Corpus Christi Estate Planning Council

February 20, 2003

Paul Premack, Attorney – 8031 Broadway, San Antonio, TX 78209
210-826-1122 // Fax 210-826-0602 // Email PAUL@PREMACK.COM

Legal and Practical Issues: Paying for Long Term Care

One of the greatest financial risks faced by the elderly in Texas is the prospect of long-term care in a nursing facility.

Nursing home costs are steadily increasing. Between 1985 and 1998 the total national outlay for nursing home care grew from $30.7 billion to $88 billion. The US Census Bureau projects that the nationwide outlay for nursing home care in 2002 was $105 billion. If the projection is confirmed, outlay will have increased by 340% in 17 years.

Paying for this care takes careful planning. To plan properly, your clients must understand their options and any limitations they will face. Private and government funding of long-term care imposes some limits and exposes some opportunities. A well thought out plan can save heartache and can save money.

There are three ways to pay for long-term care. First, privately—out of current resources. Second, through long-term care insurance. Finally, through government programs.

Expenditures from Current Resources

Paying out-of-pocket seems self-explanatory. On its face, it is. This may be the proverbial "rainy day" for which a family has saved. But four issues should be looked at in this regard:

1. Reluctance: Many elders at the stage where long term care is necessary are in modest to severe denial of that need. They do not desire to spend anything, and hold tight to their life savings. This may be combined with understandable reluctance to leave home for an institutional setting.

2. Assumption that there is no other option: Despite reluctance to spend, many elders are even more reluctant to rely on outside help (especially from the government). They may assume that there is no option but to spend their life savings. This may unfairly impoverish a spouse or other dependent. They need to understand the law and their options.

3. Filial responsibility: Some elders expect their children to contribute to their care, and some loathe the idea of being a burden to their children. Either way, Texas law does not legally require the children to fund their parents long-term care. Further, federal regulations forbid nursing facilities from requiring a guarantee from a family member as a condition of admittance[1]

4. Financing opportunities: Reverse Mortgages and Viatical arrangements.

Reverse Mortgages

Reverse Mortgages are often of greatest interest to Seniors who have extensive equity in their homes. They allow monthly payments to be made *from* the lender *to* the homeowner, and are typically on between 30-50% of the total home equity. The owner can spend the money for any purpose.

The 1997 change to the constitution[2], which was the first Texas law to allow reverse mortgages, made them available to any Texan age 55 or older. Unanticipated problems arose with the constitutional provisions authorizing these new liens. The amendment was faulty in the sense that it did not match federal underwriting regulations. As such, there was no resale market for Texas reverse mortgages. The problems resulted in lender refusals to make loans in some circumstances because of their inability to strictly comply with the constitutional requirements. (A lender cannot force a home equity borrower to repay the loan if the lender violates the constitutional provisions.) The problems were:

AGE -- The 1997 amendment made reverse mortgages available to any Texan age 55 or older. The 1999 update backed off on the age, restricting reverse mortgages to Texans age 62 plus, or whose spouse is 62 plus. This change was made to comply with federal lending regulations, which allow only those 62 or older to use reverse mortgages.

SIZE of HOMESTEAD -- The Constitution prohibited a home equity loan or a reverse mortgage from being secured with any property other than the homestead. Because many urban lots exceed one acre in size and could not be legally subdivided, lenders could not obtain a valid lien on only the homestead (one acre). To address this situation, the Constitution would have to be amended to permit (i) a legal homestead in excess of one acre, or (ii) the lender to accept property in addition to the homestead as collateral.

TYPO - A lender could not require any principal or interest payment on a reverse mortgage until: (A) the homestead property securing the loan is sold or otherwise transferred, or (B) all borrowers cease occupying the homestead property as a principal residence for more than 180 consecutive days **and** the location of the homestead property owner is unknown to the lender. Thus if the homestead was abandoned but the lender knew where the borrower was, the note could not become due. Consequently no reverse mortgages were made in Texas, substantially because the loans could not be federally insured and sold in the secondary market with this nonstandard term.

In 1999, the legislature changed the law to conform to federal regulations. The 76th Texas Legislature unanimously approved S.J.R. 12 to allow reverse mortgages loans to be offered in Texas. On November 4, 1999, that constitutional amendment was approved by voter referendum.

SIZE OF HS UPPED TO 10 ACRES -- S.J.R. 12 redefined a Reverse Mortgage to be consistent with federal law. S.J.R. 22, among other matters, increased the maximum size of an urban homestead to 10 acres. In addition, SENATE BILL 496, passed by the 76th Legislature, amended Texas Property Code Sections 5.042, 41.002, and 41.005, and added new Section 41.008, to further develop the concept of the 10 acre urban homestead, prescribe permissible uses of rural and urban homesteads, and **permit an existing lien upon part of a homestead to extend to another part of the homestead**. Certain of these amendments were contingent upon voter approval of S.J.R. 22. The bill became effective on January 1, 2000.

Interesting facts:

- The median age of those using HUD reverse mortgages tends to be older (75) than the average elderly American homeowner (72).
- Homeowners getting reverse mortgages are more likely to be single female households (56.3 percent) than the average elderly American homeowners (27.6 percent).
- The homes of reverse mortgage holders are more valuable ($107,000) than the homes of the average elderly American homeowner ($87,000).
- The properties with reverse mortgages are older (41 years) than the average elderly American homeowner's home (38 years). However, the average cost of needed repairs is lower - $666 compared with $836 - as is the square-footage of the homes - 1,327 square feet compared with 1,700 square feet.

