INTEGRATING LONG-TERM CARE INTO ESTATE PLANNING

TAKE A STAND FOR CAREGIVERS

JAN NEAL LAW FIRM LLC

Jan Neal
Jan Neal Law Firm, LLC
207 N 4th St
Opelika, AL 36801
(334) 745-2779
800-270-7635
neal@janneallaw.com
www.janneallaw.com
https://www.facebook.com/janneallaw
@janneallawllc
www.linkedin.com/in/jboydneal

These slides will be made available after the presentation through Slideshare, the PANDA Facebook page and the Jan Neal Law Firm, LLC, Facebook page.

WHY INTEGRATE ESTATE PLANNING AND LONG-TERM CARE PLANNING?

Estate Planning is the means by which we document how we want our assets to be handled when we become disabled or die and ultimately pass property to the persons of our choice. Anticipating disability we may create a power of attorney to designate agents who can handle our business for us if we cannot do that ourselves. Anticipating death we select the person/s to handle our estate and pass our property to those persons we select by will or trust. We may also set up accounts with specific beneficiary designations to pass funds directly to those persons.

A significant part of assuring we have an estate left to pass involves **Long-Term Care Planning**. This requires taking an informed look at the high cost of long-term care services and making decisions about how to fund those expenses. Many good estate plans are destroyed by failure to plan for the cost of long-term care, so it is beneficial to consider these disability expenses while looking at estate planning.

START EARLY

Planning for long-term care is best accomplished by the individual himself or herself who may need to finance long-term care in the future. Planning for long-term care expenses is best accomplished early – when the individual has full capacity and at least five years prior to the need for long-term care.

Often there is no planning, and, as a result, family members - perhaps spouses and children – find themselves having to make hard decisions. For one person to engage in planning for another there must be documented authority to act, even in many situations for a spouse to plan for another. Since a person's power of attorney will lay the authority for any opportunity to plan to preserve the estate, and because an agent can act only within the scope of the powers granted in an advance directive, a person should keep that in mind when preparing a power of attorney.

While there are strategies that can be employed closer to the time long-term care is needed, when a placement is imminent, there are fewer opportunities to save assets. So while each person's situation is different, and a comprehensive examination of his or her individual financial and health circumstances needs to be done, more time usually translates into more effective planning and savings.

WHAT IS LONG-TERM CARE?

Generally speaking, long-term care (often abbreviated as LTC) is help with activities of daily living (referred to as ADLs) such as dressing, bathing, grooming, using the toilet, the ability to move about, transferring from a bed to a chair or wheelchair, and eating. Inability to perform ADLs can impact a person's ability to live independently and will require obtaining assistance at home or in a care setting, with or without assistance for medical issues. Long-term care is usually referred to as non-health related assistance, but LTC services weave through and are part of care received in health care settings.

Home care allows a person to receive the needed assistance at home. It may include **personal care services** for help with bathing, dressing eating meals, etc. **Attendant care** (often referred to as homemaker services) includes meal preparation, laundry, light housecleaning, shopping, medication management, and non-medical transportation. **Home health care** is minimal assistance with activities related to health such as insulin injections, changing bandages, checking vitals, etc.

Adult day care provides daytime supervision for a person needing personal care. Meals and snacks are provided as well as recreational and therapeutic activities in a group setting. Some settings specialize in Alzheimer's or dementia care. This type of care is beneficial when family caregivers work or need respite from caregiving.

Assisted living is residential care for seniors who can no longer live independently in their homes. This level or care includes room and board, around the clock supervision, medication management, social and recreational activities, personal care assistance, housekeeping, laundry, and often transportation. Some assisted living facilities offer higher levels of care for persons as their abilities decline, known as **specialty care assisted living**, and the cost increases for those higher levels of care.

Alabama regulations recognize two assisted living levels of care. They are the traditional Assisted Living Facilities (ALF) and Specialty Care Assisted Living Facilities (SCALF). Both levels offer assistance with activities of daily living, medications, community meals and help with bathing or dressing if needed, but the SCALF level of care has staff trained to work with residents who suffer from dementia, and they have architectural features to assure the safety and health of the residents who have diminished capacity. These are sometimes referred to as **Memory Care** facilities.

Assisted Living Facilities (ALFs) must evaluate whether or not the facility can meet the needs of those applying for admission, and, generally, the ALF resident should not be "cognitively impaired" to where he or she cannot care for his or her own needs or direct others to do so when inability to care for his or her own needs arise from physical disability. Further, the ALF resident should not be a person with a level of dementia at risk for wandering since ALFs are not required to be locked facilities. Residents must be able to understand the unit dose medication system in use by the facility in order to live in an ALF.

