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Will You Still Need Me, Will You Still Feed Me, When I'm Sixty-Four?

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I. Introduction and overview.

- A. Elder law myths and realities.
- B. Long-term care options.
 - 1. Home.
 - 2. Assisted living facility.
 - 3. Nursing home.
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- C. Planning and paying for long-term care.
 - 1. Private pay.
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II. Elder law myths and realities.

- A. It won't happen to me; I'm never going into a nursing home.
 - 1. People are living longer past age 65 (average of 19.3 years for men, 21.6 years for women).¹ For individuals who are highly educated and with higher incomes, the average lifespan is even longer.
 - 2. According to AARP and the United States Census Bureau, over 40 million Americans are age 65 or older; by 2050, 20% of Americans will be age 65 or older.²
 - 3. As demographics and societal norms change, the likelihood that a person will not have the option to rely on family and friends increases. With a decline in the number of elderly persons who live near their adult children, the fact that many people had fewer children than previous generations, and an increase in divorces and the resulting loss of lifetime commitment, this trend is not likely to abate. Elderly women are even more likely to be in a situation where they are outliving spouses and siblings, but not moving in with their adult children, resulting in the necessity of moving to a nursing home or other long-term care facility.
 - 4. According to the U.S. Department of Health and Human Services ("HHS"), 70% percent of Americans turning age 65 will need some form of long-term care during their lifetime.³ Over 5 million individuals in the United States have Alzheimer's disease. That number is expected to triple by 2050.⁴

¹ Social Security Administration, Calculators: Life Expectancy, <https://www.ssa.gov/planners/lifeexpectancy.html>.

² Vincent, Grayson K. and Victoria A. Velkoff, 2010, THE NEXT FOUR DECADES, *The Older Population in the United States: 2010 to 2050*, Current Population Reports, P25-1138, U.S. Census Bureau, Washington, DC. <https://www.census.gov/prod/2010pubs/p25-1138.pdf>.

³ HHS, *Who Needs Care?* <https://longtermcare.acl.gov/the-basics/who-needs-care.html>.

⁴ Alzheimer's Association, 2017 Alzheimer's Disease Facts and Figures, <https://www.alz.org/facts/>.

- B. Many people are under the misconception that Medicare will pay for the cost of their long-term care.
1. Medicare does not pay for long-term care.
 - a. Medicare will pay some costs for very specific kinds of care. While “skilled nursing care” may be covered to some extent after a qualifying hospital stay, “custodial care” is never covered.
 - b. Similarly, while Medicare may cover certain care needs resulting from an acute illness, such as rehabilitation services, for a limited time, the long-term care related costs of a chronic illness, such as dementia or Alzheimer’s disease, are not covered.
 - c. Long-term care is a range of services and support for personal care needs, including help with activities of daily living, such as bathing, dressing, toileting, transferring, caring for incontinence, and eating. It may also include assistance with instrumental activities of daily living, such as housework, managing finances, taking medication, shopping, or using the telephone.
- C. Many people are surprised to learn how expensive long-term care is.
1. The average annual cost of long-term care often exceeds \$100,000; in major metropolitan areas, it can easily exceed \$200,000.⁵
 2. The costs of long-term care often bankrupt middle-class families since the United States has no health insurance system for long-term care. Medicare does not cover long-term care and Medicaid has very strict income and asset requirements that must be met before benefits are provided.
- D. A common misconception held by married individuals is that they are not responsible for the cost of their spouse’s care. Although the law does provide some spousal protections, spouses are generally responsible for the cost of each other’s long-term care.
1. The well spouse living at home (the “community spouse”) is entitled to certain allowances, including a community spouse resource allowance (“CSRA”) and a minimum monthly maintenance needs allowance (“MMMNA”).
 2. Even for couples who maintain separate finances, the responsibility for long-term care costs of the spouse exists since the marital estate is deemed to be one entity for these purposes.
 3. While divorce can extinguish a spouse’s responsibility for payment of long-term care costs in the future, there will likely be an equitable, or some other, distribution of marital assets in most states. The sick spouse’s share of those assets will be available to pay for the cost of his care.
 4. Pre-nuptial agreements that include provisions limiting or eliminating the responsibility for the cost of a spouse’s long-term care are typically disregarded by government agencies since they are not a party to the agreement.
 5. In a second marriage situation, it often makes sense for the spouse with the greater net-worth to consider purchasing long-term care insurance for his spouse, if possible. If the purchase of such insurance is not feasible, then consider setting aside funds in a trust to pay for long-term care.
- E. The ability to make one’s own financial and medical decisions often diminishes with age. Such issues as who will make these decisions for oneself can be addressed through advance directives such as powers of attorney and health care directives.
1. Issues such as where to receive care, how much to spend on care and visitation rights can be a source of family conflict.

⁵ Genworth, Long Term Care Costs Across the United States (2017), <https://www.genworth.com/about-us/industry-expertise/cost-of-care.html>.

2. These issues can become extremely contentious, especially in a second marriage situation where children from a prior marriage do not agree with the individual's spouse.

III. Long-term care options.

A. Home.

1. There are many advantages to receiving care at home for those who have the necessary support and finances to allow for this decision.
 - a. Often, individuals prefer to age in place, meaning that they want to remain in their homes with familiar surroundings for as long as possible.
 - b. If choosing to receive care at home, family and friends can provide much of the required care. In fact, it has been estimated that unpaid caregivers provide approximately 80% of care given at home, spending 20 hours a week, on average, giving care.⁶
 - c. In certain cases, it might make sense to compensate informal or family caregivers for their services. If the ultimate goal is Medicaid qualification, there generally must be a written caregiver agreement in place prior to the performance of services for which the caregiver is being compensated. The agreement should define the scope and duration of services being provided and the payments to the caregiver should be actuarially sound based on the life expectancy of the Medicaid applicant. To the extent all services required to be performed under the contract are not done, Medicaid may require a payback to the estate for the unused portion. Moreover, the rate paid for the services must be comparable to what is customary in that particular community.
 - d. The performance of caregiving services raises a number of significant income tax issues, including whether the caregiver is an independent contractor or an employee.
2. Although care at home is often an attractive option, there are pitfalls to be mindful of.
 - a. Home care can be very expensive, sometimes costing as much as or more than institutional level of care.
 - b. There is an increased risk of both financial and physical elder abuse by caretakers at home. Although there is significant under-reporting of cases, the National Center on Elder Abuse presents a variety of studies that find the perpetrators of elder abuse are most often friends, family members, and caregivers.⁷
 - c. In addition to the risks of abuse, sequester in the home often contributes to social isolation and may place an individual at risk for both physical and psychological medical problems.

B. Assisted living facility.

1. An assisted living facility is an option for those who do not wish to, or cannot, remain in the community, but do not yet need the skilled level of care provided by a nursing home.
 - a. A typical assisted living facility will provide for custodial care in an apartment-like setting, providing three meals a day, and supportive assistance. However, assisted living facilities are generally not licensed to provide medical care.
 - b. While this is a good option for some, it should be noted that there are restrictions and requirements imposed on residents in an assisted living facility that do not apply to other

⁶ HHS, Who Will Provide Your Care? <https://longtermcare.acl.gov/the-basics/who-will-provide-your-care.html>.

