News You Need to Use – Michigan Medicaid in 2010

Tom Brokaw refers to my father's generation as the "Greatest Generation." They came of age during the Depression and fought World War II, went to school under the GI Bill, and raised their children under threat of thermonuclear holocaust. "Saving Private Ryan" may give you a hint of the significance of World War II for them.

2001 U.S. Family Net Worth by
Age of Head of Household

H of H	Median	Mean
55 to 64	$181,500	$727,000
65 to 74	$176,300	$673,800
75 and up	$151,400	$465,900

Although my father had excellent pension benefits from business and academic careers, nursing care costs more than $7,000 per month–more than his income. Lacking another source, he would have had to use savings to pay for nursing care.

Since most U.S. households have a net worth of less than $200,000, the cost of nursing care is potentially ruinous and should be a part of any financial plan. Assuming a $6,500 cost of care, $1,200 in retirement benefits, and a 3% rate of return, a single nursing home resident with $181,500 would zero out financially in 40 months. A couple, with a similar net worth and $2,000 in retirement benefits, would go bust in 20 months.

There are three alternatives to private pay for nursing care: long-term care insurance (LTCI), Medicare, and Medicaid. They will be discussed in order, beginning with LTCI.

Long-Term Care Insurance

According to the U. S. Administration on Aging, LTCI pays less than 5% of nursing home bills. Why are so few people buying LTCI? After all, everyone who has had to use their LTCI is happy they bought it. A vigorous advocate for LTCI, Martin K. Bayne learned at age 45 that he was afflicted with

Parkinson's disease. Fortunately for him, he had purchased a LTCI policy four years before his diagnosis. Why shouldn't all of us follow his example?

Bayne put his finger on it, at least in part. "Most people don't buy LTCI at age 40," he said in February 2001 interview, "it's not their fault! Regardless of whether their employer has offered it to them, people in their 40s worry about sending their kids to college and paying their mortgage, among other financial concerns. Who would expect them to start thinking about paying for nursing home care?"

Most people buy insurance. They insure their homes and cars; they buy life and health insurance; many even buy disability insurance. However, the LTCI agent meets unusually stiff resistance. Partly this is due to the high cost and the fact that the favorable time to purchase it comes when many wage earners are still struggling with other commitments. It is also due to reluctance to admit the possibility of going into a nursing home.

The federal government encourages the purchase of LTCI through tax incentives. The federal government also attempted to establish a plan for federal employees, but there is little incentive, if any, to buy into the plan, compared to insurance purchased privately.

New health care reform legislation may include a long-term care provision called the Community Living Assistance Services and Supports (CLASS) Act of 2009. This would create a national, voluntary disability insurance program funded by payroll deductions. All employees would automatically be enrolled, but would be allowed to waive enrollment. The benefits--probably $50-$75 per day--would be available to purchase nonmedical services and supports to maintain independence. It would not provide a nursing care benefit.

Plenty of information about LTCI can be found on the Internet. Much of this is from folks who sell it. The American Health Care Association offers a number of "Issue Briefs" arguing that the government should subsidize the purchase of long-term care insurance at

http://www.ahca.org/news/briefs.htm. The information on this Web page is accurate, but biased. The AHCA and its associated organization, the National Center for Assisted Living, reflects the view of the nursing care industry that paying privately or through insurance is preferable to qualifying for Medicaid.

Another LTCI advocacy group, the Center for Long-Term Care Financing, warns that the long-term care system is in crisis and that the solution is for everyone to plan on paying privately for long-term care, at home or in a nursing home. Of course, since most people don't have the money to do this, the CLTCF says to buy LTCI.

Why should people buy LTCI if Medicaid will pay the nursing home? The CLTCF says, "Medicaid is a means-tested public assistance program. It is welfare intended as a safety net for the genuinely needy. The program has a dismal reputation for problems of access, quality, reimbursement, discrimination and institutional bias." Is this true? Are nursing homes that accept Medicaid inferior to those that do not?

Consumer Reports has found in the past that source of payment is not correlated with quality of care. Its website says that LTCI for the moderately well-off http://www.consumerreports.org/cro/money/insurance/long-term-care-insurance/overview/long-term-care-insucance-ov.htm. The report suggests that households with a net worth below $300,000 (which is more than 60% of U.S. households) should plan to rely on government assistance, while households above $2 million could self-insure.

The United Seniors Health Cooperative cautions that if paying the premiums is going to cause financial hardship, the client should carefully consider the alternatives. They suggest that no more than 7% of annual income go toward the cost of this coverage, but even that seems high.

The industry lobby says that the long-term care system is a wreck. Major nursing home chains have filed for bankruptcy protection and some claim that liability suits against them are driving them

out of some states. According to CLTCF, it is the height of irresponsibility to advocate continuing reliance on Medicare and Medicaid. They say that only private money will save the system.