Reverse mortgages turn home equity into three things:

- LOAN ADVANCES paid to the borrower;
- LOAN COSTS paid to the appraiser, lender, insurer, servicer, and others; and
- LEFTOVER EQUITY, if any, paid to the borrower or heirs at the end of the loan.

Rules must be followed:

1. The lien must be voluntary and both spouses must sign it. It is not possible for only one spouse, acting alone, to place a lien against the homestead unless that spouse either a) has a Durable Power of Attorney from the other, or b) is the court-appointed Guardian of the other or community administrator.
2. The loan must be without recourse for personal liability against each owner.
3. The lender is not allowed to reduce the amount or number of advances because of an adjustment in the interest rate if periodic advances are to be made. If the lender doesn't live up to its end – it fails to make loan advances as contracted and doesn't cure its default as required in the loan contract – then the lender forfeits all principal and interest of the reverse mortgage.
4. The Texas constitution further requires that before signing a reverse mortgage, the owner must attest in writing that he or she received counseling on the advisability and availability of reverse mortgages. The counseling must include a discussion of other financial alternatives.

How Much Can be Borrowed?

The maximum amount you can receive will be determined by factors including the age of the borrower(s), and the appraised value of the property (or the maximum FHA mortgage amount for this area, if lower). For example, based on a loan at recent interest rates, a 65-year-old could borrow up to 26 percent of the home's value, a 75-year-old could borrow up to 39 percent, and an 85- year-old could borrow up to 56 percent.

Repayment

The loan must, of course, be repaid – but not until either:

1. All borrowers have died;
2. The homestead property securing the loan is sold or otherwise transferred;

3. All borrowers cease occupying the homestead property for a period of longer than 12 consecutive months without prior written approval from the lender; or

4. The borrower:

(i) defaults on an obligation specified in the loan documents to repair and maintain, pay taxes and assessments on, or insure the homestead property;

(ii) commits actual fraud in connection with the loan; or

(iii) fails to maintain the priority of the lender's lien on the homestead property, after the lender gives notice to the borrower, by promptly discharging any lien that has priority or may obtain priority over the lender's lien within 10 days after the date the borrower receives the notice, unless the borrower:

(a) agrees in writing to the payment of the obligation secured by the lien in a manner acceptable to the lender;

(b) contests in good faith the lien by, or defends against enforcement of the lien in, legal proceedings so as to prevent the enforcement of the lien or forfeiture of any part of the homestead property; or

(c) secures from the holder of the lien an agreement satisfactory to the lender subordinating the lien to all amounts secured by the lender's lien on the homestead property.

Using Life Insurance Values

Viatical: From Latin viaticus, *relating to a journey*, from via, *road*. Thus, "viatical settlement" is a euphemism for "money that helps you on your journey" – that is, that assists you prior to death.

- "Life settlement" is a fairly recent development. Companies offer to buy life insurance policies covering relatively healthy seniors (at least of 65 years of age, who do not have a terminal illness, and who have a life expectancy of at least two years).

The purchase is made for an amount less than the policy's face value, but more than the cash surrender value of the policy. The purchaser then makes all future premium payments (often there are none) and receives the death benefit.

- "Accelerated benefits" involve early payment of benefits, directly from the life insurance company, usually for people with terminal conditions and life expectancies of six months or less. Accelerated payment of insurance benefits is *not* available from all life insurance companies.

Some insurers add accelerated benefits to life insurance policies for an additional premium, usually computed as a percentage of the base premium. Others offer the benefits at no extra premium, but charge the policyholder for the option if and when it is used. In most cases, the insurance company will reduce the benefits advanced to the policyholder before death to compensate for the interest it will lose on its early payout. There also may be a service charge.

Each viatical settlement company sets its own rules for determining which life insurance policies it will buy. For example, most viatical companies will require that:

1. Client has owned the policy for at least two years;

2. The current beneficiary signs a release or a waiver;

3. Client is terminally ill. Some companies require a life expectancy of two years or less, while others may buy the policy even if client's life expectancy is four years.

4. Client must sign a release allowing the viatical settlement provider access to his/her medical records.

Most companies will require that the company issuing the life insurance policy be financially sound. If the life insurance policy is provided by an employer, purchasers will want to know if it can be converted into an individual policy or otherwise be guaranteed to remain in force before it can be assigned.

Collecting accelerated benefits or making a viatical settlement also may affect client's eligibility for Medicaid. Once a policyholder cashes in the policy and receives a payment, the money may be counted as income, and while it sits in the bank it will count as a resource.

In 1997, Congress changed the tax code so that proceeds from accelerated benefits and viatical settlements are tax-exempt[3]. Under the law, proceeds from accelerated benefits and viatical settlements are tax-exempt as long as client's life expectancy is less than two years and the viatical settlement company is licensed. In Texas, visit the Department of Insurance website for a list of who is licensed to handle viatical & life settlements. The site is: HTTP://WWW.TDI.STATE.TX.US/COMPANY/VIATLISTR_INCL.HTML

Before purchasing a policy, a lengthy disclosure is required by Texas regulations[4]. Among other things, the regs require that the following information be disclosed:

1. That a viatical or life settlement may affect an individual's ability to receive supplemental social security income, public assistance and public medical services, including Medicaid.