Many people who would like to receive care in an ALF or SCALF cannot live there due to the cost of care not covered by Medicare or Medicaid. The cost of ALF and SCALF varies from facility to facility, and SCALF is more expensive than ALF, but as a rule of thumb, ALF/SCALF care is half to 60 percent of the cost of nursing home care. The state median charge for ALF in 2019 was approximately $3250 per month. Considering that the maximum Social Security benefit rate in 2020 is $3011 and the average is $1503, that cost places assisted living beyond the monthly income of many persons with only Social Security retirement income in Alabama.

Skilled nursing facilities offer 24/7 medical care and supervision and are considered the locations needed for the most medically needy persons. Apart from skilled nursing care, residents received personal care, medication management, rehabilitation therapies and social and recreational activities.

SO WILL YOU NEED LTC SERVICES?

About 60% of those turning 65 can expect to use some form of long-term care in their lives, according to the U.S. Health and Human Services Department. That may include a nursing home, assisted living or in-home care. This is not surprising when you consider the broad range of services covering LTC.

Congressional testimony in the last several years indicated that although many may never require substantial care in a nursing home, 20% will need 2 to 5 years of substantial care and another 10% may need more than 5 years of care.

COST OF CARE

Genworth 2019 Cost of Care Report states that “the world’s population is aging at a faster rate than ever before and people are living longer. Every day until 2030, 10,000 Baby Boomers will turn 65 and 7 out of 10 people will require long term care in their lifetime.”

Based on the Genworth 2019 Cost of Care Report the following are median costs of care in Alabama:

Homemaker Services $3394 per month/$40,728 per year
Homemaker Health Aids $3432 per month/$41,184 per year
Adult Day Health Care $ 758 per month/$9,096 per year
Assisted Living (one bedroom) $3,250 per month/$39,000 per year
Nursing Home (semi-private room) $6,388 per month/$76,656 per year
Nursing Home (private room) $6,784 per month/$81,396 per year

SOURCES OF PAYMENT

Sources of payment in different setting include:

Private Pay – all settings
Insurance – all settings insured
VA – limited financial assistance for in-home care, assisted living and nursing home care
Medicare – limited home healthcare, limited nursing home
Medicaid – very limited home healthcare, primary payor for nursing homes

LONG-TERM CARE INSURANCE

More than 8 million Americans have long-term care insurance, according to the American Association of Long-Term Care Insurance. However, the cost of that insurance is rising, and that is the primary problem for most purchasers.

To give you an idea of the cost, in 2019 the American Association for Long-Term Care Insurance gave these estimates:

$2,050: The average annual premium for long-term care insurance for a 55-year-old male
$2,700: The average annual premium for long-term care insurance for a 55-year-old female
$3,050: The combined premium for long-term care insurance for a couple when both individuals are 55 years old

Some typical characteristics of LTC policies today:

- Once issued, coverage cannot be denied based on pre-existing conditions
- Once issued, premiums may only be increased with the approval of the state insurance commissioner
- Coverage is not limited to location, whether receiving services at home, in an assisted living facility, or in a skilled nursing facility, but benefits may vary depending on location
- Coverage begins with the event described in the policy, usually the insured's inability to complete at least two ADLs
- An elimination period is a deductible and usually varies from 30 to 90 days
- Benefits are paid at the rate of the daily benefit amount defined in the policy and established at the time of purchase, but, if the policy includes inflation protection, the daily benefit amount may be adjusted (a standard inflation protection term is 5 percent compounded annually).
- Benefits will be paid for the policy's benefit period which may be as little as one year (allowed under Alabama law now) or greater lengths of time
- Whether benefits received are taxable as income depends on whether the policy is tax-qualified by inclusion of several minimum terms

Insurance companies in Alabama issue long-term care (LTC) insurance policies known as Long-Term Care Insurance Partnership Policies. The Long-Term Care Insurance Partnership Policy (Partnership Policy) must meet specific requirements outlined in the Deficit Reduction Act of 2005 to contain consumer protection and inflation provisions.

