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Long-Term Care Asset Protection Planning

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Introduction. This information outlines common long-term care asset protection planning consideration and planning techniques. It is organized in terms of commonly asked questions.

This information is intended to provide only general information and is not intended to constitute legal advice to a specific situation. You should consult with an attorney regarding your particular situation.

In this brochure, the term "applicant" is used to refer to an individual in need of long-term care or a person applying for long-term care insurance or Medicaid benefits.

What is Long-Term Care? "Long-term care" describes the care required for an applicant who, due to a disability, whether by an illness, accident, cognitive impairment (such as Alzheimer's), or old age, needs assistance performing activities of daily living. "Activities of daily living" include: eating, bathing, dressing, continence, transferring, and toileting. Long-term care services are generally necessary when an individual cannot independently perform two or more activities of daily living. Long-term care is provided by caregivers in the individual's home or through services offered by an assisted-living facility or community based residential facility or nursing home.

What is Long-Term Care Asset Protection Planning? Long-term care asset protection planning generally involves the purchase of an insurance product or the transfer of assets to shelter wealth in the event of a long-term care need. Among other things, this planning is intended either to provide an alternative source for paying for long-term care, or to accelerate the date by which an applicant qualifies for Medicaid benefits without spending down all of his or her assets on medical expenses.

Why is it Important to Plan for Long-Term Care? Proper planning for long-term care can preserve substantial family wealth in the event of a long-term care need. Long-term care is extremely expensive. For example, the median cost of an assisted living or a semi-private room in a nursing home in Milwaukee during 2018 exceeded $4,200 and $9,500 per month, respectively. Care at home is similarly expensive. Unfortunately, there is a strong likelihood that we will all eventually need some long-term care. A study conducted by the AARP concluded that the lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people age 65 and older. *See AARP. Beyond 50.2003: A Report to the Nation on Independent Living and Disability*, 2003, (11 Jan 2005). Planning is prudent to minimize the impact of these very high potential costs.

How can you Plan to Cover the Costs of Long-Term Care? Planning generally involves obtaining insurance, either private or public, to help cover the costs of long-term care. Private insurance comes in the form of life or long-term care insurance while public insurance comes through Medicaid. The general intent for purchasing private insurance is to provide a dedicated funding source for long-term care. To qualify for private insurance, an applicant must be in reasonably good health and be able to pay premiums. For those who cannot obtain private insurance, Medicaid may be available. Unlike private insurance, to qualify for Medicaid, an applicant must have an immediate need for long-term care, and have income and assets that are below certain minimum levels.

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Why can't I just rely on Medicare? Unfortunately, in many cases Medicare is not sufficient. Medicare coverage is very limited; it only pays a portion of nursing home costs. It pays the entire cost for 20 days, and a portion of the cost for the next 80 days. Thereafter, the resident must pay for all long-term care. Conversely, private insurance and Medicaid are not as limited.

Private long-term care insurance coverage can be broad. It may cover care at home as well as in an assisted living or a nursing home, and this coverage may be for a number of years. The extent of the coverage is directly related to the type of policy and the amount of premiums the applicant pays. Medicaid coverage is at least as broad as private insurance in terms of benefits and duration of coverage.

How can Private Insurance be used in Long-Term Care Asset Protection Planning? Private insurance can be used to recoup funds expended on long-term care. Such recoupment may come through traditional life insurance which restores the applicant's heirs funds expended on the applicant's long-term care. For example, the death benefit on a life insurance policy may be used to restore savings used to pay for the applicant's care; thus, preserving an inheritance for the applicant's surviving spouse and children.

This benefit can be increased in cases where the applicant has substantial funds in an IRA or 401(k). These funds can be used to pay for the applicant's cost of care, and then be replaced in whole or in part with life insurance proceeds on the applicant's life. While the withdrawal of funds from a tax deferred IRA or 401(k) account causes the applicant to realize taxable income, this income can be offset with a medical expense deduction reflecting the applicant's long-term care costs, and result in a nominal tax on such funds. The applicant's heirs may then receive life insurance proceeds without a resulting tax liability.