2. That the proceeds of a viatical or life settlement may not be exempt from creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.

3. That all confidential information solicited or obtained by a viatical or life settlement provider shall not be disclosed in any form to any person, unless disclosure has been given by prior written consent from the viator, life settlor, or owner on a form which identifies to whom the confidential information may be released, and the purpose for releasing the confidential information.

4. That the owner has the right to rescind a viatical or life settlement contract at any time, but not later than the 15th day after the date the owner receives the viatical or life settlement proceeds. If the viator or life settlor dies at any time prior to the end of the rescission period, the viatical or life settlement contract shall be deemed to have been rescinded.

5. That the individual may wish to contact an attorney, accountant, estate planner, financial planning advisor, their insurer, insurance agent, tax advisor, or social services agency regarding potential consequences resulting from entering into a viatical or life settlement.

6. That the viator, life settlor, or owner may file a complaint by contacting the Texas Department of Insurance, Consumer Protection Division, Mail Code 111-1A, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701, or by calling the department's Consumer Help Line between 8 a.m. and 5 p.m., Central Time, Monday-Friday at 1-800-252-3439; by faxing a complaint to the department at 1-512-475-1771;

by completing a complaint on-line at WWW.TDI.STATE.TX.US.

LTC Insurance

LTC insurance has improved over the last decade, from being over-priced and under-paying to being affordable and beneficial. Still, clients need to be careful of what policy terms they buy and what insurance company they deal with.

Be aware that neither Medicare nor Medigap policies provide significant long-term coverage for nursing home care. An LTC policy is yet another type of insurance. Client must acquire it separately from other insurance, and it will cost extra. Like any insurance, client has to buy the policy while he/she is still healthy and able to pay premiums to the insurance company.

Legal Provisions to Watch For

1. How does the policy define "nursing home care"? Does the policy cover all levels: skilled, intermediate, custodial and home care? If it covers only skilled care, client might never be ill enough to draw on the benefits. On the other hand, adding home care may cost extra. The Texas Insurance Commission[5] requires that any LTC policy issued in Texas must provide benefits for more than one level of care. Generally, newer LTC policies offer coverage for both nursing home and in-home care. Texas regulations require the policy to pay for lower level care (like in-home care) without first requiring client to be in a nursing home.

2. What dollar benefit does the policy provide? Most pay a fixed per-day rate. Will that be enough to cover the cost of care in your area? Look for broad benefits.

3. Does the policy adjust for inflation, or will the policy pay for less-and-less as inflation makes care more expensive? Be sure client does not buy too much coverage, either. For example, if a nursing home will cost $100 per day and social security already pays client $40 per day, client may need to buy only $60 of additional coverage.

4. How long is the elimination period? Most policies contain a waiting period before they will pay. The first 20 (or more) days of care have to come out of client's pocket even though LTC insurance exists.

5. Does the policy pay for pre-existing conditions? Most policies will not pay the bills for any illness client had before buying the policy; some have a waiting period of up to 2 years before they begin to pay. The shortest wait is the best.

6. Older policies often required client to be in the hospital for a certain number of days before admission to the nursing home. Texas regulations now forbid this practice. Legally, an LTC policy cannot require client to be hospitalized before admission to a nursing home.

7. Any LTC policy issued in Texas after September 1, 1992 must pay benefits based on:

- A functional impairment in performing the activities of daily living (ADLs) like eating, transferring, bathing, walking, toileting and dressing, or

- An impairment of cognitive ability (loss of intellectual capacity requiring continual supervision as supported by clinical diagnosis). Insurance regulations require that LTC policies pay for nursing home care due to Alzheimer's disease.

8. If the policy was issued before September 1, 1992, then those more liberal terms may not be in the policy.

9. Look for a policy where the contract provisions include:

- Guaranteed renewability (they cannot cancel so long as client pays the premiums);
- Waiver of payment of the premium after client enters a nursing home; and
- A flat premium that does not increase as client ages.

Deductible Premiums

The "Health Care Portability and Accountability Act" passed by Congress in August 1996 included a major tax change. Premiums for an LTC policy are partially deductible with two limits:

First, these premiums are deductible just like health insurance premiums. Client needs to itemize, and then they are deductible only after medical expenses reach 7.5% of adjusted gross income.

Second, the amount deductible depends on client's age. In 2003, those above age 71 can deduct up to $3,130 per year[6]. People age 61 to 70 can deduct up to $2,510 per year, etc. The younger client is, the less client is allowed to deduct.

Federal law currently allows deductions only for Long Term Care policies issued after 1996 or for those that were approved by the State Board of Insurance before 1996. The Texas Department of Insurance has LTC Information online at HTTP://WWW.TDI.STATE.TX.US/CONSUMER/CBO32.HTML and now has a "rate guide" on the net at HTTP://WWW.TDI.STATE.TX.US/CONSUMER/LTCRGINTRO.HTML

Medicaid

Qualification Requirements

Medicaid is not available to everyone. As a government welfare program, much of its funding is spent on providing medical care to dependent children, disabled persons, and the poor. Despite the fact that it is difficult to qualify for coverage, in year 2000 Medicaid paid $39.5 billion for nursing care for the elderly.

Qualifying for Medicaid is like shooting at a moving target. The dollar limits set by Medicaid change at least annually.