⁷ NCEA, National Center on Elder Abuse, <https://ncea.acl.gov/whatwedo/research/statistics.html>.

settings. For example, many assisted living facilities have age and financial requirements for admission. In addition, as a provider of purely custodial care, there are no federal regulations governing these facilities, although many states have their own laws, regulations and licensing standards.

2. A signed admissions agreement is typically required prior to admission. This is a contract between the facility and the resident.
 - a. The agreement is often non-negotiable. However, be wary of provisions regarding personal guarantors. If a family member is signing on behalf of a resident who cannot sign on his own, the signor should sign “as agent” or “as representative” to avoid being personally responsible for the costs of the facility.
 - b. Additionally, assisted living admissions agreements typically contain a binding arbitration provision. Many such provisions are not consumer-friendly and families often feel pressured to sign the agreement because their loved one needs care.
3. Most assisted living facilities require private payment for services, and even those that accept Medicaid as payment often require that a resident prove that he has sufficient assets to cover a minimum period of time before having to rely on government benefits. Even where the resident is eligible for government benefits, the resident will sometimes remain private pay until the facility has a Medicaid bed available.
 - a. The cost of an assisted living facility can range from \$4,000 to more than \$10,000 a month depending on location, quality of care provided, and degree of luxury.
 - b. The cost could also be higher if private duty nurses are needed to supplement care provided due to the resident’s deteriorating condition.
 - c. In addition to the typical costs, add-ons to the daily rate for services such as keeping track of prescription refills, accompanying residents to doctor appointments, etc. are common.
 - d. Some of the costs of an assisted living facility may be deductible for income tax purposes as a medical expense, subject to the limitations of Section 213 of the Internal Revenue Code (the “IRC”). For this purpose, it is important to obtain a statement from the facility setting forth what portion of the cost is related to medical needs.
4. Notice requirements to vacate the facility vary widely but most provide for 30-days’ notice.
 - a. A resident can be discharged for failure to timely pay for services rendered.
 - b. A resident may also be discharged if his level of care needs exceeds that which can safely and appropriately be provided at the assisted living facility.

C. Nursing home.

1. Skilled nursing facilities participating in the Medicare and Medicaid programs must meet certain requirements outlined in the Nursing Home Reform Act of 1987 (the “Nursing Home Reform Act”) and the attendant federal regulations⁸. As such, residents of nursing homes have far more recourse in dealing with the facility than residents at other types of facilities, such as assisted living facilities, where their rights are typically governed by contract and/or state law.
2. The nursing home cannot require or request a third party guarantee of payment to the facility as a condition of admission or continued stay in the facility. However, the facility may require a resident representative, who has legal access to the resident’s income and resources available to pay for nursing home care, to sign a contract, without incurring personal liability, to provide financial payment from the resident’s income and resources. The person who has legal access to

⁸ 42 C.F.R. § 483

the resident's funds is often referred to as a "responsible party." Many nursing home admissions agreements attempt to impose additional liability on the responsible party above that which is permitted under the Nursing Home Reform Act. Nursing home admissions agreements must be reviewed carefully, especially the provisions relating to the definition of a responsible party and the obligations and responsibilities of that person.

3. A nursing home may not require a security deposit, as a condition of admission, from an individual who is being admitted to the facility for skilled nursing care after a qualifying hospital where the individual is eligible for Medicare coverage for a portion of his stay in the nursing home. If the prospective resident does not have a qualifying hospital stay (discussed below) prior to admission to the nursing home, then there is no Medicare coverage available for the nursing home stay. In these cases, the facility is permitted to require a security deposit and often requires payment in advance for the first month's charges as well as a two-month security deposit.
4. Mandatory pre-dispute arbitration provisions are common in nursing home admission agreements. The Centers for Medicare and Medicaid Services ("CMS"), a federal agency within HHS responsible for administering the Medicare and Medicaid programs, had announced on September 28, 2016 that, as of November 28, 2016, mandatory pre-dispute arbitration provisions were no longer permitted. However, on November 7, 2016 the United States District Court for the Northern District of Mississippi, Oxford Division, issued an order preliminarily enjoining CMS from enforcing the arbitration ban.⁹ On December 9, 2016, CMS announced that it would no longer enforce the ban. On June 8, 2017, CMS issued a proposed rule which would remove the provisions prohibiting binding pre-dispute arbitration and strengthen requirements regarding transparency of arbitration provisions in nursing home admission agreements.

D. Continuing care retirement community.

1. CCRCs offer the entire residential continuum, from independent housing, to assisted living, to nursing home care.
2. For many seniors, there is nothing more important than living out their final years with the highest quality of life possible. Thus, a CCRC offers the ability to age in place and is very attractive to an individual who wants to remain in familiar surroundings for the remainder of his life, but does not have the support system to facilitate long-term care at home.
3. For married couples, admission to a CCRC can aid in ensuring that they are not separated as a result of their differing care needs. Spouses at varying care levels can remain near one another while receiving the appropriate level of care.
4. The foregoing benefits, however, come at a price. CCRCs can be very expensive. Typically, there is an entrance fee, which can range from over one hundred thousand (\$100,000) dollars to more than one million (\$1,000,000) dollars. The disposition of the entrance fee money when the resident dies or moves is a major issue to be addressed when reviewing the residency agreement. Depending on the CCRC, all or a portion of the fee may be refundable. Sometimes the amount of the refundable portion is a function of how long the person has resided in the CCRC.
5. In addition to the entrance fee, the CCRC will require a monthly fee of several thousand dollars. The amount of the monthly fee varies based on, among other things, the level of care provided and the geographic area of the facility.
6. The financial health of the CCRC (and possibly a parent company) must be examined. In 2003, the Continuing Care Accreditation Commission (CCAC) merged with the Commission on Accreditation of Rehabilitation Facilities (CARF) to form CCAC-CARF. CCAC-CARF sets forth accreditation standards for CCRCs in the United States. Not all CCRCs are accredited, but that does not mean that their financial health is not sound. Conversely, CCAC-CARF accreditation is not a guarantee of the entity's financial solvency. Prospective residents and their counsel (and

⁹ *Am. Health Care Ass'n v. Burwell*, 3:16-CV-00233, 217 F.Supp.3d 921, 2016 WL 6585295 (N.D. Miss. Nov. 7, 2016).

accountant) should perform their own due diligence, especially if the CCRC has a substantial amount of debt.

7. A portion of the monthly service fees and the non-refundable entrance fee may be deductible as a medical expense, subject to the limitations set forth in Section 213 of the IRC.

IV. Planning and paying for long-term care.

A. Private Pay.

1. As discussed above, long-term care is expensive. If paying privately using their own funds, individuals should maximize the available income tax benefits, if any.
2. Long-term care expenses, together with all other unreimbursed medical expenses, must exceed 10% of an individual's adjusted gross income in order to be claimed as an itemized deduction for federal income tax purposes.
3. The definition of medical expenses includes the cost of long-term care if a doctor has determined that the individual is "chronically ill." A "chronically ill" individual is someone who needs help with the activities of daily living, such as eating, toileting, transferring, bathing, dressing or continence.

B. Medicare.

1. Overview.

- a. Medicare is a federally-funded health insurance program administered by CMS and designed to provide basic medical care to people age 65 and older and individuals receiving Social Security Disability (after an applicable waiting period) or certain other individuals with other specific illnesses.
- b. Medicare coverage is limited in many respects and there are numerous deductibles and co-payments required.
- c. Medicare does not have any income requirements for eligibility, but an individual's income does determine his monthly premium amount. Individuals with annual income over \$85,000 pay an increased monthly premium for Part B.
- d. Medicare is a secondary payer; thus, if an individual is employed and covered by his employer's health insurance, that insurance must provide coverage before Medicare will pay.