Recoupment may also come through long-term care insurance, which provides funds for long-term care expenses during the applicant's life. The benefits of long-term care insurance include payment for care at home, assisted living, as well as a nursing home, payment to relatives for providing care, and a death benefit. The benefits paid on certain qualified long-term care insurance policies can also increase an applicant's Medicaid asset limit by the amount of the total long-term care insurance benefit. For instance, if a single individual has a qualified long-term care policy with a total $100,000 benefit, this person's Medicaid asset limit may be increased from $2,000 to $102,000.

Long-term care insurance can be obtained through a stand-alone policy or through a hybrid life insurance product. For example, long-term care insurance is commonly offered as a rider to a life insurance policy. Under such policies, the total life insurance may be reduced by the amount of long-term care benefit provided.

The disadvantage of private insurance stems from insurability and affordability. Private insurance can only be purchased by those who have no immediate need for it, and who have the ability to pay premiums. In many cases, an applicant may be uninsurable or premiums may be cost prohibitive. The issue becomes how much private insurance may be affordable. If an applicant can only afford the premiums on an insurance policy providing a limited long-term care or death benefit, such insurance can still be beneficial to long-term care asset protection planning, especially if used in conjunction with Medicaid eligibility planning.

What is Medicaid? Medicaid is a government insurance program which covers the cost of long-term care. Expenses covered by Medicaid include nursing home and assisted living expenses, as well as limited at home care. For the elderly, Medicaid is commonly used to cover the cost of extended nursing home stays.

In some respects, Medicaid is the opposite of commercial health insurance. To qualify for commercial medical insurance, you must be healthy and able to pay expensive premiums. Conversely, to qualify for Medicaid, you must need medical assistance and have no means of paying for it. In that respect, Medicaid is a welfare program. It is available only to those who need long-term care and cannot afford to pay for it.

Even though it is a welfare program, Medicaid does not provide inferior care. Most nursing homes accept

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Medicaid, and Federal law prohibits nursing homes from providing less care to a resident because he or she receives Medicaid benefits. Accordingly, a nursing home resident should receive the same care whether he or she is privately paying or receiving Medicaid.

How is Medicaid Eligibility Determined? Medicaid eligibility depends on both financial and non-financial considerations. Specifically, the applicant must be both functionally and financial eligible. To be functionally eligible, an applicant, who is over the age of 65, must be a U.S. citizen and need assistance with certain activities of daily living, such as eating, bathing, dressing and moving about. To be financially eligible, the applicant's income and assets must be below certain levels. Finally, the date on which Medicaid eligibility begins depends upon whether the applicant made a "divestment" within the "look back period." Specifically, a penalty period may be imposed based upon "divestments" made by the applicant during the "look back period." "Divestments" are gifts, and the "look back period" is the sixty-month period preceding the filing date of a Medicaid application. A penalty period is the number of days the applicant is ineligible for full Medicaid benefits because of a divestment. If there are divestments, full eligibility begins upon the expiration of the penalty period. If there are no divestments, then full eligibility begins upon the first day of the month in which the Medicaid application is filed.

What is the Income Limit for Medicaid? The income limit depends on the applicant's cost of care. If the applicant's cost of care exceeds his or her income, then the applicant satisfies the income limit. The applicant must use his or her income towards their cost of care, and Medicaid pays the excess. For example, if an applicant has $3,000 of monthly income and the applicant is in a nursing home which costs $6,000 a month, the applicant satisfies the income limits because his or her cost of care exceeds their income. For most people, the income limit is easy to reach.

What is the Asset Limit for Medicaid? The hardest part of Medicaid eligibility is satisfying the very low asset limit. For a single applicant, the limit is $2,000 of "countable assets." For a married couple the asset limit is substantially higher because of spousal impoverishment protections afforded to a healthy spouse. To the extent the value of the applicant's countable assets exceeds the limit, the excess must be "spent down" or converted to "non-countable assets."