There is a financial incentive to purchasing a Partnership Policy in Alabama. In determining eligibility, Medicaid will allow the insured individual to disregard resources in an amount equal to LTC insurance benefits paid by a Partnership Policy for LTC services received. To qualify for this resource exclusion, the insurance benefit payments may have been made for any LTC services received (including those not usually covered by Medicaid) for any length of time in any long-term care setting. Resources excluded in determining Medicaid eligibility under this provision will be exempt from estate recovery.

Alabama requires LTC policies to offer graduated coverage in different settings by prohibiting the sale of long-term care insurance policies which provide ONLY nursing home care.

A comprehensive shopper’s guide to long-term care insurance written by the National Association of Insurance Commissioners in 2019 is available at https://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf

Other Insurance Products for LTC

Other options to insure for long term care include **hybrid life insurance policies** (essentially an accelerated benefit clause) **which contain no separate rider** nor any benefits beyond the death benefit. Essentially, these policies allow the death benefit (or a certain percentage of it) to be accelerated for long-term care expenses. If the policy's death benefit is exhausted, there are no more funds for long-term care nor a payable death benefit. If only some of the death benefit is used for LTC expenses, the rest remains as a payable death benefit.

Another type of **hybrid insurance is life insurance policies which include a long-term care rider** to provide additional long-term care benefits beyond the life insurance policy's death benefit – benefits for which the consumer pays a significant upfront cost. For this product, the consumer must qualify for long-term care insurance (though medical underwriting may be less strict) and must pay a significant lump sum premium upfront for the long-term care rider.

The policy accelerates the death benefit when the insured qualifies for long-term care and usually pays it on a monthly basis. If the death benefit is exhausted, payments continue under the long-term care rider. Another significant benefit of these policies is that the insured can cancel at any time prior to receiving benefits and receive a refund of premiums paid.

Another product for long term care is the **hybrid annuity with long-term care rider**. An existing annuity can be exchanged tax free for this type of annuity.

VA FACILITIES

The Veterans Administration has a federal and state program addressing health care needs of veterans and provides an option for long-term care. There are 704 beds currently available at four Alabama nursing facilities:

Bill Nichols State Veterans Home in Alexander City;
William F. Green State Veterans Home in Bay Minette;
Floyd E. “Tut” Fann State Veterans Home in Huntsville; and
Col. Robert L. Howard State Veterans Home in Pell City.

In the VA system State VA and Federal VA contribute toward the charged rate, leaving the veteran responsible for the remainder. Actually the VA system is a highly affordable nursing home care option after the state and federal government provide subsidies.

In 2020 the out of pocket cost for care in the VA facilities in Alexander City, Bay Minette and Huntsville is $355.02 per month, and the out of pocket cost for care in the Pell City facility is $732. The average wait for a bed in 2019 was four to five months for Alexander City; six months for Bay Minette; three to four months for Huntsville; and two to three years for Pell City. These estimated wait times are not available for 2020 due to the COVID disruptions to the system.

In January 2020 The Alabama Department of Veterans Affairs announced plans to build an additional $60 million veteran’s home on 27 acres in Enterprise. The new nursing facility will provide care for 150 – 175 elderly veterans.

The VA is required to provide nursing home care to any veteran who needs that level of care because of a service-connected disability, has a combined disability rating of 70 percent or more or has a disability rating of at least 60 percent and is deemed unemployable or has been rated permanently and totally disabled. Other veterans in need of nursing home care will be provided services if resources are available after the priority groups are served.

VA AID AND ATTENDANCE

Aid and Attendance is a cash benefit for veterans and surviving spouses who require long-term in-home care, assisted living, or nursing home care.

Through the A&A pension benefit, veterans and surviving spouses are given a monthly cash allowance. Until 11/30/20, a single veteran with no dependents may be entitled to as much as $1,912 per month, a married veteran or a veteran with a dependent may be entitled to as much as $2,266 per month, and a surviving spouse may be entitled to as much as $1,230 per month.

The Housebound Pension is also available to disabled veterans who are mostly unable to leave home. Until 11/30/20, the maximum monthly benefit for an unmarried veteran without dependent children is $1,400 per month. A married veteran or a veteran with a dependent child can potentially draw up to $1,755 per month. A surviving spouse with no dependent children can draw up to $939 / month.

There are resource requirements, and the VA looks back at transfers for three years to disqualify applicants based on transfer of assets.

Any veteran needing long-term care should check with the local VA officer to be screened for any potential benefits available to help pay long-term care expenses.