	2003 Amounts
Income Cap (single)	$1,656
Income Cap (couple)	$3,212
Protected Resource Amount (minimum)	$18,132
Protected Resource Amount (maximum)	$90,660
Protected Income allowance	$2,266.50
Gift Penalty	$2,908

To qualify for Medicaid funds for nursing home care, the patient must clear five hurdles - Age, Residency, Level of Care, Monthly Income Amount, and Asset Amount.

1 - Aged, Blind or Disabled

The nursing home resident must be 65 or older, or must be blind or disabled. This is perhaps the simplest of the five hurdles that must each be jumped prior to qualifying for Medicaid assistance.

2 - Citizenship and Residency

An applicant for Texas Medicaid benefits must be a Texas resident[7]. He/she must have established residence in Texas and must express intent to remain in Texas. The law and regulations do not give a technical definition of "residence," so relying on common experience, it means that the person must live in Texas and not live in another state.

If a Texas resident temporarily visits another state, with intent to return to Texas, then Texas residency is considered to have never ended. The absence from Texas must have a specific purpose, and when that purpose is fulfilled, the person must move back to Texas.

The patient must also be a legal resident of the United States: a citizen, a permanent resident alien or a person permanently living in the U.S. "under color of law."

The "color of law[8]" exception is broad. If a person can prove that he/she has resided in the U.S. continually since January 1, 1972 until now, then he/she is a resident under "color of law." Further, any alien living in the U.S. indefinitely with the knowledge and permission of the Immigration and Naturalization Service is a resident under "color of law." Finally, any person who entered the U.S. before January 1, 1972 and who may be eligible for permanent residence at the discretion of the Attorney General is a resident under color of law.

3 - Level of Care

Medicaid will not pay for custodial care. Hence, by default the patient must be classified at either the "intermediate" or "skilled" care level. The determination is made near the time of application for benefits by the Director of Nurses, an "assessor" who is a Nurse, or by the Physician. This hurdle is usually not difficult to overcome.

4 - Monthly Income Amount

In 2003, an individual's income cannot exceed $1,656 per month. A married couple's income cannot exceed $3,212 per month if both will be in a nursing facility under Medicaid at the same time.

The income limit is raised annually. Generally, when social security benefits go up, so does the income limit. For instance, in 1997 the limit was $1,452. The income limit is based on the Federal Benefit Rate (FBR), which is the limit that Social Security uses to decide if someone is eligible for SSI (Supplemental Security Income). The FBR is multiplied times three to get the Texas Medicaid income limit.

Money received is counted only if client's name is on the check. The social security check made out to client is his income. The check made out his spouse is not his income.

For years, the income cap was very harsh. If income was even one dollar over the limit, Medicaid would not pay a penny for care. Then the idea of a "Qualified Income Trust" was invented.

The Qualified Income Trust (Miller Trust)

First, be aware that a Qualified Income Trust[9] will not shelter assets. It is not a way to "hide money" nor is it a way to save resources. It is a way to get around the income cap otherwise imposed by Medicaid.

This arrangement grew out of a federal case in Colorado with the lead plaintiff named Miller[10]. A nursing home resident (Miller) had too much income to qualify for Medicaid. His family created a Guardianship, and obtained a court order imposing a limit on the amount of retirement funds he could use each month. The Court created a trust, placed all of the retirement funds in that trust, and ordered

the trustee to limit withdrawals to an amount that was less than the Medicaid income cap.

Colorado contested the trust, but eventually the federal court affirmed the trust idea. Mr. Miller was allowed to receive Medicaid benefits even though his income would be too high without the trust.

As a result of this case, Congress passed an amendment to the Social Security Act, 42 USC 1396p, to formalize the idea. Medicaid officially refers to this arrangement as a Qualified Income Trust, but you may hear it called a "Miller Trust" or even a "96p trust."

The federal law says that a Qualified Income Trust may contain only pension funds, social security funds, and other income due to the nursing home resident. It cannot own any other asset, even a car or a savings bond.

The Qualified Income Trust legally restricts the amount that can be withdrawn to pay for the resident's needs.

Here is an example

Charles has regular monthly income of $1670. This is his social security check of $1000 and his retirement pension check of $670. His wife Margaret has income of $750 from social security.

At this point, Medicaid looks only at the checks written to Charles totaling $1670. This, however, exceeds the $1,656 cap. He cannot qualify unless he uses a Qualified Income Trust.

Each month, Margaret deposits Charles' $670 retirement pension check to the trust's bank account. Medicaid is allowed to ignore that amount when calculating Charles' income – and since he is left with $1,000, which is below the cap of $1,656 – he qualifies for Medicaid assistance.

What happens to the money in the trust? It must be spent each month to pay for Charles' nursing care. It is not accumulated nor saved. Depending on the amounts involved, it might also be paid (in part or wholly) to Margaret. Federal law sets out four priorities for spending the money in a Qualified Income Trust. They are:

- Paying the $60 "personal needs allowance" for the resident.
- Paying the "spousal allowance."
- Paying for the resident's nursing home and other medical care; and
- Paying other expenses, like bank fees, taxes or legal costs. In real life, all the money in a Qualified Income Trust is consumed for the first three priorities.

5 – Asset Amount

Medicaid categorizes assets as either "countable" or "exempt." All assets not exempt are "countable." If countable assets exceed $2,000 value for a single person or $3,000 for a married couple (both of who are applying for benefits), Medicaid will not pay for nursing home care.