It is important to observe that not all assets are "countable." Specifically, countable assets do not include "unavailable assets" and "exempt assets." Unavailable assets are assets that cannot be converted to cash within thirty days. Examples of unavailable assets include property listed for sale, a life estate interest in real estate, and certain annuities and promissory notes. Exempt assets are assets specifically protected by statute. They include the value of the applicant's home, wedding ring, one car, prepaid funeral funds and assets in a qualified special needs trust. The value of unavailable and exempt assets is not counted when determining Medicaid asset eligibility.

Generally, there are two ways of reaching the minimal asset level. The first approach involves no planning, just spending down all assets on medical expenses until the minimal asset limit is reached. This option will certainly result in Medicaid eligibility, but it leaves the applicant with no funds to supplement Medicaid benefits, and it eliminates any inheritance for the applicant's heirs. The spend-down of assets to qualify for Medicaid is generally referred to as a "Medicaid spend-down."

The alternative approach is to plan for Medicaid eligibility by transferring assets prior to the "look back period"[1] or converting countable assets to exempt or unavailable assets. For example, a parent may transfer assets to a child or to an irrevocable trust prior to the look back period to avoid spending down the assets on long-term care expenses. The child or a trustee of an irrevocable trust can then retain the assets and use them to supplement the parent's Medicaid benefits so that the parent can benefit from both Medicaid and the transferred assets. The goal of this type of planning is to preserve the parent's assets in the hands of a child or a trust in order to preserve the parent's options for long-term care.

This strategy is risky because if the transfer is made within the look back period, it may be considered a divestment and result in a period of ineligibility for Medicaid. Thus, a transfer strategy should be limited to individuals who do not anticipate needing long-term care within the next sixty months. Sixty months refers to the look back period.

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Another approach is to convert countable assets to exempt or unavailable assets. Substantial wealth can be protected in this manner. For example, cash can be converted to exempt assets by making improvements to the applicant's home, paying down a mortgage, or purchasing a car. Similarly, real estate can be made an "unavailable asset" by listing it for sale. Through proper planning, an applicant can satisfy the $2,000 countable asset limit even though he or she has an expensive home, car and wedding ring. This type of planning is more appropriate to individuals seeking immediate Medicaid eligibility. For instance, an individual in a nursing home may convert countable assets consisting of cash to an exempt asset such as the homestead by spending the cash on improvements to the homestead.

Are there any Protections for the Spouse of a Medicaid Applicant? The Medicaid rules provide protections to the spouse of the Medicaid applicant who lives at home. These protections are referred to as "spousal impoverishment protections." The protected spouse is referred to as the "community spouse." These protections are intended to prevent the community spouse from being impoverished by the applicant's nursing home costs. Generally, the assets of both spouses are considered in determining whether the applicant spouse satisfies the Medicaid asset limit. Accordingly, in the absence of spousal impoverishment protections, all of the couple's combined assets would have to be spent down before one spouse could qualify for Medicaid. Fortunately, Medicaid does not impose such a hardship.

The spousal impoverishment protections generally allow the community spouse to retain substantial assets and income. For example, Medicaid exempts from the applicant's countable assets the community spouse's qualified retirement accounts and tangible personal property; it also allows the community spouse to own a home of any value. Accordingly, a community spouse may have a large IRA and live in a $1 million dollar home without disqualifying the applicant spouse for Medicaid.

Medicaid further increases the countable asset limit of a married applicant by the amount of the "community spouse's resource allowance" (the "Resource Allowance"). In 2018, the amount of the Resource Allowance is the greater of one-half of the value of the couple's combined countable assets up to $247,200 or all of the couple's combined countable assets up to a total of $50,000.[2] For example, if the value of a couple's combined assets equals $300,000, the Resource Allowance would equal $123,600, which is one-half of $247,600. The Resource Allowance would also equal $123,600, if the value of the couple's combined assets equaled $275,000, $260,000 or $250,000 because the total would exceed the maximum of one-half of $247,600.