2. Enrollment.

- a. There is a seven-month period to enroll in Medicare. The enrollment period begins three months before an individual's 65th birthday, includes the month he turns 65, and ends three months after his 65th birthday.
- b. If the seven-month enrollment period is missed, an individual may enroll in Medicare during the general enrollment period, beginning on January 1 and ending on March 31.
 - (1) If this occurs, coverage does not begin until July 1.
 - (2) There is a late penalty fee for individuals who do not enroll within the seven-month period.
 - (a) The penalty is 10% of the monthly premium for every 12-month period when the individual was eligible for Medicare but didn't enroll. This comes as a surprise to many. There is a bill pending in Congress

that would require notification to individuals as they approach Medicare eligibility of the imposition of a late enrollment penalty for failure to timely enroll.¹⁰

- (b) This penalty is permanent and must be paid for as long as the person has Medicare. The goal is to try to prevent people from signing up for Medicare only when they think they will need it.
- (c) Individuals who are actively working and who receive certain employer benefits past age 65, do not have to pay a late penalty fee. For these individuals there is a special 8-month enrollment period beginning on the first day after the employer health coverage ends.

3. Part A.

- a. Covers inpatient hospital stays, hospice, and limited skilled nursing and home health care costs.
- b. Individuals (and their spouses) who have worked for 10 years or more and paid at least 40 quarters of Medicare taxes will receive Part A at no charge. Otherwise, the monthly premiums can be as much as \$413.¹¹
- c. Part A has a hospital deductible of \$1,316 for each benefit period.
- d. After the individual meets the deductible, the co-insurance amount is:
 - (1) \$0 for the first 60 days;
 - (2) \$329 per day for days 61 through 90, and then
 - (3) \$658 per each “lifetime reserve day” starting with day 91 (up to 60 days over the person’s lifetime).
 - (4) Individuals are responsible for all costs beyond the lifetime reserve days.
- e. Skilled nursing home coverage under Part A is limited. Medicare will cover up to 100 days per benefit period in a nursing home, provided that the individual had a “qualifying” 3-day hospital stay in the 30-day period prior to being admitted to the nursing home. A benefit period begins upon hospitalization and ends when the recipient has not received any hospital care or skilled nursing care for at least 60 days. Provided the individual is receiving “skilled nursing care” and not “custodial care,” the first 20 days are covered in full and days 21-100 have a co-insurance amount of \$164.50 per day. After 100 days, there is no Part A coverage unless a new benefit period commences.
 - (1) Although Part A provides for up to 100 days of skilled nursing coverage, in many cases, the individual actually receives less than that amount of coverage. Often, the individual is denied coverage because his condition is no longer improving and the care is no longer medically necessary. This so called “improvement standard” appears nowhere in federal law or regulations.
 - (2) As a result of a class action lawsuit,¹² a settlement agreement was reached which clarified that Medicare coverage is available so long as the individual

¹⁰ H.R.2575 - BENES Act of 2017 115th Congress (2017-2018), <https://www.congress.gov/bill/115th-congress/house-bill/2575>.

¹¹ Many of the Medicare and Medicaid co-payment, deductible amounts, limitations, etc. change annually. For purposes of this outline, 2017 numbers are used.

¹² *Jimmo v Sebelius*, No. 5:11-cv-17, 2011 U.S. Dist. LEXIS 123743 (D. Vt. Oct. 25, 2011).

needs the skilled care in order to maintain function or to prevent decline or deterioration. Thus, the proper standard is one of “maintenance” and not “improvement.”

- f. The 3-day hospital stay requirement has also been the subject of litigation.
- (1) A patient in a hospital is eligible for Medicare coverage for a nursing home stay only if he has a qualifying hospital admission, which does not include days on which the patient was physically receiving care in the hospital, but was not formally admitted. In these cases the patient is not eligible for nursing home services covered by Medicare since he was not “admitted” to the hospital but was merely on “observation status.” Thus, it is possible to be hospitalized but not be “admitted” to the hospital. In this scenario, there is no nursing home Medicare coverage regardless of the length of stay in the hospital. This often comes as a surprise to individuals when presented with a large nursing home bill that they thought was covered by Medicare. Medicare does not allow individuals to appeal this issue.
 - (2) On August 6, 2015, the Notice of Observation Treatment and Implication for Care Eligibility Act (the “Notice Act”)¹³ was enacted.
 - (a) The Notice Act requires that a hospital provide a patient with written and oral notice, within 36 hours that they are receiving care on an “observation” or other “out-patient” status for more than 24 hours. The notice must explain why the patient has not been formally admitted and must explain the benefits eligibility implications for the patient.
 - (b) CMS developed and implemented the Medicare Outpatient Observation Notice (“MOON”) to fulfill the above requirement, and its use was mandated by CMS as of March 8, 2017. Some states had previously enacted their own state observation status notice laws.
 - (c) A class action lawsuit has been commenced on behalf of Medicare beneficiaries who have received “observation services” as an outpatient during a hospitalization.¹⁴ The plaintiffs in the case are seeking the right to administrative review of the decision to treat their hospital stay as “observation” rather than “inpatient.”
4. Part B.
- a. Covers doctor visits, outpatient procedures, diagnostic tests, medical supplies, vaccines, and certain screenings.
 - b. Part B monthly premium is \$134.
 - (1) Those who receive Social Security benefits via direct deposit pay \$109 per month.
 - (2) Individuals with income above \$85,000 per year pay up to \$428.60 (based on a sliding scale) in monthly premiums.
 - c. The Part B deductible is \$183 per year. After meeting the deductible, the individual is responsible for 20% of the Medicare-approved amount for most doctor services, durable medical equipment, and outpatient therapy.

¹³ Public Law 114 - 42 – “Notice of Observation Treatment and Implication for Care Eligibility Act” or the “NOTICE Act” <https://www.gpo.gov/fdsys/pkg/PLAW-114publ42/content-detail.html>.

¹⁴ *Alexander v. Price*, No. 3:11-cv-1703 (MPS), 2017 U.S. Dist. LEXIS 119517 (D. Conn. July 31, 2017).