CARE AT HOME THROUGH AGING PROGRAMS

Limited supportive services to help people stay in their homes are available through the Aging and Disability Resource Centers (ADRCs), also known as Area Agencies on Aging (AAAs) throughout Alabama. There are 13 regional offices, and your local agency can be located at The Alabama Department of Senior Services. An array of services are available through Aging and Disability Resource Centers. Contacting the local ADRC for a complete screening is always beneficial to determine if there are programs that can assist with long-term care expenses.

The Alabama Cares Program is a federally funded program offering limited support to caregivers and to grandparents who are raising their grandchild/children. The Alabama Cares program provides caregivers with supportive services including respite services, supplemental services, education, counseling, and access to other resources throughout the community.

Also available through the ADRCs is Home and Community Based Services (HCBS), also known as Medicaid Waiver Services. This service provides in-home services to older adults and persons with disabilities who are at risk of institutional care. Attention is given to client care, protecting the health and welfare of the client, and client free choices in providers and workers. Services available through this program include Case Management, Respite, Homemaker, Personal Care, Companion, Frozen Meals and Adult Day Health.

Services in the home through HCBS is the wave of the future. The only problem is that in Alabama a person must have very low income and resources to qualify for this service. If applying for nursing home care, a person with income greater than $2349 could create a Medicaid Qualifying Income Trust (MQIT) to qualify for Medicaid to pay for institutional care, but that trust is not available to persons applying for care at home. There are also limits on resources that make this service available only to those with very modest savings, $2000 in countable resources for a single person and $27,284.00 for a couple ($25,284.00 protected for spouse + $2000 allowed for applicant).

MEDICARE LIMITATIONS

Medicare provides very limited long-term care assistance. It does not provide 24 - hour care at home, meals delivered to the home, homemaker services or personal care. It does provide limited home health care, hospice and durable medical equipment, and a very small amount of coverage for institutional long-term care in very limited circumstances. So it is important not to hang your long-term care expectations on Medicare.

Medicare will pay for the first 20 days of care in a nursing home if the patient has a three day prior hospitalization and is admitted to a nursing home within 30 days and requires skilled care. While the Medicare literature will indicate that Medicare pays for up to 100 days of nursing home care, the truth is that if the patient continues to have skilled care ordered by the doctor, on day 21 a co-payment of $176 per day begins.

That means that in a month, even with Medicare paying, the patient will pay over $5000 per month in co-payments. Under the best of circumstances Medicare will pay for only 20 full days of care and another 80 days if, and only if, skilled care continues to be ordered, and will pay for only about 1 /3 of the cost of care while the patient pays the lion’s share through the $176 per day co-payment. After 100 days Medicare pays nothing.

Medicaid is the primary payor for nursing home long-term care in Alabama.

MEDICAID FOR INSTITUTIONAL CARE

As you can see, qualifying for Medicaid to pay for nursing home care quickly becomes an important concern for those who will need nursing home care on a long-term basis. In order to qualify for Medicaid to pay for long-term care a person must be medically sick enough and have income and resources low enough. The income limit in 2020 is $2349. If income exceeds $2349 a Medicaid Qualifying Income Trust (MQIT) can resolve the problem of excess income. The resource limit is $2000 but do recognize that there are some types of property that can be excluded (see Slide 22 – 23).

For a married couple Medicaid allows the spouse staying at home (Community Spouse) to keep part of the assets and income to meet his or her needs at home (see Slide 20). These provisions are known as Spousal Impoverishment Protections.

After Medicaid is awarded, a budget is prepared to determine the personal liability the resident is required to pay from his or her income. The resident can keep $30 for his or her personal needs allowance, enough money to pay for unreimbursed health insurance, and he or she is allowed to send home to the spouse at home enough of his or her income to bring the income of the spouse at home up to $2114. The rest of the resident's income is paid to the nursing home as his or her personal liability, and Medicaid pays the difference in that amount and the nursing home charges.

If assets are given away Medicaid will deny coverage at the rate of one month for every $6400 transferred within five years of application. (See Slide 24) This is why early financial planning for long-term care is so critical. There are multiple strategies to reduce countable assets, but some of those strategies, such as irrevocable trusts and life estate deeds, require a five year leeway before long-term care will be needed without Medicaid penalties being assessed.

DETERMINING ASSETS AT RISK FOR SPEND DOWN

To determine assets that will have to be spent down to qualify for Medicaid an applicant's marital status is the first consideration since the agency rules are applied differently to single and married persons. It is important to understand that even if a person is separated from a spouse, they are still treated as a married person, and prenuptial agreements will not shield assets from being countable by Medicaid.

