Medicare, their health insurance, will pay for their health care costs if they enter a nursing home. Nothing could be further from the truth. Under Medicare, coverage is severely limited. Home health services are only covered for beneficiaries who are homebound, and personal care services are not covered by Medicare. Post-acute nursing facility care is only covered for up to 100 days following a qualified hospital stay.

ASSET TRANSFERS TO QUALIFY FOR MEDICAID

Medicaid planning often involves the transfer of assets from the institutionalized person to others, generally their adult children. Congress has established a period of ineligibility for Medicaid for those who transfer assets. For transfers made after February 8, 2006, the so-called "look-back" period for all transfers is 60 months, or five years.

While the look-back period determines what transfers will be penalized, the length of the

penalty depends on the amount transferred. The penalty period is determined by dividing the amount transferred by the average monthly cost of nursing home care in the state. For instance, if the nursing home resident transferred $100,000 in a state where the average monthly cost of care was $5,000, the penalty period would be 20 months ($100,000/$5,000 = 20). The 20-month period will not begin until (1) the transferor has moved to a nursing home, (2) he has spent down to the asset limit for Medicaid eligibility, (3) has applied for Medicaid coverage, and (4) has been approved for coverage but for the transfer. Therefore, if an individual transfers $100,000 on April 1, 2017, moves to a nursing home on April 1, 2018 and spends down to Medicaid eligibility on April 1, 2019 and applies for Medicaid, that is when the 20-month penalty period will begin, and it will not end until December 1, 2020.

Transfers should be made carefully, with an understanding of all the consequences. People who make transfers must be careful not to apply for Medicaid before the five-year look-back period elapses without first consulting with an attorney. This is because the penalty could ultimately extend even longer than five years, depending on the size of the transfer.

Caution is needed before making transfers. Any transfer strategy must take into account the nursing home resident's income and all of his or her expenses, including the cost of the nursing home. Bear in mind that if you give money to your children, it belongs to them and you should not rely on them to hold the money for your benefit. However well-intentioned they may be, your children could lose the funds due to bankruptcy, divorce, or a lawsuit. Any of these occurrences would jeopardize the savings you spent a lifetime accumulating. Do not give away your savings unless you are ready for these risks.

In addition, be aware that the fact that your children are holding your funds in their names could jeopardize your grandchildren's eligibility for financial aid in college. Transfers can also have serious tax consequences for your children. This is especially true of assets that have appreciated in value, such as real estate and stocks. If you give these to your children, they will not get the tax advantages they would get if they were to receive them through your estate. The result is that when they sell the property, they will have to pay a much higher tax on capital gains than they would have if they had inherited it.

As a general rule, never transfer assets for Medicaid planning unless you keep enough funds in your name to (1) pay for any care needs you may have during the resulting period of ineligibility for Medicaid and (2) feel comfortable and have sufficient resources to maintain your present lifestyle.

Remember: You do not have to save your estate for your children. The bumper sticker that reads "I'm spending my children's inheritance" is a perfectly appropriate approach to estate and Medicaid planning.

PERMITTED TRANSFERS

While most transfers are penalized with a period of Medicaid ineligibility of up to five years, certain transfers are exempt from this penalty. Even after entering a nursing

home, you may transfer any asset to the following individuals without having to wait out a period of Medicaid ineligibility:

- Your spouse (but this may not help you become eligible since the same limit on both spouse's assets will apply).

- Your child who is blind or permanently disabled.

- Into trust for the sole benefit of anyone under age 65 and permanently disabled.

- In addition, you may transfer your home to the following individuals (as well as to those listed above):

- Your child who is under age 21.

- Your child who has lived in your home for at least two years prior to your moving to a nursing home and who provided you with care that allowed you to stay at home during that time.

- A sibling who already has an equity interest in the house and who lived there for at least a year before you moved to a nursing home.

Even though a nursing home resident may receive Medicaid while owning a home, if the resident is married, he or she should consider transferring the home to the community spouse (assuming the nursing home resident is both willing and competent). This gives the community spouse control over the asset and allows the spouse to sell it after the nursing home spouse becomes eligible for Medicaid. In addition, the community spouse should consider changing his or her Will to bypass the nursing home spouse. Otherwise, at the community spouse's death, the home and other assets of the community spouse will go to the nursing home spouse; not only will the recipient cease to be eligible for Medicaid due to the inheritance, but he or she will also have to spend down the inheritance before being able to receive Medicaid again.

MEDICAID UPDATES

Medicaid publishes updated allowance and related numbers annually. The Medicaid numbers for 2017 were updated earlier this year. (See the graphic on page 3). Medicaid law provides special protections for the spouses of Medicaid applicants to make sure the spouses have the minimum support needed to continue to live in the community while their husband or wife is receiving long-term care benefits, usually in a nursing home.