Conversely, if a couple's combined assets equaled $220,000, $150,000, or $100,000, the Resource Allowance would be equal to one-half of the combined total, e.g., $110,000, $75,000, and $50,000, respectively. For any amount below $100,000, however, the Resource Allowance is the lesser of $50,000 or all of the couple's combined assets. For example, if the value of a couple's combined assets equaled $75,000, $40,000 or $30,000, the Resource Allowance would be equal to $50,000, $40,000 and $30,000, respectively.

Medicaid also provides income protections to the community spouse. First, the community spouse's income is not considered in determining whether the applicant spouse is income eligible, and the community spouse's income does not need to be used to pay for the long-term care expenses of the applicant spouse. For example, the community spouse does not need to expend his or her social security or pension benefits on the nursing home expenses of the applicant spouse.

Second, if the community spouse's income is below a "minimum monthly maintenance allowance," Medicaid allows some of the applicant spouse's income to be transferred to the community spouse. Essentially, the community spouse can retain enough of the applicant's income to raise the community spouse's income to an amount equal to the minimum monthly maintenance allowance. In 2018, the maximum minimum monthly maintenance allowance is $3,090; consequently a community spouse with income of only $1,000 a month may be eligible to receive up to $2,090 of the applicant's income. This is intended to allow the community spouse to remain in the community without an unnecessary hardship. The balance of the applicant's income needs to be used for his or her cost of care.

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Can assets be given away to qualify for Medicaid? A Medicaid applicant generally cannot give away assets to become eligible for Medicaid. Such gifts constitute divestments that cause an ineligibility period. Specifically, the value of all "divestments" made within the "look back period" are added together to determine a "penalty period." An understanding of this requires a definition of the key terms. A "divestment" is a gift of countable assets or income; the "look back period" is the sixty (60) month period prior to the date of the Medicaid application; and the "penalty period" is the number of days following the date of the Medicaid application during which the applicant is ineligible for Medicaid because of the divestment. The penalty period is determined by dividing the total divestments made during the look back period by the average daily cost of a nursing home. The result is the number of days of the penalty period.

A penalty period is determined through the Medicaid application process. The Medicaid application requires a list of all gifts made by the applicant within the past sixty (60) months. The value of all of these gifts is added up, and the total is divided by the average daily cost of a nursing home to determine the days of the penalty period going forward. As of July, 2018, the average daily cost of a nursing home in Wisconsin was $286.15. Accordingly, divestments of $100,000 listed on a Medicaid application filed in July, 2018 would result in a penalty period of 349.47 days. Again, this is determined by dividing $100,000 by $286.15. The penalty period begins when the Medicaid application is filed and the applicant is otherwise eligible for Medicaid. During the penalty period the applicant is ineligible for institutional Medicaid benefits. Other Medicaid benefits, however, remain available.

Not all gifts constitute divestments; certain gifts are specifically excluded from the divestment rules. These include gifts to a spouse or to a child who is disabled. Accordingly, an applicant can make gifts to support his or her spouse or disabled child without causing a penalty period. Assets transferred to a spouse, however, generally remain countable to the applicant for asset eligibility. Conversely, assets transferred to a disabled child or to a trust for a disabled child do not remain countable to the applicant for asset eligibility.

In addition, a gift of a home to a "caregiver child" does not constitute a divestment. A caregiver child is a child who lived with the applicant for at least two years before the applicant applied for Medicaid and by living with the applicant the child delayed the time in which the applicant needed to apply for Medicaid. Similarly, money paid by the Medicaid applicant to live in the home of one of his or her children does not constitute a divestment as long as the payment is reasonable and is pursuant to a written lease. In this context, the Medicaid rules provide a substantial benefit to disabled children and to children who provide long-term care to a parent.

Can Medicaid take an Applicant's Home? Medicaid does not take an applicant's home, nor does the State require a home to be transferred for Medicaid eligibility. A home can be lost, however, through an obligation to reimburse the State for Medicaid benefits. Essentially, an applicant's home may need to be sold to reimburse the State for Medicaid benefits provided to the applicant. This loss can only occur after the applicant receives Medicaid benefits and the State puts a Medicaid lien on the applicant's home to recover the cost of the benefits provided.

