UNDERSTANDING ELDER LAW:

Issues with Financing Long-Term Care with Medicaid

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I. What do Elder Lawyers do?

Although Estate Planning attorneys typically focus on preserving an individual's assets, Elder Lawyers have particular focus on planning for the care of elderly (and/or disabled) individuals and their families.

As individuals move into retirement and old age, Elder Lawyers address the client's need for 1) income during retirement, 2) financing the costs of health care after retirement, and 3) planning for the potential disability or incapacity of the client.

To do so involves tools such as long-term care insurance, living wills, revocable living trusts, beneficiary designations, medical directives, powers of attorney, and assisted care facilities. These tools are the same tools utilize in estate planning generally, however, there is an emphasis on customized drafting to address the needs of the elderly and/or person with a disability.

An elder lawyer's tasks include planning for and promoting adequate acute and long-term care if the individual's health declines; creating surrogate decision-making plans to protect the individual in the event of incapacity; ensuring optimal housing, including assisted or supportive housing; and preserving the value of the assets to the extent possible.

Elder Lawyers are primarily concerned with preserving the individual's autonomy during elderly years of someone's. Generally, Estate Planning attorneys are planning for the death and transmission of the individual's wealth, which could happen at any point in time.

So Estate Planning and Elder law have considerable overlap. Elder Law and Estate Planning should be coordinated as part of an integrated planning measure to assist the individual.

Additionally, planning for elder care ideally should be concerned at an early stage of the individual's life, not only the legal end but with financial side as well. For example, Insurance products such as whole, universal or variable life insurance could be sought to secure not only permanent coverage in case of later health concerns, but also fixing the premium at a much lower cost due to obtaining a policy at a younger age. In addition, these types of permanent life insurance products can allow for cash value accumulation, which can provide a fund to cover the costs of long-term care later in life.

This pamphlet will focus on the concern that brings many elder law clients into my office: financing the costs of long-term health care after retirement, particularly when Medicaid is needed.

II. What are the Different Areas of Elder Law?

There are 12 accepted core and non-core areas of elder law. Every Elder Lawyer should do the core areas but which non-core areas is handled will differ by attorney. I have highlighted those non-core areas that I incorporate into my elder law practice.

o **Core Area 1: Health and Personal Care Planning** including giving advice regarding, and preparing, advance medical directives (medical powers of attorney, living wills, and health care declarations), counseling older persons, individuals with supplemental/special needs, attorneys-in-fact, and families about life care, medical and life sustaining choices, and related personal life choices.

- **Core Area 2: Pre-Mortem Legal Planning** including giving advice and preparing documents regarding wills, trusts, durable general or financial powers of attorney, real estate, gifting, and the financial and income, estate and gift tax implications of any proposed action

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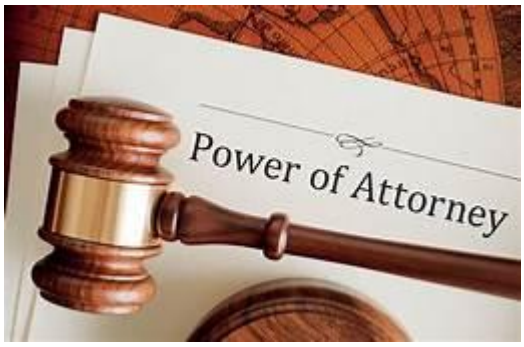
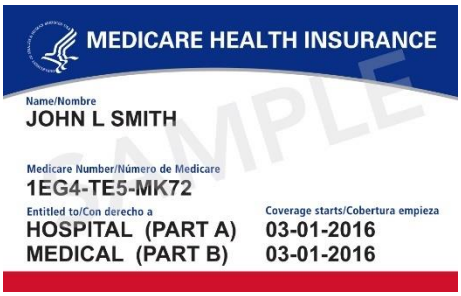


o **Core Area 3: Fiduciary Representation** including seeking the appointment of, giving advice to, representing, or serving as executor, personal representative, attorney-in-fact, trustee, guardian, conservator, representative payee, or other formal or informal fiduciary.