It is necessary to gather information about income and all assets owned by the potential long-term care recipient and his or her spouse. Investments, retirement and bank accounts, and deeds need to be obtained. These items will be necessary for a Medicaid application as well, so it is better to begin gathering the information as soon as possible.

SINGLE PERSONS

The income for a single person must be at or below $2349 or a Medicaid Income Qualifying Trust (MQIT) will need to be established.

Countable resources must be at or below $2000

MARRIED PERSONS

Income: The applicant's income must be no greater than $2349 (or MQIT). For a married person, Medicaid considers only his or her income, and the spouse's income does not count.

The Minimum Monthly Maintenance Needs Allowance for the community spouse is an allocation of income from the institutional spouse to the community spouse to bring the community spouse's income up to $2114 in 2020.

Resources: An inventory of all assets owned is compiled when a Medicaid application is being filed. The resource limit is $2000. That means that a person can only have $2000 worth of "countable" assets, but recognize that there are some types of property that do not count at all (like the home when the spouse or disabled child lives there).

A single person can clearly establish eligibility when resources reach $2000. It is, however, a little harder to establish financial eligibility in the case of a married person. In order to determine how much a spouse at home can preserve for himself or herself (pursuant to the Spousal Impoverishment Rules), a married person applying for Medicaid must provide an inventory of property/assets the couple jointly and individually owned on the "snapshot" date (defined as when the person entered long-term care, which might be when he or she entered a hospital from which a placement was made to a nursing home without a 30 day break in institutional care). From those resources that existed on the snapshot date, the home is protected for the spouse who will continues to live there.

Besides the home and vehicle, the community spouse is allowed to keep the first $25,728. If joint assets exceed $50,000, the community spouse can keep one-half up to a limit of $128,640. This is called the Spousal Impoverishment Protected Resource Amount. After reserving what can be set aside for the spouse, all remaining funds over $2000 plus the income of the applicant/institutionalized spouse must be spent down by the applicant/institutionalized spouse.

Example One: A couple has $20,000 in countable assets. The community spouse keeps $18,000 (because all assets are below $25,728), $2000 is assigned to the institutional spouse for his or her resource allowance, and the institutional spouse qualifies for Medicaid without a spend down.

Example Two: A couple has $40,000 in countable assets. One-half is $20,000, but the spouse keeps the first $25,728. The applicant must spend down the rest except for $2000 ($40,000 - $25,728 = $14,272 - $2000 = $12,272) before qualifying for Medicaid. The institutional spouse spends down $12,272 and his or her income before qualifying for Medicaid.

Example Three: A couple has $60,000 in countable assets. The community spouse keeps one-half, $30,000. The applicant must spend down the rest except for $2000 ($60,000 - $30,000 = $30,000 - $2000 = $28,000). The institutional spouse spends down $28,000 and his or her income before qualifying for Medicaid.

Example Four: A couple has $300,000 in countable assets. One-half is $150,000, so the cap of $128,640 applies, and that amount is retained by the community spouse. The applicant spouse must now spend down the rest except for $2000 ($300,000 – 128,640 = 171,360 – 2000 = 169,360). The institutional spouse spends down $169,360 and his or her income before qualifying for Medicaid.

EXCLUDED PROPERTY

When applying for Medicaid, all property counts unless it is specifically excluded. Some excluded resources include the following:

- Household goods and personal effects
- One automobile
- The home for the community spouse as long as he or she lives there (no lien can be taken)
- The home if a dependent relative other than a child under 21, blind or disabled lives there (a lien may be taken)
- The home if a dependent child who is under 21, blind or disabled lives there (no lien may be taken and the property may be transferred without penalty)
- The home if a sibling with an equity interest lives there and was lawfully residing in the home for at least one year immediately prior to the applicant being admitted to the medical institution (no lien may be taken and property may be transferred without penalty)
- The home if the applicant has a reasonable intent to return home (a lien may be taken but dissolves if the patient actually does return home)
- Real property where a joint owner lives for whom sale of the property would cause a loss of housing (a lien may be taken)
- Up to $6000 equity value in income producing property (remaining equity is a countable resource)
- Life estates (value does not count and no transfer penalty if the deed dates back over five years)
- Assets held in a special needs trust