5. Part C.
 - a. Medicare Advantage plans.
 - b. Offered through Medicare-approved private health insurance plans for individuals enrolled in Medicare Parts A and B. Benefits are received through the Medicare Advantage plan instead of original Medicare.
 - c. Medicare Advantage plans provide all of the Part A and Part B benefits, as well as certain other additional benefits such as vision, dental and hearing.
 6. Part D.
 - a. Prescription drug coverage.
 - b. Offered by insurance companies.
 - c. Each plan has a list of generic and name brand drugs covered. Each drug is assigned to a tier. The tier determines the cost of the drug paid by the individual.
 7. Medicare supplemental insurance (Medigap).
 - a. Supplemental health insurance sold by private insurance companies to cover co-payments, co-insurance, and deductibles. To participate, individuals must be enrolled in Medicare Parts A and B and pay the monthly premium for Part B as well as the Medigap monthly premium.
 - b. Individuals enrolled in Medicare Part C cannot purchase a Medigap policy.
 - c. Some Medigap policies cover the skilled nursing care co-insurance amounts for days 21 through 100. Otherwise, Medigap policies do not cover long-term care.
- C. Medicaid.
1. Overview.
 - a. The Medicaid program, enacted by Congress as Title 19 of the Social Security Act of 1965, provides medical care to the indigent and disabled. Medicaid is the payer of last resort. The federal government provides the guidelines for the program and partial funding to the states. Federal, state and local governments share responsibility for administering Medicaid. At the federal level, CMS promulgates regulations and oversees the program to ensure that states comply with the federal guidelines.
 - b. The sources of law at the federal level include statutory provisions located at title 42 of the U.S.C. and regulations found at title 42 of the C.F.R.
 - c. Each state has its own policies and interpretations of the federal rules and thus the Medicaid programs and benefits available often vary from state to state. Although many of the programs differ, at a basic level the programs each provide a broad range of services to recipients.
 - d. The Medicaid program is a third-party payer system, meaning that recipients of Medicaid submit the bill for services provided to the state for payment. As such, Medicaid recipients are free to choose any Medicaid-approved medical facility/provider for their care.
 - e. The Affordable Care Act created a new category of Medicaid called Modified Adjusted Gross Income ("MAGI") Medicaid, for which eligibility is determined based on an

income formula alone. MAGI Medicaid does not generally cover long-term care and thus will not be addressed in this outline, which will focus on traditional or “Non-MAGI” Medicaid for which eligibility is based on financial and medical need.

2. Medicaid eligibility.

- a. Medicaid may be authorized for individuals who are over the age of 65 or those who are certified blind or disabled. In some states, individuals who receive Supplemental Security Income (SSI) from the Social Security Administration automatically qualify for Medicaid.
- b. With certain exceptions for emergency medical treatment, an individual must be a United States citizen, permanent resident, or a qualified alien in order to receive Medicaid.
- c. Medicaid is a means-tested program with restrictions on income and resources established by the state. There are Federal minimum standards for coverage and eligibility, but a state is allowed some flexibility to set its own standards within federal guidelines.
- d. There are separate eligibility rules for single individuals and married couples, as well as for care at home as opposed to a nursing home.
- e. Income and Resource limits.

(1) Income.

(a) Spend-down state v. income-cap state.

- 1. In income-cap states, to be eligible for Medicaid, the applicant’s monthly income cannot exceed \$2,205. The income cap states are Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Nevada, New Mexico, New Jersey, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, and Wyoming. If a person lives in an income-cap state, he will not be eligible for Medicaid unless his excess income is paid into a “Qualified Income Trust.”¹⁵
- 2. In income spend-down states, if a person has income in excess of the monthly allowable amount but has medical bills that are greater than the excess, Medicaid will pay the difference up to the Medicaid rate. If the Medicaid recipient is a resident of a nursing home, all of his income must be spent on the cost of his care except for a modest amount (approximately \$50, depending on the state), which will be deposited into a personal incidental account at the nursing facility.

(2) Resources.

- (a) A Medicaid recipient is entitled to have no more than \$2,000 to \$14,850 in non-exempt resources (depending on the state). In addition, the individual may retain certain exempt assets and may prepay funeral expenses, provided that such funds are placed into an irrevocable pre-paid funeral trust.

¹⁵ 42 U.S.C. § 1396p(d)(4)(B).

1. If an individual has more than the allowable resource amount, the excess must either be spent down on the cost of his care or transferred to someone else. If the assets are transferred, certain penalty period rules may apply.
 - (b) An individual's entrance fee paid to a CCRC is considered a resource available to the individual to the extent that he has the ability to use the entrance fee to pay for care, if necessary; the amount is refundable to the individual or his estate upon the individual no longer residing in the CCRC; and the entrance fee does not confer an ownership interest in the CCRC.¹⁶
3. Transfers of assets.
- a. The look-back period is the 60-month period prior to the time that the individual applies for Medicaid benefits.
 - b. Penalty period.
 - (1) All non-exempt transfers of assets made by an individual or his spouse for less than fair market value (FMV) during the look-back period will generally make the individual ineligible for Medicaid for a certain period of time (the "penalty period"). Some states do not penalize asset transfers when applying for certain types of non-institutional Medicaid, such as community or home-care Medicaid.
 - (2) With respect to an institutionalized individual, the penalty period is equal to the total, cumulative, uncompensated value of all assets transferred by the individual (or spouse) during the look-back period divided by the average monthly cost ("regional rate") to a private patient of nursing facility services in the state (or the community where the individual is institutionalized). For example, a transfer of \$400,000 where the average nursing home cost in the state is \$10,000, would result in a penalty period of forty (40) months. The penalty period for nursing home care following a transfer can be unlimited, and in certain cases the individual should not apply prior to the expiration of the 60 month look-back period. The penalty period generally does not commence until the individual is institutionalized, has applied for Medicaid and is otherwise eligible for benefits.¹⁷
 - (3) When either spouse makes a transfer that results in a penalty period for the institutionalized spouse, some states apportion the penalty period equally between the spouses if the community spouse subsequently enters a nursing facility. If one spouse is no longer subject to a penalty (e.g., the spouse dies), the remaining penalty period for both spouses may be applied to the surviving spouse.
 - (4) When a transfer is made during an existing penalty period, a new penalty period cannot begin until the existing penalty period has ended. For multiple transfers made during the look-back period, in which assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, the penalty period is calculated by adding together the uncompensated value of all assets transferred, and dividing by the applicable Medicaid regional rate. When a penalty period ends at any time during a month and a subsequent transfer occurs at any time during that same month, the subsequent transfer is

¹⁶ 42 U.S.C. § 1396p(g).

¹⁷ 42 U.S.C. § 1396p(c)(1)(E).

considered to have occurred in an overlapping penalty period and would be treated as a multiple transfer.¹⁸

- (5) For purposes of the transfer of asset rules, assets include all income and resources of the individual and his spouse, including those which the individual is entitled to or would have been entitled to if action had not been taken to avoid receiving the assets, such as:¹⁹
- (a) Irrevocably waiving pension income;
 - (b) Waiving the right to receive an inheritance or refusing to assert one's right of election against an inheritance;
 - (c) Not accepting or accessing injury settlements, although individuals are not required to initiate personal injury litigation;
 - (d) Settling a tort (personal injury) action so as to have the defendant place settlement funds directly into a trust or similar device to be held for the benefit of the individual;²⁰ or
 - (e) Refusing to take action to obtain a court-ordered payment that is not being paid, such as child support or alimony.

c. Life estates.

- (1) When an individual transfers a remainder interest in property and reserves a life estate, a transfer of assets for less than FMV occurs. In order to compute the penalty period, the value of the remainder interest must be calculated. To do this, the value of the life estate is determined using the Medicaid life expectancy tables and this value is subtracted from the overall value of the property to determine the value of the remainder interest.²¹
- (2) Generally, a life estate is not considered a countable resource, and no lien may be placed on the life estate. States generally do not require an individual possessing a life estate to try to liquidate the life estate interest or to rent the life estate property. Some states, however, have attempted to expand their estate recovery efforts to include life estates. If the holder of a life estate transfers the life estate during the look-back period, it must be determined if FMV was received for the life estate. If fair market value was not received, a transfer penalty is imposed.
- (3) If an individual possessing a life estate rents the life estate property, any net rental income received is counted in determining eligibility. If under the terms of the life estate, the life estate holder must pay taxes and maintenance, then these costs should be deducted from the rental income.
- (4) The purchase of a life estate interest in another individual's home using the values in the Medicaid life expectancy tables is not considered a transfer of assets for less than fair market value so long as the purchaser lives in the other person's home for a period of at least one year after the date of the purchase.

