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Long-Term Care Planning Terms

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A discussion of long-term care planning will inevitably include one or more of the following terms:

Countable Assets

Countable assets are those which are available to a Medicaid applicant and not exempt. A person's eligibility for Medicaid depends upon the amount of his or her countable assets. A single person can only have $2,000 in countable assets to be eligible for Medicaid. Depending on the circumstances, married individuals may be allowed substantially more countable assets through "spousal impoverishment protections." Certain assets, such as a person's home, are exempt from countable assets even though they may be available to the person. Other assets, such as real property listed for sale or life estate interests in property are considered to be "unavailable" to the owner, and are not countable assets for Medicaid purposes.

Divestments

A major component of long-term care planning is for the transmission of family assets to younger generations without the disqualification of the older generation for Medicaid benefits. In general, an individual cannot become qualified for Medicaid by giving away assets. To prevent individuals from qualifying for Medicaid by giving away their assets, Medicaid laws impose penalties for the divestment of assets. A "divestment" is the transfer of assets as a gift or in exchange for an insufficient amount of assets or services during the "look back period." A divestment can be made, among other ways, by making a gift of cash or property, by paying a relative too much for services rendered, by foregoing an inheritance, or by not exercising a right to an asset. The normal penalty for a divestment during the look back period is the imposition of a period of time during which the divesting individual is ineligible for certain Medicaid benefits, including nursing home care and certain home and community-based care benefits. This period of ineligibility is referred to as the "ineligibility period." Because of these divestment penalties, care must be taken to transfer or shelter assets in a manner that does not disqualify the transferor from these Medicaid benefits.

Ineligibility Period

An ineligibility period is the duration of time in which an individual is disqualified for certain Medicaid benefits because he or she made a divestment of assets within the look back period. Specifically, during an ineligibility period, the affected individual may be disqualified from Medicaid assistance for the cost of nursing home care, home health and personal care services, private duty nursing services, and certain other home and community-based services. The number of days of an "ineligibility period" is determined by dividing the value of the assets divested by the statewide average daily cost to a private pay patient in a nursing home (*e.g.*, $286.15 in 2018); the quotient is the number of days of the ineligibility

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period. For example a gift (divestment) of $20,000 may result in an ineligibility period of 70 days ($20,000/$286.15 = 69.89). Recently enacted legislation has changed the starting date of an ineligibility period from the day in which the divestment was made to the date in which the individual is eligible for and would otherwise be qualified to receive Medicaid except for the divestment. Because of this change, a divestment in year one could cause an ineligibility period to begin in year five when the affected individual is in a nursing home and without money to continue paying.

Long-Term Care Insurance

Long-term care insurance is an option for privately paying for the costs of long-term care, which includes the cost of intermediate or skilled nursing care provided at a nursing home, at an assisted living facility, or in the home. This insurance can be used to shelter other assets of the insured from the high costs of long-term care or to increase an individual's ability to receive in home care. Such insurance is often referred to as "stay at home insurance" because it can pay for care at home by a family member or an unrelated caregiver. Before benefits from a long-term care policy can be paid, the insured must suffer from at least one of the following: a medical necessity requiring long-term care services (*e.g.*, a stroke which leaves the individual partially paralyzed); cognitive impairments that necessitate supervisions (*e.g.*, Alzheimer's dementia); or an inability to perform one or more of the "activities of daily living," such as the ability to dress oneself, to feed oneself, to bathe or shower, get in and out of bed, or use the toilet without assistance. Long-term care policies normally do not cover all of the costs of long-term care. They generally cover a fixed, daily benefit rate expressed as either a fixed per-diem dollar benefit for the insured (*e.g.*, $125 a day of benefit payments available to the insured to cover the costs of long-term care) or a percentage of the incurred daily rate. Benefit payments may be increased over time if inflation protection is purchased. Long-term care policies are generally expensive, and they involve many complicated variations in coverage.

There are tax benefits to long-term care policies such as limited deductions for premiums and exemption for benefits. Because of the expense and complications of long-term care insurance, such policies should not be purchased without the assistance of a trusted professional and a review of the history of the company underwriting the policy. While the annual premiums on long-term policies may be expensive, they rarely exceed the cost of a single month in a nursing home. Statistically speaking, the potential need for a long-term care insurance benefit is 120 times more likely than automobile insurance and 600 times more likely than fire insurance. Considering the cost of long-term care, long-term care insurance may be the best investment you ever make.

Look Back Period

The look back period refers to the period of time immediately preceding an individual's application for Medicaid during which the individual's finances are examined to determine if he or she has made a "divestment." This period is currently 60 months (five years). Accordingly, individuals applying for Medicaid should be prepared to disclose gifts made within five years prior to their application for Medicaid. Therefore, elderly individuals should exercise care before making a substantial gift if they contemplate the need for institutional Medicaid benefits in the following five years.

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Medicare Eligibility

Medicare is a federally subsidized health care insurance program that pays certain costs for hospitalization and other institutionalized care, physician charges, and certain prescription drugs. Medicare, however, provides only limited coverage for long-term care costs. It covers only a portion of the costs of "skilled nursing or rehabilitation care" when certain technical requirements are met, such as a prior three-day inpatient hospital stay, and then for only a limited duration of 100 days. An individual who is 65 or older and who qualifies for social security benefits or whose spouse qualifies for social security benefits is eligible for Medicare. An individual under the age of 65 can also qualify for Medicare if he or she has received social security disability benefits for at least 25 months or if he or she suffers from certain chronic disease, such as ALS or end-stage renal disease. Unlike Medicaid, Medicare is an entitlement; it has no income or resource limitations for eligibility.

Medicaid Eligibility

Medicaid is a federal and state funded program that provides funds for, among other things, skilled and custodial nursing home care. For example, Medicaid may cover the cost of physician services, inpatient and outpatient hospital services, dental services, nursing home services, prescription drug services, mental health services, and physical therapy services. While Medicare covers only skilled care and only for a limited duration, Medicaid covers unlimited skilled care in a nursing home as well as two levels of intermediate care. Unlike Medicare, Medicaid is not an entitlement. There are very strict asset and income limitations for eligibility for Medicaid. The amount of income and assets an individual may have and still qualify depends upon the type of Medicaid coverage an individual receives and whether or not the individual receiving benefits has a spouse who is not receiving benefits. For example, a single individual seeking nursing home care can have no more than $2,000 of countable assets to qualify for Medicaid. The resource limits for married individuals are not quite so limited. Married individuals can take advantage of "spousal impoverishment" rules which permit a healthy spouse to retain certain assets.

Spousal Impoverishment Protections

In the long-term care context, spousal impoverishment protections refers to certain asset and income protections provided to a spouse remaining at home, when his or her spouse is otherwise eligible for Medicaid. Essentially, while a single person must spend his or her countable assets down to $2,000, the spousal impoverishment protections permit a spouse remaining at home to retain a significant share of the couple's marital assets, regardless of title, while allowing the other spouse to qualify for Medicaid. Specifically, in 2019, spousal impoverishment rules permit a couple with total countable assets of $247,200 or more to retain up to $123,600 of countable assets and still qualify for Medicaid; while spouses with total countable assets of between $50,001 to $100,000 may retain up to $52,000. Spousal impoverishment rules also permit an institutionalized spouse to transfer monthly income of up to $3,090, depending on the circumstances, to the spouse remaining at home. Certain technical rules must be followed in order to take advantage of these protections.

Additional Resources

- Wisconsin Department of Health Services-Medicaid Page
- Coalition of Wisconsin Aging Groups
- Center for Medicare and Medicaid Services
- National Academy of Elder Law Attorneys

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