Exempt assets include:

- Burial allowance of $1,500. This can be in life insurance or in an earmarked burial fund (but not both). Or it can be a prepaid burial plan. If it is irrevocable, then there is no limit on the value of the burial plan;
- A burial plot, casket and vault, regardless of their value;
- $4,500 value in an automobile. However, if the car is needed for transportation to-and-from the doctor, there is no limit on the value;

- Certain annuities, under extremely tight rules (discussed later); and

- The homestead and home furnishings.

Medicaid does not care if an asset is owned just by the husband or just by the wife. It does not make a distinction for community property versus separate property. Moreover, it does not honor a premarital agreement.

A married couple's exempt assets include the entire list above, plus a "spousal impoverishment" allowance. The spouse who is living at home is allowed to retain funds so that he or she will not become impoverished.

Homestead Exemption

The largest exemption is for the homestead: the full value of the home (whether $10,000 or $1,010,000) is exempt. But there is an important condition: the home is exempt only if the patient expresses intent to return to it, or if his spouse or a dependent continues to reside there.

In this context, "homestead" means the principal place of residence before moving to the nursing home. It is broader than the use of the word "homestead" in Texas property law, because for Medicaid purposes there is no limit on the number of contiguous acres that are non-countable.

Medicaid Planning

Medicaid Planning involves legally manipulating client's income and resources so the government will pay part or all of the cost of long-term health care.

Some people, politicians included, construe Medicaid planning as unethical (see, for instance, Newsweek, 1/27/03, *Cheating Uncle Sam for Mom and Dad*, by Diane Conway and response by NAELA President Bernard Krooks, WWW.NAELA.ORG).

Many people wrongly believe that they can simply give away their savings and immediately qualify for Medicaid. That was never the case. Instead, the law has for years imposed a civil sanction: you can be disqualified from receiving Medicaid assistance if you give away assets. The basic premise is "if you could have kept the money and paid for the nursing home, Medicaid won't pay even after you've given the money away."

Former Criminal Penalties

Medicaid planning is not a crime. But for a short time in 1996, Congress tried. This history is important so you will understand that under today's law, Medicaid planning is legal and cannot land you in jail.

Back in 1996, Congress was trying to accomplish some important national health care goals, and passed the lengthy and complex Health Care Portability and Accountability Act. The act was literally hundreds of pages long. In one section was a provision making Medicaid planning into a criminal act. When the public (and some in Congress) became aware of it, they were not pleased.

The criminalization law was passed without comment or hearing. Many members of Congress later said, essentially, that they did not know this provision was in the bill. Public and media perception of the criminalization provision was very negative. The popular press referred to it as the "Send Granny to Jail Law."

Technically, the provision was flawed in many ways. It required several unrelated actions to occur, and it was probably unenforceable. The only known federal case that came under the law was Peebler & Nay vs. Reno (in the U.S. District Court for Oregon). In it, an elderly client and her attorney sued the U.S. for a declaration that she would not be committing a crime if she

gave away her $10,000 savings. The Justice Department asked for the case to be dismissed, agreeing that no crime was possible until several layers of administrative decisions were made.

Repeal and Refocus

During the summer of 1997, Congress debated and passed a new budget reconciliation act. As they like to do, they hid in this massive bill a provision to repeal the Granny law. Instead of sending Granny to jail, they proposed to send Granny's *lawyer* to jail.

The proposal passed and became law on August 5, 1997. It was no longer a crime to give away an asset with the intent of qualifying for Medicaid. Instead, it became a crime for the lawyer, for a fee, to counsel or assists an individual "to dispose of assets… in order for the individual to become eligible" for Medicaid. Just like the Granny law, a crime would be committed only if Medicaid imposed an administrative "ineligibility period" on the applicant.

Attorneys objected to this "gag law" on first amendment grounds. The State Bar of New York took up the issue, and filed suit in federal court. After months of litigation, the court ruled against the government, holding that the "gag law" is unconstitutional[11].

Current law, thus, allows you to safely provide legal counsel on Medicaid issues.

Transfer of Assets

Since it is not a criminal act to plan for Medicaid, clients have the legal right to give away assets in any manner they choose. They need to consider Medicaid's rules and gift tax law. These are two very different issues. Federal gift tax is usually not an impediment to Medicaid planning due to the $11,000 gift tax exclusion and the lifetime gift exclusion of $1 million.

Medicaid's disqualification penalty has changed dramatically through the years. To give you a basis for comparison, here are the outdated penalty rules first:

Prior to October 1, 1993 giving away assets caused a disqualification penalty for up to 30 months. The only gifts that would trigger the disqualification were ones you made within 30 months of the date of the application for Medicaid benefits.

For Example:

By the pre-1993 rules, if client gave away $110,000 he was disqualified for 30 months. If he gave away $300,000, he was disqualified for 30 months. The disqualification period started to run on the day the gift was made. The more money he had, the more he could save. The disqualification penalty could not legally exceed 30 months.

After October 1, 1993 up to today, rules included in the Omnibus Budget Reconciliation Act of 1993 determine the way the disqualification period is imposed. However, the artificial 30-month disqualification cap no longer exists.