If the Medicaid applicant is married, the countable assets of both the community spouse and the institutionalized spouse are totaled as of the date of "institutionalization," the day on which the ill spouse enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. (This is sometimes called the "snapshot" date because Medicaid is taking a picture of the couple's assets as of that date.)

If most of the couple's income is in the name of the institutionalized spouse and the community spouse's income is not enough to live on, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. How much the community spouse is entitled to depends on what the Medicaid agency determines to be a minimum income level for the community spouse. Under the new rules adopted in 2016, a Medicaid recipient whose monthly gross income exceeds $2,205 must now use a

Qualified Income Trust ("QIT" aka Miller Trust) to receive and distribute all income above that level each month, including the income that must be shared with the community spouse. The rules for QIT's are not only new, they are complex, and making a mistake in administering such trusts can result in Medicaid ineligibility for the month in which an error occurs. Because the Medicaid recipient's spouse or adult child will often be the trustee of the QIT, consultation with an attorney is recommended.

Transfers: The average monthly cost of nursing home care according to Ohio is $6,570. In general, this means that for every $6,570 given away within the last five years before you apply for Medicaid, one month of nursing home coverage will be forfeited.

Estate Recovery: Under Medicaid law, following the death of the Medicaid recipient a state must attempt to recover from his or her estate whatever long-term care benefits it paid for the recipient's care. States also have the option of recovering all Medicaid benefits from individuals over age 55, including costs for any medical care, not just long-term care benefits. However, no recovery can take place until the death of the recipient's spouse, or as long as there is a child of the deceased who is under age 21 or who is blind or disabled.

While states must attempt to recover funds from the Medicaid recipient's probate estate, meaning property that is held in the recipient's name only, they have the option of seeking recovery against property in which the recipient had an interest but which passes outside of probate. This includes jointly held assets, assets in a living trust, assets with beneficiary designations, or life estates. Ohio has significantly expanded the definition of "estate" to include almost everything a person owns at death, including those that are jointly owned or in a living trust, etc.

Home Equity Limit: Nursing home residents do not automatically have to sell their homes in order to qualify for Medicaid. If you are married or have other family members living in the home who are dependent on you for support, your home is exempt, which means that your spouse and dependents can continue to live in the home, and the state cannot make you sell it. State Medicaid agencies must place a lien on real estate owned by a Medicaid recipient during his or her life, for recovery of Medicaid expenses if the house is sold during the recipient's life, unless certain dependent relatives are living in the property. The exceptions to this rule are cases where a spouse, a disabled or blind child, a child under age 21, or a sibling with an equity interest in the house is living there.

If the nursing home resident is single and the house is not occupied by a dependent family member or a co-owner, the house's value is counted toward the applicant's financial eligibility unless the applicant intends to return home. However, due to the Medicaid income and asset restrictions, the owner will no longer have assets available to pay for the home's upkeep and maintenance. This exemption for the house ends when the owner establishes a principal residence elsewhere (such as a nursing home) so a single person must often decide to keep or to sell the house before applying for Medicaid.

Principal residences are not counted as assets by Medicaid only to the extent the applicant's equity interest in the home is less than $560,000 (figures are adjusted annually for inflation). Your home will immediately be counted as a Medicaid resource if your equity in the home exceeds this amount. The equity value of the home is the fair market value minus any debts secured by the home, such as a mortgage or a home equity loan. For example, if your home has a fair market value of $400,000 and an outstanding mortgage of $100,000, the equity value is $300,000, but it may differ depending on whether you own the home by yourself or with someone else. The home equity rule does not apply if certain qualified persons live in the home. Again, the home may be subject to estate recovery after the Medicaid recipient's death depending on various factors, including ownership at the time of application and subsequent transfer to an allowable person, etc.

THE ATTORNEY'S ROLE IN MEDICAID PLANNING

Do you need an attorney for "simple" Medicaid planning? This depends on your situation, but in most cases, the prudent answer would be "yes." The social worker at your mother's nursing home assigned to assist in preparing a Medicaid application for your mother knows a lot about the Medicaid program, but maybe not the particular rule that applies in your case or the newest changes in the law. In addition, by the time you are applying for Medicaid, you may have missed out on significant pre-planning opportunities. Also, because every state has its own rules regarding Medicaid, the rules that applied to your cousin in Vermont are not the same as those that apply to you or your mother in Ohio.

The best course of action is to consult with a qualified professional who can advise you on your unique situation. What you learn can mean significant financial savings or better care for you or your loved one. This may involve the use of trusts, transfers of assets, purchase of annuities or increased income and resource allowances for the healthy spouse, if any.

It is true that many older Americans may end up in a nursing home. This does not mean that nothing can be done to ameliorate the financial and emotional toll that often accompany residence in a long-term care facility. All estate planning is better done before it is needed, and Medicaid planning is no different. So taking the time now to explore your options and to develop a comprehensive plan for your personal situation is time well spent.

Contact us for more information about the topics discussed in this article. This information is provided as a service to our clients and is not intended to be and does not constitute legal advice.

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