• Real property the applicant is making a bona fide effort to sell (a lien will be taken)
• Term life insurance with no cash surrender value
• $5000 titled for burial or designated in a Statement of Claimant form
• Prepaid burial funds worth $5000 (in calculating the amount invested, do not count the space items such as plot, marker, casket, vault, opening and closing the grave which are completely excluded as a resource)
• **Face value** of life and burial Insurance policies that have a **combined face value of $5000 or less** (the face value is a countable resource but may be excluded when designated for burial)
• **Cash surrender value** of life and burial insurance policies that have a **combined face value exceeding $5000** where up to $5000 is designated for burial (the amount not designated for burial is treated as a countable resource)
• Proceeds paid by a long-term care Partnership Policy (for each dollar of benefits paid one dollar of assets is not counted toward the eligibility limit). For more about what qualifies as a Partnership Policy see

https://www.aldoi.gov/Consumers/LongTermPartnership.aspx

MEDICAID TRANSFER PENALTIES

Medicaid looks back at all financial transactions for 5 years prior to application, and all gifts or sales of property for less than the value assigned by Medicaid is added and divided by $6400 to determine the months of ineligibility for Medicaid that will be assessed.

The penalty begins to run when the person is institutionalized and would otherwise be eligible if it were not for the transfer.

Example:
A second home valued at $175,000 is transferred to a child in January 2017. The parent applies for Medicaid in January 2020 (within five years). A penalty of 27.34 months (175,000 ÷ 6400) would be imposed. That penalty would not begin to run until the parent is in the nursing home and has used all of his resources and, but for the transfer, would be eligible for Medicaid. That means someone will have to privately paying for care for over two years during the time the penalty runs.

Gifting is not just giving away property. It is any transfer of an asset for less that the value assigned by Medicaid. An example might be selling a home for less than the tax assessor's appraised value. Often people trying to sell property will reduce the price to unload the property, and this is fine unless the owner is, or may become, a Medicaid applicant within five years. A better plan is to have the property reassessed or to obtain a commercial appraisal if the appraised value is over one year old. A house sold for $35,000 when the tax assessors appraised value is $52,000 will be a $17,000 uncompensated transfer and result in a 2.65 month penalty.

Be careful of WHEN to apply:
A person gives away $350,000 in March 2015. He has a stroke in December 2019 and is placed in a nursing home. If he applies for Medicaid in January 2020, a 54.68 month penalty will be assessed, and he won't be eligible for Medicaid until August 2024. If he had waited until April 2020 to apply he would have qualified with no penalty because he was past five years from when he gave away the money.

PERMISSIBLE TRANSFERS

Permissible transfers are those allowed by law resulting in no penalty being imposed. While some property is totally excluded, some property can be excluded and a lien taken, and some property can actually be transferred without creating a penalty. This would include:

- Home when a child under 21, blind or disabled lives there
- Home when a sibling with an equity interest was residing there for at least one year prior to the institutionalization
- Home when a son or daughter of the claimant who was residing in the applicant's home for a period of at least two years immediately before the date of applicant's admission to the medical institution or nursing facility, and who provided care to such claimant which permitted the applicant to reside at home rather than in an institution or facility
- Transfers of money into a Special Needs Trust.

CONVERTING COUNTABLE RESOURCES INTO EXCLUDED RESOURCES

If a person needs to spend down a certain amount of money to qualify for Medicaid, it makes perfect sense to use that money instead to convert it into non-countable resources or put it to use toward reducing the community spouse's monthly income needs. Examples might be:

- Paying off debt on a vehicle
- Paying off credit card debt
- Making needed home repairs
- Paying off a mortgage
- Purchasing pre-paid burial arrangements
- Using money to fund a Special Needs Trust
- Purchasing a Medicaid compliant annuity

LIFE ESTATE DEEDS

A life estate is a form of joint ownership that allows one person to remain on property until his or her death, at which time it passes to the other owner, referred to as the person with the remainder interest. Life estates can be used to avoid probate while giving a house to children without losing the ability to live in the home, remaining responsible for property tax (with the benefit of homestead and age related tax exemptions), remaining responsible for homeowner insurance, yet creating ownership in the children at the death of the parent.

This type of deed can play an important role in Medicaid planning since Medicaid does not assign any value to a life estate when the parent applies for Medicaid to pay for nursing home care. If the transfer occurred prior to five years before application, there will be no penalty for the transfer.