For Example:

Under current law, the disqualification period is calculated by dividing the amount of the gift by the "average cost" of nursing home care in Texas. If the average cost per month is $2,908 and client gives away $110,000 he is disqualified for 37 months (110,000 ÷ 2908 = 37 -- Medicaid always rounds down to the next lower integer).

Look-Back Period

It may appear so far that client cannot give away assets without facing a civil transfer penalty. However, Congress chose to create an opportunity for a penalty-free transfer of assets. Under current rules, Medicaid can only ask about any transfer made (to another individual) within the last 36 months before the Medicaid application.

Consequently, client could give away an asset and then wait 36 months before applying for benefits. Medicaid cannot ask about the transfer, so they cannot impose a disqualification period. So if you give away that $300,000 then wait 36 months, you avoid any penalty except for the 36-month wait.

> Rule of Thumb: There is a financial point at which it becomes unreasonable to do transfers to qualify for Medicaid. If a resident has more than about $300,000 to $400,000, plus monthly income, then it may be better to remain outside Medicaid, focusing on proper investment of the funds so client can pay privately for nursing home care.

Risks

There are risks to relying on the 36-month look back. First, Congress can change the rules in mid-game. For instance, before 1993 the look-back period was 30 months. Several years earlier, it was 24 months. There is nothing to stop Congress from expanding the time again, giving Medicaid power to ask about a broader time period than it could when the gift was made. You would then be required to report the gift, and a disqualification period could be imposed.

For Example

Assume that Mrs. Smith gave $40,000 to her four children in April 2002. This results in a 13-month Medicaid disqualification period. The clock starts in the month the gift is given – so the disqualification starts in April 2002 and ends on the last day of May 2003.

To qualify for Medicaid's nursing home coverage, Mrs. Smith's countable assets must be valued at $2,000 or less. Manipulating assets to reach this low level is legal, but must be done with great caution. An applicant must report any gifts given to individuals counting back from the date of application for 36 months. If the applicant gave a gift to an irrevocable trust, she must report the gift counting back from the date of application for 60 months.

Hopefully, Mrs. Smith is planning well in advance of her need for Medicaid, since she will not qualify for 13 more months. If Congress changes the rules during that period, she'll have to live with the new rules.

Homestead Transfer Exceptions

Generally, transferring title to an exempt resource (like the homestead) incurs a transfer penalty. If the nursing home patient did not want to keep the asset, reasons Medicaid, then they could have used that value to pay for nursing home care.

However, a transfer between spouses does not trigger the penalty. Medicaid does not care if title to the house is in the name of both spouses, in the name of the patient, or in the name of the community spouse. Often, it is sensible to put the house into the name of the community spouse. Why? If the patient dies, there will be no need to probate a Will to pass title to the survivor.

Likewise, a transfer of the home to an adult child who is either blind or disabled does not trigger the penalty.

Finally, transfer of the home to an adult child causes no transfer penalty if 1) that child has lived in the house for at least two years before the parent moved into the nursing home, and 2) that child provided support services to the parent that allowed the parent

to avoid moving to the nursing home for some time. Proof of those services must take the form of a letter from the doctor attesting to the services provided.

Transfer Resources to a Trust?

Medicaid labels a trust that is set up by an applicant, with the applicant's own money and that allows the applicant to get limited benefits, a "Medicaid qualifying trust." The rules count all assets in a Medicaid qualifying trust as though they still belong to the applicant (should be a "disqualifying" trust).

Under the 1993 reform law, the rules were tightened further to control revocable trusts. Current law is that any trust client can revoke, whether he retains other benefits or not, counts against him.

The look-back period is also increased from 30 months to 60 months for transfers to a trust.

Irrevocable Trust has Modest Usefulness

Current Medicaid law does allow use of some irrevocable trusts, but in a very restrictive fashion. Any irrevocable trust counts against client if there are any circumstances under which client could receive benefits from the trust—whether or not he actually receives the benefits.

However, if an irrevocable trust follows certain rules, it can act as an asset shelter. The rules are:

- The grantor cannot be a trustee. An independent third party, over whom the grantor has no legal control, must be trustee.
- The trust must be irrevocable. The grantor cannot change his or her mind once it owns the resources.
- The grantor is entitled to minor benefits only—no access to the principal is allowed, and income is restricted.

Additionally, the 5-year look- back rule applies to this type of irrevocable trust. So client may have to wait up to five years before he gets any benefit from this arrangement. And Congress retains the option to expand the look-back period without warning.

Spousal Protection Rules

Congress passed the Medicare Catastrophic Coverage Act (MCCA) in 1987. A large part of that law would have set up a program to pay for nursing home care for all Americans, regardless of their assets or income. Sadly, it also imposed new taxes on Senior citizens – and after loud objections from the Senior community, Congress repealed most of the law. One provision, however, still exists today. It deals with Medicaid, and protects healthy spouses from "spousal impoverishment."

The spousal impoverishment rules (which should really be called the "non-impoverishment rules") apply to any married couple, one of whom was in a nursing home on or after September 30, 1989 for any period longer than 29 days.

When one spouse lived in a nursing home and the other lived at home (the at-home spouse is often called the "community spouse") the community spouse often went broke before Medicaid would step in to help. The spousal impoverishment rules from the MCCA provide some protection to the community spouse.

Protected Resource Amount (PRA)

The protection works as follows:

First, a "snapshot" of the couples' asset value is taken. The value is fixed at midnight of the first day of the month in which the ill spouse enters the nursing home. This is called a "spousal resource allocation" and you must request it from the Medicaid intake worker.