o **Core Area 4: Legal Capacity Counseling** including advising how capacity is determined and the level of capacity required for various legal activities and representing those who are or may be the subject of guardianship/conservatorship proceedings or other protective arrangements.

o **Core Area 5: Public Benefits Advice** including planning for and assisting in obtaining Medicaid, Medicare, Social Security benefits, Supplemental Security Income, Veterans benefits and housing and food programs.



o **Non-Core Area: 6 Special Needs Counseling** including the planning, drafting and administration of special/supplemental needs trusts, housing, employment, education and related issues.

o **Non-Core Area 7: Advice on Insurance Matters** including analyzing and explaining the types of insurance available, such as health, life, long term care, home care, COBRA, Medigap, long term disability, dread disease, prescription coverage, and burial/funeral policies.

o **Non-Core Area 8: Resident Rights Advocacy** including advising patients and residents of hospitals, nursing facilities, continuing care retirement communities, assisted living facilities, adult care facilities, and those cared for in their homes of their rights and appropriate remedies in matters such as admission, transfer and discharge policies, quality of care, and related issues.

o **Non-Core Area 9: Housing Counseling** including reviewing the alternatives available and their financing such as: renovation loan programs, life care contracts, home equity conversion, reverse and other mortgage options.

o **Non-Core Area 10: Employment and Retirement Advice** including pensions, retiree health benefits, unemployment benefits, and other benefits.

o **Non-Core Area 11: Counseling with regard to age and/or disability discrimination** in employment, housing and related areas.

o **Non-Core Area 12: Litigation and Administrative Advocacy** in connection with any of the above matters, including will contests, contested capacity issues, elder abuse (including financial or consumer fraud), fiduciary administration, public benefits, nursing home torts, and discrimination.

III. Why is Planning for the Elderly so important?

1. **Long-term care is very expensive.** Families want to ensure their loved one receives the care they require, which they could not otherwise afford.

2. **If pursuing Medicaid to provide for health care, each state's Medicaid has its own requirements for eligibility, which are updated every year.** Even simple errors can result in a denial of benefits.

3. **Long term care benefits from Medicaid are most commonly provided in a nursing home. However, almost all states also offer "Home and Community Based Services".** HCBS is both medical care and non-medical support services provided to persons living at home, in assisted living residences, memory care communities for persons with Alzheimer's or in the homes of their loved ones.

4. **To protect as much as possible any healthy spouse.** This spouse would still live at home (i.e., the "community spouse") and want them to have the financial resources to continue doing so.

5. **To preserve a family's limited assets to ensure passage of those funds to the next generation.** Without advance preparation, many families end up paying out-of-pocket for nursing home costs, or other long-term care costs, until their assets run out. Advance preparation is the best action to help protect one's assets, while still being able to qualify for Medicaid when the need arises.

6. **Nursing home care by Medicaid is an entitlement.** This means if one meets the financial and level of care requirements, a state must pay for that individual's nursing home care.

7. **HCBS Waivers are designed for persons who require a nursing home level of care, but prefer to receive that care while living at home or in assisted living** ("memory care" for persons with Alzheimer's is a type of specialized assisted living). HCBS Waivers will not pay for the room and board costs of assisted living, but they will pay for care costs. **Waivers are not entitlements.** Many Waivers have waiting lists.

8. **HCBS Waivers, in all 50 states, offer home care as a benefit.** Unfortunately, HCBS Waivers are not entitlements. Therefore, being eligible does not necessarily mean one will receive care. **It is very likely one will be put on a waiting-list for assistance.** Waivers have the same level of care and financial eligibility criteria as nursing home Medicaid.

IV. Medicare

- Medicare is the federal insurance program to help cover the costs of medical care for Americans age 65 and over (younger if disabled). (Dental coverage is generally not covered by Medicare.)

- Although Medicare comes in four parts, two are considered basic (Parts A and B) (referred to as Original Medicare). Medicare **Part A** covers the cost of hospitalization and hospice care, whereas **Part B** covers doctor visits and other outpatient costs (e.g., physical therapy and medical equipment) and preventative costs (e.g., diabetes testing and glaucoma screening).