¹⁸ 42 U.S.C. § 1396p(c)(1)(H).

¹⁹ CMS Transmittal No. 64 § 3257.

²⁰ This action is distinguished from the individual contributing the lawsuit proceeds to a first party special needs trust pursuant to 42 U.S.C. § 1396p(d)(4)(A).

²¹ CMS Transmittal No. 64 § 3258.9(A).

d. Joint accounts.

- (1) In the case of an asset held by an individual with another person(s) in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of the asset) is considered to be transferred by the individual when any action is taken either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.²²
- (2) Adding another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. The individual may still possess ownership rights to the account or asset and have the right to withdraw all of the funds in the account at any time. However, actual withdrawal of funds from the account, or removal of the asset, by the other person would remove the funds or property from the control of the individual and would constitute a transfer of assets. If placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset, where no such agreement was necessary before), such placement would constitute a transfer of assets.²³

e. Exceptions to application of the penalty period rules.

- (1) Certain transfers are exempt from the penalty period provisions, even if made for less than FMV.²⁴
 - (a) The asset transferred is the individual's home and title to the home is transferred to:
 1. The spouse of the individual;
 2. A child of the individual who is under age 21;
 3. A child who is blind or permanently and totally disabled;
 4. The sibling of the individual who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately before the date the individual becomes institutionalized; or
 5. A son or daughter of the individual (other than a child described above) who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who (as determined by the state) provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.
 - (b) The asset, other than the individual's home, is transferred:
 1. To the individual's spouse.²⁵

²² 42 U.S.C. § 1396p(c)(3).

²³ CMS Transmittal No. 64 § 3258.7.

²⁴ 42 U.S.C. § 1396p(c)(2).

²⁵ It should be noted, that while transfers made from the institutionalized spouse to the community spouse are unlimited prior to a determination of eligibility for Medicaid, transfers made after Medicaid is approved are typically limited to the CSRA as per 42 U.S.C. § 1396r-5(f)(1). Further, the determination of eligibility referenced therein has been held to apply only to the first determination of eligibility. In a case where a Medicaid recipient lost Medicaid coverage after receiving additional

2. From the individual's spouse, or to another for the sole benefit of the individual's spouse;²⁶
 3. To the individual's child, or to a trust established solely for the benefit of the individual's child who is blind or permanently and totally disabled; or
 4. To a trust established for the sole benefit of an individual under 65 years of age who is disabled.
- (c) The individual intended to dispose of the assets at FMV or for other valuable consideration. Written evidence of attempts to dispose of the asset for FMV, as well as evidence to support the value (if any) at which the asset was disposed must be provided.²⁷
- (d) The assets were transferred exclusively for a purpose other than to qualify for Medicaid.²⁸ Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for Medicaid include, but are not limited to: the unexpected onset of a serious medical condition subsequent to the transfer; the unexpected loss, subsequent to the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or the existence of a court order specifically requiring the transfer of a certain amount of assets. Estate planning gifts (i.e., gifts up the annual exclusion amount) are often done for purposes other than Medicaid planning. A prior history establishing a pattern of such gifts is often helpful in showing that the gifts were made for a purpose other than to qualify for Medicaid.
- (e) All or part of the assets transferred for less than FMV have been returned to the individual.²⁹
1. If all transferred assets are returned to the individual prior to the Medicaid eligibility determination, no transfer penalty is imposed. If a portion of the transferred assets is returned prior to the Medicaid eligibility determination, the uncompensated value of the transfer is generally reduced by the amount of assets returned.
 2. If all transferred assets are returned after the Medicaid eligibility determination, the existing penalty period is rescinded and the individual's eligibility for Medicaid during such period must be re-determined as though the assets were never transferred. If a portion of the transferred assets is returned after the Medicaid eligibility determination, the existing penalty period is recalculated, reducing the uncompensated value of the transfer(s) by the amount of assets returned; if the recalculated penalty period has already elapsed, the individual's eligibility for Medicaid subsequent

resources from a lawsuit, the Court held that spousal transfers were restricted to the CSRA. *Fagan v Bremby*, 2017 U.S. Dist. LEXIS 41117 [D. Conn. Mar. 21, 2017, No. 3:16cv73 (JBA)].

²⁶ The above has also been held true for post-eligibility transfers made by the spouse to another for the spouse's sole benefit. *Hegadorn v Dept. of Human Servs. Director*, 2017 Mich. App. LEXIS 892 [Ct. App. June 1, 2017, Nos. 329508, 329511, 331242].)

²⁷ CMS Transmittal No. 64 § 3258.10 (C) (1).

²⁸ 42 U.S.C. § 1396p(c)(2)(C)(ii).

²⁹ 42 U.S.C. § 1396p(c)(2)(C)(iii).

to the penalty period must be re-determined as though the returned assets were never transferred.

3. For purposes of these rules, assets transferred by an individual are considered to be returned if the person to whom they were transferred uses them to pay for nursing facility services for the individual or provides the individual with an equivalent amount of cash or other liquid assets.
- (2) Imposition of a penalty period and denial of Medicaid eligibility would work an undue hardship. Undue hardship exists when:³⁰
 - (a) The individual applying for nursing facility services is otherwise eligible for Medicaid;
 - (b) Despite his best efforts, as determined by the state, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive FMV; and
 - (c) The individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered. Undue hardship does not exist when the application of the penalty period provisions merely causes the individual inconvenience.
 - (d) States have considerable flexibility in deciding the circumstances under which the undue hardship provisions will be applied.
4. Exempt assets.
 - a. Retirement accounts.
 - (1) In some states, a Medicaid applicant's retirement account can be an exempt resource so long as the account is in "payout status." An account is deemed to be in payout status if the applicant is receiving distributions from the retirement account. In these states, the amount distributed is considered income and the corpus of the retirement account is not considered a disqualifying resource for Medicaid eligibility purposes.
 - b. Annuities.
 - (1) Under certain circumstances, an annuity can be an exempt asset for Medicaid eligibility purposes. By purchasing an annuity, the individual converts an otherwise non-exempt resource into an income stream. Subject to certain exceptions, the purchase of the annuity will be considered a transfer of assets for less than FMV unless the state is named as the remainder beneficiary for at least the total amount of Medicaid benefits paid on behalf of the individual.
 - (2) For purposes of calculating an individual's eligibility for Medicaid, his non-exempt assets will include an annuity unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for equal payments during the term of the annuity, with no deferral or balloon payments.³¹
 - c. Promissory note.
 - (1) Similar to annuities, promissory notes are also sometimes treated as exempt assets for Medicaid eligibility purposes. Purchasing a promissory note or

³⁰ 42 U.S.C. § 1396p(c)(2)(D) and CMS Transmittal No. 64 § 3258.10(C)(4) and (5).

³¹ 42 U.S.C. § 1396p(c)(1)(G).

lending resources to another person may convert an otherwise non-exempt resource into an income stream.