Second, the value of the couple's exempt (non-countable) assets is deducted.

Third, an exemption is granted to the community spouse for ½ of the countable resources, but not less than $18,132 nor more than $90,660. This exemption is called the Protected Resource Amount (PRA).

Everything above the allowance is viewed as a resource of the ill spouse, and is counted against the ill spouse's ability to qualify for Medicaid. When the portion allocated to the ill spouse is spent, the ill spouse is qualified for Medicaid benefits.

PRA Example 1: Carl and Elizabeth are married. On March 1, Carl entered a nursing home. They have a house (valued at $70,000), a certificate of deposit (valued at $20,000) and stocks (valued at $30,000.) The house is not included in the calculations, but the CD and stock value of $50,000 are part of the "snapshot" taken on March 1. One-half of $50,000 (that is, $25,000) is set aside as Elizabeth's share.

Carl's $25,000 share is too much to allow him to get Medicaid, so the caseworker will deny Medicaid coverage until those funds are spent down. They can be spent on medical care, home repairs, living expenses or transfers. When they are consumed, Carl's application for Medicaid will be approved. Elizabeth will still have her $25,000 cash and a $70,000 house to care for her own needs.

The most advantageous way to use the spousal impoverishment is to report as high a countable asset base as possible (at least, hopefully, assets exceeding $181,320 in value, at least under the 2003 limits). Why? Because you want the protected set-aside of assets to be as large as possible.

PRA Example 2: What if Carl and Elizabeth had countable assets of $190,000 and their house had a $50,000 mortgage? Elizabeth wants to pay off the mortgage.

If she pays off the mortgage first, before the snapshot date, she hurts herself financially. Their $190,000 has been reduced to $140,000 – so her resource allowance is set at only $70,000.

If, however, Elizabeth asks Medicaid to take the snapshot first, and pays of the mortgage afterward, she protects more resources. The snapshot would set aside the maximum allowance of $90,660. The balance of the resources ($99,340) counts against Carl and must be spent before he qualifies for Medicaid. Elizabeth can then pay off the mortgage of $50,000 from Carl's "share." She ends up with a clear title to the home, a PRA of $90,660, and only $49,340 to be spent before Carl qualifies for Medicaid.

Income Allowance

The spousal impoverishment allowance also includes income. The community spouse is allowed to keep up to $2,266.50 per month to maintain the household. This is called the Minimum Monthly Maintenance Needs Allowance or the MMMNA.

Assume that Carl has monthly income of $1,400, and Elizabeth has monthly income of $1000 from Social Security. Each month, Elizabeth would keep $2,266.50 from this combined income, and would pay the balance ($133.50) to the nursing home for Carl's care (part of that being Carl's $60 per month personal needs allowance).

This income allowance often interacts closely with the establishment of a Qualified Income Trust. If, in the above example, Carl has income of $1,700 per month and Elizabeth's

income is $700 per month. Carl would only qualify for Medicaid if he has a Qualified Income Trust to bring his $1,700 below the $1,656 limit. But Elizabeth is still entitled to her $2,266.50 per month allowance, so part of her allowance will be paid from funds that were diverted to the Qualified Income Trust.

Expanded Protected Resource Amount

The income allowance has one other major role to play. What if the income from both spouses does not reach 2,266.50?

Say that Carl's income is $800 and Elizabeth's income is $300. According to the income allowance, she is entitled to keep all that income, $1,100, for her monthly needs. Clearly, $1,100 is far less than the maximum $2,266.50 she would be allowed if their monthly incomes were higher.

Look at PRA Example on the prior page. Carl had excess assets of $25,000 that had to be "spent down" before he would qualify for Medicaid. Instead of spending that money, the Expanded PRA rule allows Elizabeth to keep and invest the money – shifting it from Carl's exposed assets into her Protected Resource Amount. Thus, Carl will qualify for Medicaid sooner (without waiting for "his" $25,000 to be spent) and Elizabeth can invest the $25,000 so that the interest it earns supplements her spousal income allowance.

What is the process for getting an expanded PRA? Until recently, the Medicaid caseworker would have issued a denial of benefits because of excess assets and an appeal to a hearing officer would have been mandatory. Now, the caseworker is allowed to calculate the Expanded PRA[12].

How much can be saved using this technique? It depends on two factors: 1) the amount of retirement income the couple has, and 2) current interest rates for a one-year CD in your community. Below is a step-by-step guide to the calculation, based on Carl and Elizabeth's situation:

In this example, the community spouse (Elizabeth) would be allowed an investment pool of up to $943,440. The contributing factors, again, are the amount of retirement income (step 2) and the interest rate (step 7). If income is higher and/or the interest rate is higher, then the expanded PRA in step 8 will be smaller. Interest rates can be obtained

Step 1:	Enter the minimum monthly maintenance needs allowance (MMMNA)	$ 2,266.50
Step 2:	Enter community spouse's non-investment income, including diversion from the institutional spouse, if any (minimum diversion is $1)	$ 301.00
Step 3:	Subtract Step 2 from Step 1, enter the difference:	$ 1,965.50
Step 4:	If step 3 is $0 or a negative number, STOP / otherwise, proceed to step 5	
Step 5:	Multiply the amount in step 3 by 12	$ 23,586.00
Step 6:	Multiply the amount in step 5 by 100	$2,358,600.00
Step 7:	Enter the interest rate (number, not percentage) for a 1-year CD here	2.50
Step 8:	Divide the amount in Step 6 by the above number and enter result here	$ 943,440.00

from your local bank – many of them post rates on the Internet. Just choose the lowest rate that they publish for a one-year CD.