- **Part C** is Medicare Advantage, which is an optional **private plan** through Medicare that provides an alternative to Parts A and B. Medicare Part C, called Medicare Advantage, is **offered by private insurance companies that contract with Medicare** to provide all Part A and Part B benefits. Most Medicare Advantage plans also include the Part o prescription drug benefits (for an additional cost). To obtain a Medicare Advantage plan, the individual must enroll in BOTH Parts A and B and then join a specific Medicare Advantage plan.

- **Part D** is a separate policy available for purchase from a private insurance to provide prescription drug coverage.

- A **Medigap** (also called Medicare Supplement Insurance) policy is private health insurance **designed to supplement Original Medicare (Part A and Part B).** It helps cover some of the health care costs ("gaps") that Medicare does not cover (e.g., copayment, coinsurance, and deductibles). Medigap policies may also cover certain procedures not covered by Medicare.

- **Many clients presume that Medicare will pay for their long-term care. Unfortunately, this is often not the case.**

- **Most long-term expenses will be paid from one or more of the following sources**:
  - Private pay (i.e., if the individual has sufficient savings and resources);
  - Medicare (Traditional Parts A and B **or** Part C Medicare Advantage);
  - Medigap (Medicare Supplemental Insurance to Parts A and B);
  - Medicaid;
  - Long-Term Care Insurance;
  - Life Insurance ("living benefits"/cash values);
  - Irrevocable Income Only Trusts/Medicaid Asset Protection Trusts; and
  - Qualified Income Trusts/Miller Trusts (only in "income cap" states).

V. Medicaid

- Medicaid is designed to provide health coverage for low income individuals. Unbeknownst to many clients, Medicaid can cover **both** skilled nursing facilities **and** community-based services.

- Unlike Medicare & Social Security, Medicaid is a federal program that is run by departments of state governments. The program is also funded jointly by the federal government and your state's government. States differ in how they manage the Medicaid program.

- Available to anyone who is ***65 or over (i.e. elderly), blind or disabled*** and has exhausted their financial resources.

- **Medicaid has two types of eligibility requirements: functional and financial.** Functionally, individuals usually must require the level of care provided in a nursing home or an intermediate care facility. Financially, Medicaid eligibility looks at both the applicant's income and their total resources (i.e. their "countable" assets).

FUNCTIONAL ELIGIBILITY

- For the Functional eligibility, there is a "level of care" requirement for Medicaid for seniors changes based on the type of Medicaid program from which one is seeking assistance. Long term care in a nursing home or for home and community-based services via a Medicaid waiver requires a high level of care need

- **The level of care requirement for a nursing home admission or for assistance via a HCBS Waiver might be referred to in a number of ways depending on one's state of residence.** The formal rules change by state as well.

- At a minimum, program participants must require assistance with their **Activities of Daily Living (ADLs). ADLs are activities that are routinely done daily, such as bathing/grooming, dressing, eating, toileting, eating, and mobility.**

- Sometimes it is also considered if seniors are able to perform their **Instrumental Activities of Daily Living (IADL). These activities include preparing meals, shopping for essentials, housecleaning, and medication management.**

- In most cases, a medical professional must do an assessment to determine one's level of care needs or their inability to perform ADL's and / or IADL's.

FINANCIAL ELIGIBILITY

- **For Financial Eligibility, many of the figures used in Medicaid planning (income limits, asset limits, penalty calculations, etc.) vary state to state.**

- Supplemental Security Income (SSI) is a federally funded, ***needs-based*** program that provides a cash benefit to individuals with limited income and resources. It is administered by the Social Security Administration. **In most states, Medicaid eligibility is automatic once Social Security establishes eligibility for SSI benefits**.

- Each state has chosen to administer Medicaid under one of three options:

  1. **In "1634 states", *the state agrees to use Social Security's approval of SSI benefits as an automatic approval for Medicaid***. 1634 states are Alabama, Arizona, Arkansas, California, Colorado, Delaware, Florida, **Georgia,** Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, **North Carolina,** Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. It also includes Washington, DC.