A Medicaid lien entitles the State to a portion of the proceeds from the sale of the home. The amount of the lien equals the amount of the benefits the applicant received from Medicaid. If the Medicaid applicant received $100,000 of Medicaid benefits, then the lien on the home would equal $100,000. If the home is sold for $200,000, then the State would receive $100,000 and the applicant or his or her heirs would receive the balance.

The State can file a lien on an applicant's home only if none of the following reside in the home: the applicant, his or her spouse, and any minor or disabled children. Similarly, a lien on the home generally cannot be foreclosed upon while the applicant is alive or the home is occupied by a spouse, minor, disabled or caregiver child. A caregiver child is a child who lived with the applicant for two years prior to his or her application for Medicaid and, by doing so, delayed the applicant's need for Medicaid.

Another method used by the State to recover the cost of Medicaid benefits is to file a claim in the probate estate of a deceased applicant. This recovery can occur only after the death of the applicant, and the amount of the

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recovery is limited to the amount expended by the State for the care of the applicant.

The State receives a substantial discount on the cost of care. Because of this discount, the cost of reimbursing the State for Medicaid benefits is normally substantially less than the cost of paying for such care in the first place. For example, the private pay rate for Milwaukee nursing homes generally exceeds $300 a day, while the Medicaid pay rate for such nursing homes may be only around $170 a day. Accordingly, even though a Medicaid applicant may have to pay the State back for Medicaid benefits, this obligation is limited to the lower amount paid by the State.

How do I plan for Medicaid Eligibility? Medicaid eligibility planning generally falls into one of two categories. The first category involves sheltering assets before long-term care is needed in order to protect the assets from a Medicaid spend down. For example, a parent can shelter assets by transferring them to an irrevocable trust or a child more than sixty months before a Medicaid application is filed. Gifts made more than sixty months before a Medicaid application do not cause a penalty period regardless of the value of the gift. Certain assets can be transferred, moreover, with minimal impact to a parent's standard of living. For instance, insurance on a parent's life can be transferred with no impact on the parent's standard of living. A parent can also transfer his or her home or other real property to children or an irrevocable trust but retain some right to continue using the property by entering into a lease to the property. A lease may allow the parent to continue living in the property while making the property an unavailable asset for Medicaid purposes.

The second category involves sheltering assets when long-term care is immediately necessary. This category is referred to as "crisis planning" because it occurs when the applicant is in a nursing home. Substantial wealth can be preserved even after the applicant is in a nursing home. For instance, countable assets can still be converted to exempt assets by making repairs to the applicant's home, purchasing a car, prepaying funeral costs, paying relatives for services rendered or transferring assets to a qualified special needs trust. Countable assets can also be converted to unavailable assets by listing real property for sale or exchanging liquid assets for a qualified annuity or a promissory note. Through such techniques, Medicaid eligibility can be obtained without spending down all assets on medical expenses.

Can Private Insurance be Helpful in Medicaid Eligibility Planning? The purchase of some private life or long-term care insurance can be a very valuable component of Medicaid eligibility planning. For example, life insurance can be used to recoup funds expended during a Medicaid spend down. The benefit of such insurance can be particularly valuable if the Medicaid spend-down involves the use of tax deferred funds, such as an IRA account, to pay for long-term care expenses. To realize this benefit, however, the life insurance should be owned by the applicant's children or an irrevocable trust because life insurance owned by an applicant is a countable asset which may need to be spent down.

Private long-term care insurance, moreover, can provide even greater benefits. First, the Medicaid asset limit can be increased by the amount of the benefit paid on a qualified long-term care insurance policy. For example, a qualified long-term care policy providing a $100,000 total benefit increases the Medicaid asset limited from $2,000 to $102,000. Second, long-term care insurance can be used to pay for an applicant's care during a penalty period. For example, a long-term care policy providing for three years of coverage could cover the costs of a penalty period imposed on a divestment of $313,334. This sum is the equivalent to three years of care at the State's current average daily pay rate which is used to calculate a penalty period.