Once the expanded PRA has been established, the excess funds can be invested in any way that the community spouse elects. Just because you used a low one-year CD rate to calculate the amount does not mean that you need to actually invest the funds in CDs at that rate. If the money is tied up in stocks, it can stay there.

Deeming of Spousal Resources

Under the federal Medicaid statutes and regulations, all assets owned by either spouse are generally considered "available" to pay for medical care of either spouse. The policy set by Congress assumes that married people will take care of each other before asking the taxpayers to do so.

Premarital Agreements

What if client is in a second marriage, and thinking ahead about long term care he and wife signed a premarital agreement? They both agreed that the assets he owned prior to marriage remain separate property, and that they will bear no liability to pay for each others health care. Can they rely on the premarital agreement to shelter wife's assets from paying for husband's nursing home costs?

No. Medicaid is a federal program (it is just administered by the state). As such, its rules preempt state law. Federal Medicaid law and state regulations[13] require that all of the countable resources that belong to either husband or wife be reported to Medicaid, regardless of the existence of a premarital agreement. If those combined resources exceed $2,000 – after taking the spousal allowance into consideration—then no assistance will be provided.

The spouse's money is still her separate property. She is not required by law to pay for her husband's nursing home bill. But under these circumstances, Medicaid is also not required by law to pay. Federal law says that a spouse must use his or her resources before taxpayer dollars are used. So she is put to the test: does she refuse to pay with her own money - meaning that her husband does not get needed care - or does she pay with her own money? The choice is not a pretty one.

Clients do not like this suggestion, but it must be examined—they could get a divorce. When the marriage ends, her money will no longer be counted against husband, and Medicaid will contribute to the nursing home bill. This approach is risky, since some Judges may refuse to grant a divorce if it is based on the need for a federal benefit (they say that state law does not allow divorce for that cause).

Asset Recovery Liens

By federal mandate, Texas must attempt to recoup the funds it spends by making a claim against the recipient's estate. But Texas has not passed enabling legislation. Although 48 out of the 50 states allow asset recovery liens, to my knowledge the there is not even a bill introduced in the 78th legislature that addresses this issue.

If Texas begins to use this type of lien, it will only be collected after both the recipient and the spouse have died. If they have a surviving child under age 21 or who is blind or disabled, the lien cannot be collected. Also, if an adult child resided in the house with the parent for at least 2 years before the parent went to the nursing home, and if that child has lived in the house continuously since then, and if that child's assistance enabled the parent to stay at home longer, then the lien cannot be collected.

Medicaid Annuities

In the past, annuities have been pushed as the miracle cure for Medicaid woes. This cure, if it ever really worked as advertised, is now outmoded.

The concept was to take money (which was a countable resource) and buy an annuity with it. The insurance company, in exchange, agreed to make a payment to client. The payment was income. The investment was no longer considered to be a countable resource. As a result, client would have qualified for Medicaid promptly.

New rules were drawn up, effective July 1, 1997, eliminating much of the annuity's attractiveness in the Medicaid arena. Under today's annuity rules[14], any death benefit must be payable to the Department of Human Services. The family can no longer receive the funds left over when the patient dies.

Further, today's annuity rules require that payments under an annuity be made in equal amounts each month over the projected lifetime of the patient. This increases the size of the payment, making it more likely that the money will be used to pay for nursing home costs. Hence, much or all of the savings is eliminated.

The annuity strategy may still be viable under a set of limited circumstances: if 1) the nursing home patient has too much cash, 2) the community spouse has very little income, and 3) the community spouse is named as owner of the annuity. Under those circumstances, the annuity's monthly check can be used to increase the community spouse's income until it reaches the MMMNA. Since the community spouse owns the annuity, Medicaid may not make a claim against it when the patient dies.

While that strategy sounds useful, compare it to the Expanded Protected Resource Amount discussed earlier. The Expanded PRA allows a great deal of money to be sheltered as part of the spousal allowance and the funds can be invested in any fashion. This can avoid the negatives often associated with annuities: high commissions, penalty for early withdrawal, and (after the initial year or two) low rates of return.

Thus, annuities are a much less attractive Medicaid planning tool.

---

[1] 42 CFR 483.12(d)

[2] Section 50, Texas Constitution

[3] Internal Revenue Code, §101(g)

[4] 28 TAC 3.1708

[5] 28 TAC, Part 1, Chapter 3, Subchapter Y

[6] IRC 213(d)(10); Rev. Proc. 2002-70

[7] 40 TAC 15.301

[8] 40 TAC 15.300(b)

[9] 42 USC 1396p(d)(4)(b), 40 TAC 15.417(f)(3)

[10] Miller v. Ibarra, 746 F. Supp. 19 (D.Colo.1990)

[11] New York State Bar v Reno, 97-CV-1760, US Dist Ct, N. Dist, NY). See www.seniorlaw.com/mcavoy.htm

[12] See Form 1275, Medicaid Eligibility Handbook

[13] 40 TAC 15.410

[14] 40 TAC 15.442(g)