Further, purchasing a life estate should not result in a transfer penalty if you buy a life estate in someone else's home, pay an appropriate amount for the property (determined by Life Estate and Remainder Tables at 26 C.F.R. §20.2031.7) and live in the house for more than a year. For example, an elderly man who can no longer live in his home might sell the home and use the proceeds to purchase a life estate interest in his child's existing home. Assuming the father lives in the home for more than a year and he paid a fair amount for the life estate, the purchase of the life estate should not be a disqualifying transfer for Medicaid.

INCOME ONLY IRREVOCABLE TRUSTS

It is possible to remove assets from consideration through a Medicaid Asset Protection Trust. This is an irrevocable trust, meaning it cannot be revoked or changed once created. The trust must prohibit the grantor from accessing any of the principal under any circumstances (with only income being paid to the grantor). If the trust is not structured correctly all of the property it holds will be considered as countable resources by Medicaid.

Five years from when the trust is funded is needed before applying for Medicaid. Otherwise the transfer of assets into the trust will create a transfer penalty.

Do not confuse this type of trust with a revocable living trust or traditional family trust which does not work to shield assets from being considered as countable assets for Medicaid purposes.

MEDICAID SPEND DOWN SPECIAL NEEDS TRUST (SNT)

Special Needs Trusts in a long-term care setting are particularly useful in accomplishing spend down while acquiring additional resources for the long-term care resident.

There are many types of Special Needs Trusts (SNTs), including trusts for disabled younger persons, disabled children whose parents and grandparents want to provide for their future needs, persons on public benefits who recover money from personal injury lawsuits or who inherit money when a relative dies. Each type of SNT has highly specific requirements and responsibilities. But what they all have in common is the goal of protecting funds for a disabled person without those funds resulting in the loss of public benefits.

With the Medicaid Spend Down SNT, instead of spending down the money required to be spent by Medicaid on nursing home care before eligibility can be established, the money is paid into a SNT and can then be used to pay for special needs not otherwise paid for by Medicaid for the disabled person once he or she becomes eligible. Medicaid eligibility can be immediately established while these funds remain available to pay for special needs for the nursing home resident such as a private room in a nursing home (since Medicaid will only cover a semi-private room), sitters, and items items and services that can improve the quality of life for the nursing home resident. This could be hair salon charges, manicures, telephone, newspaper subscriptions, audiobooks, movies, recreation, medical and dental expenses not otherwise covered, special equipment like wheelchairs or specially-equipped vans, therapy or rehabilitation services, training and education, travel, electronic equipment including computers and mobile devices.

Another incredibly useful expenditure from a SNT is payment for nursing home charges during a penalty period. For instance, if money was transferred earlier creating a penalty period, money from the SNT can be used to pay for care to get the resident through the penalty period.

The drawback to this type of SNT is the requirement that, on the death of the person for whom the trust was established, Medicaid must be reimbursed from funds remaining in the trust up to the amount Medicaid has paid for the nursing home resident's care.

Still, creating a pool of money to meet the special needs of the nursing home resident after being awarded Medicaid is far better than simply spending down those funds before qualifying for Medicaid and leaving the resident with no resources to pay for special needs. Since Medicaid allows a nursing home resident to keep only $30 of his or her income each month to pay for personal needs, you can see how that is not enough to have needs met without families pitching in to help pay for necessary items.

RUSSIAN ROULETTE: GIFTING AND WAITING

Medicaid's five year look back permits people to give away assets they want to persons they want to have them so long as they do not apply for Medicaid within five years.

While this is a clear way to reduce assets that will have to be spent down, it also requires the relinquishment of control over those assets, and that makes many people uncomfortable. If this strategy is used, it is imperative that the money transferred be safeguarded in case the person transferring the money should need nursing home care during the five years and a penalty is assessed requiring private pay during that period.

Example: John sold some property and gave his son $75,000 in May 2017. All was well until April 2020 when he had a stroke following a COVID infection and needed a nursing home placement. His income is $2300, and the cost of care will be $6800, for a $4500 shortfall each month. After using his savings of $36,000, he will be out of money in 8 months. In November when he runs out of money he would have been eligible for Medicaid but for the fact he gave away $75,000 to his son. Because the gift was within five years, the penalty associated with it will be 11.71 months, and that penalty will start to run then. Since he won't qualify for Medicaid until almost a year later, about $52,695 will be needed to pay for his care. If the son still has the money he received as a gift and is willing to do so, he can pay the shortfall during the penalty period. The estate would still clear $22,305. If the money is gone or John's son is not concerned about him, there are no funds to pay for his care.