- (2) In order to be considered an exempt resource, the promissory note must have a repayment term that is actuarially sound, have a reasonable interest rate, provide for payments in equal amounts during the term of the loan, with no deferral or balloon payments made and prohibit the cancellation of the balance upon the death of the lender. Thus, if the individual dies prior to the repayment of the loan, the remaining payments must be made to his estate.
- (3) If the promissory note does not satisfy all of the foregoing requirements, then the value of the note is considered an outstanding balance due as of the date of the individual's application for Medicaid.³²

d. Residence.

- (1) Generally, the primary residence of an individual is considered an exempt resource as long as he continues to reside there, subject to a home equity cap of \$560,000 to \$840,000.³³ There are exceptions to the home equity cap if the applicant's spouse or minor, blind or disabled child resides in the home.
- (2) If the individual is in a nursing home or other facility, so long as he maintains a subjective "intent to return home" the primary residence remains exempt. However, as discussed below, this does not mean that Medicaid may not place a lien on the property. In addition, if certain individuals reside in the home, the home may also be considered exempt. Examples include a spouse, minor child, sibling with an equity interest who has resided in the home for at least one year prior to the date the individual enters a nursing home, or a son or daughter who resided in the home for a period of at least two years prior to the date the individual enters a nursing home and who provided care to the individual that allowed him to remain at home rather than go into a nursing home.

- e. The individual and spouse (if any) may prepay funeral arrangements, provided that such funds are placed into an irrevocable pre-paid funeral trust.

5. Trusts.

a. Revocable trust.

- (1) In the case of a revocable trust, the corpus of the trust and all payments made from the trust to or for the benefit of the individual are considered available assets for Medicaid eligibility purposes.³⁴
 - (a) Any other payments from the trust are considered assets transferred by the individual for less than FMV and subject to the transfer of asset penalty period rules.³⁵

b. Irrevocable trust.

- (1) In the case of an irrevocable trust, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of the individual is considered to be an asset transferred for

³² 42 U.S.C. § 1396p(c)(1)(I).

³³ 42 U.S.C. § 1396p(f).

³⁴ 42 U.S.C. § 1396p(d)(3)(A)(i) and (ii).

³⁵ 42 U.S.C. § 1396p(d)(3)(A)(iii).

less than FMV for purposes of the transfer of asset penalty period rules.³⁶

- (2) Payments made from the trust to or for the benefit of the individual are considered income to the individual.³⁷
- (3) Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the individual, is considered an available resource. If the language of the trust specifies that money can be made available for a specific event, that amount shall be considered an available resource, whether or not that event has occurred.³⁸
- (4) Payments which are made from trust assets considered available to the applicant and which are not made to or for the benefit of the applicant are considered to be assets transferred for less than FMV for purposes of the transfer of asset penalty period rules.³⁹
- (5) The foregoing trust provisions apply only to trusts which are established, other than by will;
 - (a) by the individual,
 - (b) by the individual's spouse,
 - (c) by a person, acting at the direction or request of the individual or his spouse; or
 - (d) by a court or administrative body with legal authority to act on behalf of the individual or his spouse.
- (6) States have varying interpretations as to how third party inter-vivos or testamentary trusts are treated with respect to the Medicaid eligibility of an individual who is a beneficiary of such trust. Such trusts may give the trustee complete and unfettered discretion to distribute trust assets; whereas, others limit distributions to an ascertainable standard. The key is to avoid the trust being considered a support trust, in which case the assets would be considered available for Medicaid eligibility purposes. Ideally, the trust should be drafted as a third party supplemental needs trust to provide maximum preservation of trust assets in the event a beneficiary needs long-term care. Another option is to include language in the trust which triggers supplemental needs trust provisions in the event the beneficiary needs long-term care or applies for means-tested government benefits.

c. Exception Trusts.

- (1) Exception trusts are trusts that are required to be disregarded as available income and resources for purposes of determining Medicaid eligibility.⁴⁰
- (2) The principal and accumulated income of exception trusts are disregarded in determining an individual's Medicaid eligibility. Any trust assets, however, that are actually distributed to the individual are counted as income in the month received and as a resource if retained into subsequent months.

³⁶ 42 U.S.C. § 1396p(d)(3)(B)(ii).

³⁷ 42 U.S.C. § 1396p(d)(3)(B)(i)(I).

³⁸ CMS Transmittal No. 64 § 3259.6(B).

³⁹ 42 U.S.C. § 1396p(d)(3)(B)(i)(II).

⁴⁰ CMS Transmittal No. 64 § 3259.7.

(3) Types of exception trusts.

(a) Special needs trust.⁴¹

1. A trust containing the assets of an individual under age 65 who is disabled and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian or a court.
2. Upon the death of the individual, the state will receive all amounts remaining in the trust, up to the amount of Medicaid paid on behalf of the individual. States have varying interpretations of these rules. Some states require the payback of all Medicaid costs, even those incurred prior to the establishment of the special needs trust.
3. Once the trust is created, additional funds can be added to the trust until the person reaches age 65. Any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets subject to the applicable asset transfer rules.

4. Qualified income trust.⁴²

- a. A trust established for the benefit of an individual in an “income cap” state if:
 1. Trust assets consist only of pension, Social Security, and other income; and
 2. The state receives all amounts remaining in the trust upon the death of such individual up to an amount equal to the total Medicaid paid on behalf of such individual.

5. Pooled trust.⁴³

- a. Trust containing the assets of an individual who is disabled.
- b. Trust is established and managed by a non-profit association.
- c. A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- d. Accounts in the trust are established solely for the benefit of individuals who are disabled by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.
- e. To the extent that amounts remaining in the

⁴¹ 42 U.S.C. § 1396p(d)(4)(A).

⁴² 42 U.S.C. § 1396p(d)(4)(B).

⁴³ 42 U.S.C. § 1396p(d)(4)(C).

beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust must pay to the state from such remaining amounts in the account an amount equal to the total amount of Medicaid paid on behalf of the individual.

- f. The assets of a pooled trust are be disregarded for Medicaid purposes regardless of the age of the individual when the pooled trust account is established, or when assets are added to the pooled trust account; however, some states treat a transfer of assets to a pooled trust by an individual age 65 and over as a transfer for less than FMV and subject to the Medicaid asset transfer rules.

6. Special considerations for spouses.

a. Community spouse protections.

(1) Rules regarding income.

- (a) States are given discretion to establish an income allowance for the community spouse to be adjusted every year for inflation.⁴⁴

- 1. The community spouse is allowed a MMMNA.⁴⁵ Depending on the particular state, the MMMNA ranges from \$2,030 to \$3,022.50. If the community spouse's income falls below the MMMNA, the community spouse is entitled to a portion of the institutionalized spouse's income to bring the community spouse's income up to the MMMNA amount.⁴⁶
- 2. The community spouse may be entitled to income above the MMMNA if a court has entered an order of support against the institutionalized spouse. In this case, the MMMNA will be increased up to the amount set by the court.⁴⁷
- 3. Alternatively, the community spouse may request a fair hearing to revise the MMMNA based on exceptional circumstances resulting in significant financial duress.⁴⁸

- (b) Federal law provides certain rules to determine how income is apportioned between the community spouse and the institutionalized spouse.⁴⁹

- 1. For non-trust property.
 - a. If income is paid solely in the name of the institutionalized spouse or solely in the name of the community spouse, the income is deemed available only to that particular spouse.⁵⁰ This is sometimes

⁴⁴ 42 U.S.C. § 1396r-5(d)(3).

⁴⁵ 42 U.S.C. § 1396r-5(d)(2).