Can a Trust be used to Protect Assets from a Medicaid Spend-Down? Various types of trusts are commonly used in estate planning. In general terms, a trust is a separate legal entity, like a corporation or a partnership, which can be used for the ownership and management of property. The person who creates and transfers assets to a trust is referred to as the "grantor" of the trust, while the person who manages the assets held in the name of the trust is referred to as the "trustee".

The typical purpose of a trust is to allow a trustee to hold assets in the name of the trust for the benefit of the trust beneficiaries. For example, a grantor may title property,

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such as a home or life insurance, in the name of a trust so that the trustee of the trust can hold and manage this property for the grantor's children following the grantor's death. Often the trustee is the grantor during the grantor's lifetime followed by one or more of the grantor's children. As a trustee, these individuals manage the assets of the trust for the benefit of the beneficiaries who are normally family members.

The most common type of trust is the "revocable" trust which is used to, among other things, transfer assets upon the death of the grantor to his or her beneficiaries without the assets needing to pass through the grantor's probate estate. A revocable trust can be changed at any time by the grantor during his or her life. Revocable trusts can provide several valuable estate planning benefits; however, they do not shelter assets from a Medicaid spend-down. Because the grantor of a revocable trust retains the right to modify the terms of the revocable trust, including the right to obtain funds from the trust, the assets of a revocable trust are considered to be "countable assets" of the grantor for Medicaid eligibility purposes. Thus, the assets of a revocable trust may need to be spent-down before the grantor can qualify for Medicaid.

However, there are certain specially-designed trusts that can be used to protect assets from a Medicaid spend-down. One such trust is an "*irrevocable trust*" into which the grantor contributes assets and retains no right to control or receive a benefit from such assets as either a trustee or beneficiary. These trusts are referred to as "irrevocable trusts" because the grantor gives up the power to modify or terminate the trust once it is established. A grantor can use an irrevocable trust to transfer assets from the grantor's ownership to the ownership of the trust; this change in ownership can remove the assets from the category of the grantor's countable assets. For example, a grantor may transfer his or her home, life insurance and/or other property to an irrevocable trust to remove this property from the category of Medicaid "countable assets" if the grantor later needs skilled care in a nursing home. Once the property is transferred to the irrevocable trust, the property is no longer owned by the grantor so it does not count for purposes of determining if the grantor is eligible for Medicaid.

Another type of trust commonly employed in Medicaid planning is a specific type of irrevocable trust commonly referred to as "supplemental needs trust" or "special needs trust". A supplemental needs trust is a trust in which the trustee holds the assets of the trust for a disabled beneficiary under an arrangement in which the trustee has broad discretion as to when and how distributions may be made for the beneficiary. Essentially, a supplemental needs trust provides the trustee with complete control over the manner in which the assets of the trust can be used for the disabled beneficiary. If the trust is set up and drafted properly, the assets will not be considered to be available to the disabled beneficiary for Medicaid purposes. This allows the disabled beneficiary to qualify for Medicaid while still being able to receive benefits from the special needs trust.

Careful drafting and proper timing is required for an irrevocable trust or a supplemental needs trust to shelter assets from a Medicaid spend-down. For example, an irrevocable trust created and funded within five years of the grantor's Medicaid Application may be considered a divestment for which a penalty period would be imposed, and a special needs trust must include certain detailed provisions in order for the trust assets to be considered unavailable to the beneficiary. The creation of these trusts requires the assistance of competent estate planning counsel.

In Closing. Unfortunately, there is a strong likelihood that we will all eventually need some long-term care. The cost of such care can be catastrophic. Fortunately, these costs can be substantially reduced by long-term care asset protection planning. For more information please contact Peter Walsh at (262) 923-8674 or pwalsh@vonbriesen.com.

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[2] The term "look back period" refers to the sixty month (60) period immediately preceding the filing of a Medicaid application. It is discussed in more detail in subsequent sections of this pamphlet.

[3] The maximum amount of the Resource Allowance is adjusted annually.

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