Example: Mary gave her niece $300,000 in July 2015. In August 2020 she needs nursing home care. There is no penalty assessed because the transfer is outside five year.

PARTIAL LOAF GIFTING

Sometimes individuals will give away some amount of money and calculate how much money they will need to live through the penalty period that Medicaid will assess. Depending on the assets a person has, his income and cost of care, sometimes modest amounts can be preserved. Again, if this is done, great care must be used to assure that the gift recipient does not take the money and leave the care recipient with no way to pay for care.

Example: John needs nursing home care. He has $100,000 which he gives to his daughter, leaving him with no other resources. His income is $3200, and the nursing home cost will be $7200 per month. He will have a $4000 monthly shortfall. The gift to his daughter creates a 16.62 month penalty. Over the course of the penalty the daughter will pay the shortfall for a total of $66,480. The estate will come out saving $33,520.

SINGLE PREMIUM ANNUITIES

A Medicaid Compliant Annuity is a single premium immediate annuity (SPIA) that contains zero cash value and provides income to the owner. Properly structured, this annuity functions as a spend-down tool that eliminates excess countable assets and converts those assets into an income stream. These products are used in emergency and non-emergency planning, and it is important to understand that the annuity needs to be tailored to meet specific requirements to make them Medicaid compliant.

An income stream may be desirable for the spouse of the nursing home resident or for the resident to pay for any penalty period.

If an annuity is not structured properly, it will be considered a resource or a transfer subject to a transfer penalty for Medicaid purposes. So the use of an annuity should be done with great caution recognizing that purchasing an annuity can either create a countable resource (if it can be sold) or create a transfer penalty if certain requirements are not met.

For an annuity to NOT be considered a transfer of assets, it must be:

- irrevocable and non-assignable
- actuarially sound based on the Period Life Table published by Social Security (http://www.ssa.gov/OACT/STATS/table4c6.html1)
- provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments
- name the Alabama Medicaid Agency as the remainder beneficiary in the secondary position after the spouse, minor child or disabled child, and name in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value

.

Drastic Solutions

Spousal Refusal happens when the spouse refuses to participate in the eligibility process and will not provide information about their assets.

Divorce is considered by some, but is questionable from a practical as well as legally ethical standpoint.

MEDICAID ESTATE RECOVERY

Federal law requires states to recoup money spent for some Medicaid services, and the rules implementing this required federal recoupment vary from state to state.

In Alabama Medicaid Estate Recovery is required for the following expenditures:

- Benefits that were not paid correctly to a person of any age (resulting in what is known as an overpayment)
- Benefits paid after age 55 for nursing home Medicaid
- Benefits paid after age 55 for home and community based waiver services
- Benefits paid for hospital and drugs for persons who received those benefits in connection with nursing home or waiver services after the age of 55
- Expenditures for services received after age 55 for SSI eligible persons who qualify for Medicaid in the community

The provider, attorney, personal representative, sponsor or case manager is asked by Medicaid to contact Alabama Medicaid Agency's Estate Recovery section to provide notification of a recipient's death within 30 days of the death. Upon notification of death, Medicaid will send a questionnaire to the next of kin to ask about property the decedent owned at the time of death. Those handling the estate of the decedent who formerly drew benefits have always been under a duty to treat Medicaid as they would any creditor and notify the agency of intent to distribute the estate, but that requirement is now more stringent, and all estates are subject to notice.

A 2019 law requires that as of 09/01/19 all estates filed in Alabama notify Medicaid to give the agency an opportunity to review its records to determine if the estate may be subject to estate recovery. This is true for probating wills, administering estates and filing for Small Estate (Summary) Distribution, and the notice is required whether the decedent ever received Medicaid or not. The agency will have 30 days to file any claim it may have against the estate.

PROCEED WITH CAUTION

No one strategy works for everyone because everyone's income, resources and objectives differ. Usually people will employ a mixture of methods to protect their assets, and many people decide to do nothing until the last minute in hopes that long-term care will not be needed.

A worst case scenario is one where the aging parent gave away property to grandchildren two years prior and now needs care, but the grandchildren will not return the property and cannot or will not contribute to the private pay expenses of long-term care. The senior faces the need for Medicaid to pay for care but is penalized for over three years with no way to pay $7000 per month when his income is only $1800. Where will the $5200 per month needed to pay for care come from?

I cannot stress enough the need for caution in planning and obtaining good legal advice since removing assets from an estate can have dire consequences for the long-term care recipient and his or her family.