⁴⁶ 42 U.S.C. § 1396r-5(d)(1)(B).

⁴⁷ 42 U.S.C. § 1396r-5(d)(5).

⁴⁸ 42 U.S.C. § 1396r-5(e)(2)(B).

⁴⁹ These rules apply except as otherwise provided in 42 U.S.C. § 1396r-5(b)(2)(A)(iii) and are applicable notwithstanding any state laws regarding community property or the division of marital property. 42 U.S.C. § 1396r-5(b)(2).

⁵⁰ 42 U.S.C. § 1396r-5(b)(2)(A)(i).

referred to as the “name on the check” rule.

- b. If income is paid in the names of the institutionalized spouse and the community spouse, one-half of the income is deemed available to each of them.⁵¹
- c. If income is paid or distributed in the names of the institutionalized spouse or the community spouse, or both, and to a third party or parties, the income is deemed available to each spouse in proportion to the spouse’s interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse).⁵²

2. For trust property.

- a. Income is deemed available to each spouse as indicated in the trust agreement.⁵³
- b. If there are no specific provisions in the trust agreement regarding allocation of income, the following rules apply:
 - 1. If income is paid solely to the institutionalized spouse or solely to the community spouse, the income shall be deemed available only to that respective spouse.⁵⁴
 - 2. If income is paid to both the institutionalized spouse and the community spouse, one-half of the income shall be deemed available to each of them.⁵⁵
 - 3. If income is paid to the institutionalized spouse or the community spouse, or both, and to a third party or parties, the income is deemed available to each spouse in proportion to the particular spouse’s interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse.⁵⁶)
- c. In the case of income not from a trust in which there is no instrument establishing ownership, there is a rebuttable presumption that one-half of the income is deemed available to the institutionalized spouse and one-half to the community spouse.⁵⁷

⁵¹ 42 U.S.C. § 1396r-5(b)(2)(A)(ii).

⁵² 42 U.S.C. § 1396r-5(b)(2)(A)(iii).

⁵³ 42 U.S.C. § 1396r-5(b)(2)(B)(ii).

⁵⁴ 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(I).

⁵⁵ 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(II).

⁵⁶ 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(III).

⁵⁷ 42 U.S.C. § 1396r-5(b)(2)(C).

(2) Rules regarding resources.

(a) Community spouse resource allowance.

1. The community spouse is entitled to a CSRA set by the state and which is adjusted annually.⁵⁸ Depending on the particular state, the maximum CSRA ranges from \$24,180 to \$120,900.
2. The computation of the CSRA commences on the first day in which the institutionalized spouse begins a period of institutionalization that is likely to last for at least 30 consecutive days.⁵⁹ The computation will be made of:
 - a. The total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest;⁶⁰ and
 - b. A spousal share that is equal to one-half of the total value of the resources.⁶¹
3. Either the institutionalized spouse or the community spouse can request, at the commencement of the period of institutionalization of the institutionalized spouse that the state conduct an assessment of the total value of the resources based upon any relevant documentation provided to the state. The state is required to indicate on the assessment that the spouse is entitled to have a fair hearing under 42 U.S.C. § 1396r-5(e)(2) and 42 U.S.C. § 1396r-5(c)(1)(B).
 - a. In attributing resources at the time of the initial Medicaid eligibility determination, all resources held by either the institutionalized spouse, community spouse, or both are deemed available to the institutionalized spouse to the extent that the value of the resources exceeds the maximum CSRA.

(b) Enhancing the CSRA.

1. 42 U.S.C. § 1396r-5(e)(2)(C) provides that if either spouse establishes that the CSRA (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the MMMNA, the CSRA is to be increased to an amount adequate to provide the MMMNA. For this purpose, all income of the institutionalized spouse that could be made available to the community spouse is considered to be available before the state will allocate to the community spouse an amount of resources adequate to provide the difference between the MMMNA and the amount of income available to the

⁵⁸ 42 U.S.C. § 1396r-5(f)(2)(A).

⁵⁹ 42 U.S.C. § 1396r-5(c)(1).

⁶⁰ 42 U.S.C. § 1396r-5(c)(1)(A)(i).

⁶¹ 42 U.S.C. § 1396r-5(c)(1)(A)(ii).

community spouse. This is known as the “income-first” rule.

- a. Depending upon the amount of income of the spouses, this provision may translate into significant increases of the CSRA.
- b. If the spousal share is deemed insufficient to raise the community spouse’s income to the MMMNA, the community spouse may request a fair hearing⁶² or seek a court order⁶³ aimed at obtaining a greater share of the institutionalized spouse’s resources.

7. Liens and estate recovery.

a. Liens.

- (1) States may not impose a lien on a Medicaid recipient’s property prior to death based on the individual’s receipt of Medicaid institutional benefits except under the following circumstances:⁶⁴
 - (a) When a court has found that an individual has incorrectly received Medicaid benefits, the state may place a lien on any real or personal property of the individual;⁶⁵
 - (b) When an individual has correctly received Medicaid benefits, the state may place a lien on the person’s real property⁶⁶ after notice and an opportunity for a hearing.
 1. A lien may only be placed if the individual cannot reasonably be expected to be discharged from the facility and return home.⁶⁷
 2. No lien may be imposed on an individual’s home if any of the following individuals lawfully reside in the home: (a) a spouse; (b) a child who is under age 21, blind, or disabled; or (c) a sibling who has an equity interest in the home and has been legally residing there for at least a year immediately before the person’s admission to the nursing home.⁶⁸
 3. Any lien imposed is dissolved upon the individual’s discharge from the nursing home and his return home.⁶⁹

b. Estate recovery.

- (1) States are mandated by federal law to have an estate recovery program. No adjustment or recovery of Medicaid correctly paid may be made, except that

⁶² 42 U.S.C. § 1396r-5(e)(2)(C).

⁶³ 42 U.S.C. § 1396r-5(f)(3).

⁶⁴ 42 U.S.C. § 1396p(a)(1).

⁶⁵ 42 U.S.C. § 1396p(a)(1)(A).

⁶⁶ 42 U.S.C. § 1396p(a)(1)(B)(i); 42 C.F.R. § 433.36(g)(2).

⁶⁷ 42 U.S.C. § 1396p(a)(1)(B)(ii); 42 C.F.R. § 433.36(d).

⁶⁸ 42 U.S.C. § 1396p(a)(2)(A)-(C); 42 C.F.R. §.433.36(g)(3)(i)-(iii).

⁶⁹ Congress wanted to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance the government’s legitimate desire to recover its Medicaid costs against the individual’s need to have the home available in the event discharge from the institution becomes feasible. *P.L. 97-248, 97th Congress, 2d Sess. (1982), reprinted in 1982 U.S.C.C.A.N. 814.*

the state may seek recovery, in certain circumstances, upon sale of the property or from the individual's estate, or upon sale of property subject to a lien imposed on account of Medicaid paid to such individual.