  2. In "**209(b) states**", ***the state uses at least one eligibility criterion more restrictive than the SSI program.*** *In these states, Social Security doesn't make any Medicaid decisions; instead, the state makes all Medicaid eligibility decisions*. Beneficiaries must apply for Medicaid at the state Medicaid agency. 209(b) states are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

  3. In "**SSI Criteria states"**, *the state uses the same income and resources rules as SSI to determine Medicaid eligibility, but a beneficiary must file an application separately with the state Medicaid agency*. SSI Criteria states are Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah. It also includes the Northern Mariana Islands.

VI. Medicaid Financial Eligibility: Income Limits

- **A rule of thumb for the year 2020 is a single individual, 65 years or older, must have income less than $2,349 / month.**

- Income limits (for nursing home Medicaid and HCBS Waivers) are not as straightforward for married applicants. **Generally, married couples' incomes are counted separately.** Therefore, the income of a non-applicant spouse is not used in determining income eligibility of his / her applicant spouse.

- Generally, all of the applicant's (i.e. the ill spouse) income must go to the nursing home. **However, in certain circumstances, the non-applicant can be allocated some of the applicant's income to enable him/her to continue living at home when his/her spouse goes into a nursing home or receives HCBS through a Medicaid waiver.** This is called the Minimum Monthly Maintenance Needs Allowance (MMMNA). In 2020, in most states, the maximum amount of income that can be allocated to a non-applicant spouse is $3,216.00 per month.

- The applicant can keep a small amount each month for their personal needs account at the nursing home. Effective July 1, 2019, this amount was raised to $70 per month in Georgia.

- Deduction for uncovered medical costs (including medical insurance premiums).

- An allowance can be allocated to the community spouse if a need can be demonstrated.

- Some states like Georgia have **income caps** (i.e., you cannot be even $1 over the $2,349 per month limit). However, the excess income can go into a "(d)(4)(B)" or "**Miller" trust** and one can qualify.

- The income of the community spouse is not counted in determining the Medicaid applicant's eligibility. Only income in the applicant's name is counted. Thus, even if the community spouse is still working and earning, say, $5,000 a month, she will not have to contribute to the cost of caring for her spouse in a nursing home if he is covered by Medicaid.

- But what if most of the couple's income is in the name of the institutionalized spouse and the community spouse's income is not enough to live on? In such

cases, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income.

- There are "countable assets" and "exempt assets".

VII. Countable Assets

- States sets their limit on "countable" resources ($2,000 for 2020 for Georgia) , which are assets that are liquid (or can be liquidated) and then used to pay for care.

- Joint accounts are generally considered 100% owned by the applicant, regardless of how many joint owners there are.

- Real estate solely owned by an applicant who no longer lives there is considered countable even though it is currently illiquid.

- Assets in a trust for which the applicant is a beneficiary may be countable, depending on the provisions of the trust agreement. ***(NOTE: REVOCABLE LIVING TRUSTS may avoid probate and will always be countable for Medicaid).***

- "Availability" is a key concept in determining which assets are countable: Is the asset in question available to pay for the care of the applicant?

VIII. Exempt Assets

- Can keep very little in liquid assets, up to $2,000 in most states.

- COMMUNITY SPOUSE PROTECTION: Medicaid law provides special protections for the spouses of Medicaid applicants to make sure the spouses have the minimum support needed to continue to live in the community while their husband or wife is receiving long-term care benefits, usually in a nursing home.

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

- In general, in many states like North Carolina, the community spouse may keep **one-half** of the couple's total "countable" assets up to a maximum of **$128,640** in 2020. Called the "community spouse resource allowance," (CSRA) ,this is the most that a state may allow a community spouse to retain without a hearing or a court order. The least that a state may allow a community spouse to retain is $25,728 in 2020.

- However, some states like Georgia, are more generous toward the community spouse. In these states, the community spouse may keep up to **$128,640** in 2020, regardless of whether or not this represents one-half the couple's assets.