- (a) In the case of an individual who was age 55 years or older at the time of receipt of Medicaid benefits, the state must seek recovery from the individual's estate for certain types of Medicaid, including nursing home and home care benefits.
- (b) Any recovery against an individual's estate may only be made after death of the individual's surviving spouse and only when there is no surviving child who is under age 21, blind or disabled.⁷⁰
- (c) Any recovery sought pursuant to a properly imposed lien on an individual's real property may only be made after death of the individual's surviving spouse and only when there is no surviving (a) child who is under age 21, blind or disabled; (b) sibling who resided in the home for at least one year immediately prior to the individual's admission to a nursing home; or (c) son or daughter who resided in the home for at least two years immediately prior to the individual's admission to a nursing home and who provided care to such individual which permitted him to stay at home rather than an institution, who is lawfully residing in the home and has done so on a continuous basis since the individual's admission to the nursing home.⁷¹
- (d) The term "estate" with respect to a deceased individual includes all real and personal property and other assets included within the individual's estate, as defined for purposes of state probate law.⁷²
 - 1. The term "estate" may include, at the option of the state, any other property in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.⁷³ Many states have expanded estate recovery statutes and some are more aggressive than others in their recovery efforts.
 - 2. States are required to have procedures that waive the application of the estate recovery rules if such application would work an undue hardship.
 - 3. Some states have attempted to recover against life estates by taking the position that the life estate has an actuarial value based on the age of the Medicaid recipient immediately prior to death. Moreover, at least one state has been successful in recovering against the entire value of the property upon the death of the life tenant, not just the value of the life estate the day before death.⁷⁴

⁷⁰ 42 U.S.C. § 1396p(b)(2)(A).

⁷¹ 42 U.S.C. § 1396p(b)(2)(B).

⁷² 42 U.S.C. § 1396p(b)(4)(a).

⁷³ 42 U.S.C. § 1396p(b)(4)(b).

⁷⁴ *In the Matter of Melvin Peterson*, 340 P. 3d. 1143 (Idaho 2014).

D. Long-term care insurance (“LTCI”).

1. In General.

- a. LTCI is insurance which is designed to cover the costs of long-term care. LTCI is regulated by the states. There is no federal law governing these policies.

2. Eligibility requirements.

a. Age.

- (1) In most states, an individual over age 80 is not eligible to purchase LTCI.
- (2) The age limit is due to the fact that the likelihood of needing long-term care services significantly increases after age 80.

b. Insurability.

- (1) Individuals typically must pass a physical and cognitive examination.
- (2) Some companies may carve out a “pre-existing” condition for a certain period of time and issue the policy for a higher premium.

c. Coverage limits.

- (1) Benefits are paid based on a daily benefit rate, such as \$300/day, not to exceed actual cost of daily care. Some policies allow you to “bank” the difference to be used in the future. To determine the value of total available benefits, multiply the total maximum days permitted to be paid by the daily rate. Benefits are paid only when a valid and timely claim is made.
- (2) Some policies contain inflation riders, which increase the daily benefit rate over time. There are different types of inflation riders, including simple inflation, CPI inflation, or compound inflation, among others. These policies are significantly more expensive than policies that do not contain an inflation rider.
- (3) Time limit on daily benefits.
 - (a) Most policies limit the number of insured days (years). Previously, lifetime benefit policies were readily available which did not have a cap on the number of years or days for which benefits could be paid. In the current marketplace, lifetime benefit policies have become practically non-existent.
 - (b) Policies also contain an elimination period, typically 90-120 days, which is akin to a waiting period or deductible. The elimination period must be satisfied before any benefits are paid under the policy.
- (4) Limits on the provider of care.
 - (a) Individuals need to make sure that the policy covers the type of care they are receiving and where they are receiving the care.
 - (b) Often, policies will not pay for care provided by an informal caregiver, such as a spouse or family member, even if the type of care is covered. The policy may require that care be provided by a

licensed caregiver.

(5) Limits on coverage.

- (a) Unlike Medicare and Medigap policies, LTCI does pay for custodial care, in addition to skilled nursing care.
- (b) Typically, the individual must require assistance with at least two (sometimes three) activities of daily living in order to receive benefits from the policy. A cognitive impairment (such as dementia or Alzheimer's disease) also triggers the payment of benefits under most policies.

3. Premiums.

- a. The ideal age to consider purchasing LTCI has been long-debated by many in the field. The cost of the policy is a function, among other things, of the age of the insured at the time of purchase. The younger the individual, the lower the cost. While premiums don't rise during the term of the policy simply as a result of the individual aging, insurance companies are permitted (and often do) to raise rates to certain classes of policy holders by applying to the state for a rate increase. Some policies provide that if premiums are paid for a certain number of years (as opposed for the lifetime of the insured), then the policy is in effect "paid up" and not subject to future increases once the premiums have been paid for the initial agreed-upon term. The annual premiums on these types of policies are significantly higher than traditional LTCI policies where premiums are paid for life.
- b. Some policies may offer spouses a discount and allow them to "share" the benefits between themselves.
- c. In most states, LTCI policies cost more for women than men due to their longer life expectancy and increased likelihood of filing claims.

4. Tax qualified policies.

- a. Most policies are "tax qualified" under IRC Section 7702B(b), meaning that they meet certain minimum requirements set forth by the National Association of Insurance Commissioners and are eligible, subject to certain limitations in the IRC, for certain tax benefits.
- b. IRC Section 7702B(b) requires that the individual need substantial assistance with at least two activities of daily living for a period of 90 days due to a loss of functional capacity or require supervision to protect himself from threat to his health and safety due to severe cognitive impairment.
- c. Benefits received under a qualified LTCI policy are not considered taxable income and benefits received under an indemnity policy are tax-free up to a daily cap of \$360.
- d. Premiums may be deductible under IRC section 213 for individuals who itemize their deductions. Medical expenses are deductible only to the extent they exceed 10% of the taxpayer's adjusted gross income. The deductibility of LTCI premiums are further limited annually as set forth below based on the individual's age:

(1)	Age 40 or less	\$420
(2)	More than 40 but not more than 50	\$780
(3)	More than 50 but not more than 60	\$1,560

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|-----|-----------------------------------|---------|
| (4) | More than 60 but not more than 70 | \$4,160 |
| (5) | More than 70 | \$5,200 |

5. State partnership policies.

- a. Partnership policies combine private LTCI with Medicaid. Individuals who purchase a certain amount of private insurance are eligible to qualify for their state's Medicaid program even though their assets exceed the state's Medicaid limits. In most states, the individual is allowed to exclude as exempt resources an amount of assets equivalent to the amount of insurance purchased. In other cases, there is total asset protection so long as a minimum amount of insurance is purchased. In either case, states are not permitted to seek recovery against assets excluded for Medicaid eligibility purposes pursuant to the provisions of a state's partnership plan.
- b. Partnership policies are portable among states that have chosen to participate in the program. This should allow an individual to move to another state and receive Medicaid benefits in that state even though the policy was purchased in another state.

6. Short-term care insurance.

- a. A relatively new product that provides insurance for the costs of long-term care for a shorter period of time than LTCI. Unlike LTCI, there is no gender-based pricing in short-term care insurance.
 - (1) This product could be useful to the following individuals:
 - (a) Those who were declined for LTCI, either because of age or a medical condition; or those who didn't buy LTCI because they felt it was too expensive. The underwriting process for short-term care insurance is not as arduous as it is for LTCI.
 - (b) Those who want insurance to cover the elimination period associated with LTCI policies.

V. Conclusion.

- A. With the enhanced federal (and many states') estate tax exemption, clients are increasingly concerned about non-tax issues, including how to plan and pay for long-term care.
- B. While it is never too late to plan, the options available to those who plan ahead far exceed the choices available to those who wait. Individuals who address these issues early on, will have greater control over their long-term care decisions, including where they receive care, the quality of such care, and how it is paid for.