- Example #1: If a North Carolina married couple has $130,000 in countable assets on the date the applicant enters a nursing home and later stays for 30 days (i.e. the "snapshot" date), he or she will be eligible for Medicaid once the couple's assets have been reduced to a **combined figure of $67,000** -- $2,000 for the applicant **and** $65,000 as a CSRA for the community spouse. **That applicant spouse would then have to spend down $63,000 to qualify for Medicaid in North Carolina** ($130,000 countable assets - $2,000 applicant spouse allowance - $65,000 community spouse resource allowance).

- Example #2: If a Georgia married couple had that same $130,000 in countable assets on the "snapshot" date, the community spouse could retain up to $128,640 instead of being limited to one-half. So for assets as a couple they could retain **a combined figure of $130,000 (i.e., all of the countable assets)** -- $2,000 for the applicant spouse **and** the remaining $128,000 as a CSRA for the community spouse ($640 of the remaining potential CSRA would go unused). **That applicant spouse would then would not have to spend down any amount to qualify for Medicaid in Georgia.**

- Personal effects, assuming no significant value and not expected to appreciate in value over time.

- **The home**, but only if a spouse/minor child/disabled child lives there, **or** ***there is a stated intent for the applicant to return home.***

- One car for the healthy community spouse. Most states allow any value.

- **Term life insurance policies**.

- Whole life insurance policies with a total face value < $10,000 (for Georgia). If greater than $10,000, then the cash value is countable.

- A prepaid, irrevocable burial or cremation plan and plot for the applicant or immediate family member.

- Assets held by a property drafted **"Special Needs Trust"** (or "supplemental needs trust") for the benefit of the applicant.

- **Retirement accounts** (however, this protection will vary state by state).

- Tools or business property that is used as a means of support (e.g. farm, rental property).

- **"Partnership" long term care insurance policies**; the ultimate payout amount is protected.

- **Annuities** (*usually a single premium immediate annuity owned by the community spouse in order to increase his/her income*) that meet certain requirements:
  - Irrevocable and non-assignable;
  - Actuarially sound;
  - Equal payments with no balloon payments (i.e., a "fixed" annuity);
  - The State is the 1st named beneficiary *(or 2nd named beneficiary, if community spouse or disabled adult child is named as the 1st beneficiary).*

IX. Gifting Issues

- The financial activity of the applicant (and the spouse, if there is one) are audited for the 5-year period (60 months) leading up to the Medicaid application.

- Any transfers of assets out of the applicant's name that is for less than fair market value is a "gift" and treated as a disqualifying transfer. **Gifting assets to third parties (children, other family members, charities, churches, etc.) is not spending down. *Gifts are disqualifying transfers of assets.***

- The size of the transfer/gift will determine the length of the period of ineligibility for Medicaid (the "penalty period").

- The penalty period begins to run once the applicant is otherwise eligible for Medicaid (i.e. once the applicant has spent down below the Medicaid asset limit).

- It may seem like it isn't possible for caregivers to get paid for the assistance they provide without jeopardizing their aging loved ones' Medicaid eligibility, but there is a way. It is called a **personal care agreement.**
- If Mom or Dad reimburses you for the care you provided over the past few years and then applies for Medicaid, s/he will face a long penalty period during which s/he will be ineligible for Medicaid assistance. Unless there is an explicit written agreement that sets forth terms of compensation, state Medicaid programs will consider even current payments made to a caregiver to be gifts as well.

X. Permitted Transfers

- Assets may be transferred back and forth between spouses.

- Transfers to a blind or disabled child are permitted.

- ***Transfers to a trust for a disabled individual who is under age 65 ("Sole Benefit Trust")***

- **The house may be transferred to (in addition to those above):**
  - **Child under age 21;**
  - **Child who has lived in the house for 2 years prior to the applicant moving to a nursing home and provided care to keep the applicant out of the home during that time;**
  - **Sibling with an equity interest in the house and who has lived there for one year prior to applicant's nursing home placement.**