It could be argued that LTCI, itself, is in distress. On November 11, 2010, MetLife announced that it would stop writing new LTCI policies at the end of 2010. Jennifer Saranow Schultz, "MetLife to Stop Offering New Long-Term Care Policies," New York Times (November 11, 2010). Other major carriers, such as John Hancock and Genworth, were reported to be requesting significant premium increases from state insurance regulators.

Is the LTC industry in crisis? Are we all destined to pay privately for quality long-term care? Joshua M. Wiener and David G. Stevenson of the Urban Institute assert that "the current method of Medicaid long-term care financing is quite economical. Payment rates are usually much lower than Medicare and the private sector. Persons receive government help only after depleting most of their assets. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system it is difficult to obtain large savings." See *Weil, There's Something About Medicaid*, HEALTH AFFAIRS, Volume 22, No. 1, January-February 2003, 13-30).

Population 65 Years and Over in Nursing Homes
by Age, 1990 and 2000

Age	Percent of age group		2000
	1990	2000	
65 years and over	5.1%	4.5%	1,557,800
65 to 74 years	1.4	1.1	210,159
75 to 84 years	6.1	4.7	574,908
85 years and over	24.5	18.2	772,733

Source: U.S. Census Bureau, Census 2000 special tabulation; 1990 Census of Population, *Nursing Home Population: 1990* (CPH-L-137).

The insurance-buying public is not likely to stampede insurance agencies in a sudden, overwhelming compulsion to by LTCI, just as federal and state governments are not likely to cut off funding for long-term care. Long-term care will continue to be heavily supported by government programs while LTCI will protect the assets of clients who are moderately well off. The family must carefully analyze the part LTCI will play in wealth protection.

The first step is to analyze the risk. There are LTC patients–some in a persistent vegetative state–who remain in nursing facilities into their third decade. Care in some regions may be $10,000 per month. Twenty years of care at $10,000 per month would have to be pre-funded with more than $1.75 million. However, the cost in most parts of the country is less than $7,000 per month and few nursing home patients survive more than two years. Furthermore, the Medicaid look-back is five years, so nearly anyone can transfer away all of his or her assets and qualify for Medicaid in five years. Therefore, the financial risk is not likely to exceed $200,000.

The other component of risk is the likelihood of going on-claim. A factoid appearing in LTCI literature is that "the average stay in a nursing home is two years." While this may be true for some subset of the population, it cannot be true that the average person will spend two years in a nursing home. According to the U.S. Census 2000 Special Tabulation, approximately one in six persons 85 years of age or older was in a nursing home. Since the life expectancy at age 85 is between five and six years, the average stay cannot be much greater than one year and the percentage of nursing home residents younger than 85 is quite small. Furthermore, the portion of the population in nursing homes has been steadily declining for more than two decades.

For the likely "loss" of less than $200,000, the premium is relatively high. For example, a comprehensive benefit of $150.00 per day, with a five-year benefit period, at age 59, was calculated to be $163.72 on the federal LTCI calculator. Since the premium would probably be paid for 26 years before the insured would have an appreciable likelihood of going on-claim, a similar investment at 3% would add up to $77,000. A client should carefully analyze any decision about LTCI.

There are many important factors in the decision to buy or not buy LTC insurance:

1. Will I have assets of $300,000 or more to protect in my 80s?
2. Will I be living month to month on social security or other investments with very little stretch in the budget?

3. Do I have $2-3 million in assets; thereby able to "Self Insure?"

Planning ahead is vital. Many diagnoses disqualify a person from LTCI, for example:

Memory Loss	Dementia	Stroke
MS	Cirrhosis of the Liver	Multiple TIAs
Parkinson's Disease	Some Cancers	Insulin-Dependent Diabetes

In buying LTCI, there are many types of policies and riders to factor into the choice of which policy to purchase. Retirement plans are also important. If the intent is to retire in Florida, the cost of long-term care will be higher than it would be in Missouri or Arkansas, but much lower than around Boston or New York City. Decisions about LTCI are made more complicated by the fact that it is marketed and regulated on a state-by-state basis. Portability of LTCI must be evaluated policy by policy.

Planners should make some investigation into the Medicaid climate, but it is not a major factor. Medicaid rules change too frequently, and are unreliable for the length of time involved in estate planning for the middle-aged.

Those who do not buy LTCI, will have to rely on Medicare, Medicaid, or their own funds to pay for care. This article will next explain Medicare, followed by Medicaid.

Medicare

Medicare is nationwide health insurance for the aged and disabled. Part A, paid for by payroll taxes, covers inpatient hospital services, skilled nursing care, and some home care. Part B, voluntary Supplemental Medical Insurance funded with enrollee premiums and federal general revenues, covers physician and other health care services. Neither Part A nor Part B will cover the cost of long-term care after the first 100 days.

Individuals 65 or older who are eligible for Old Age, Survivor's and Disability Insurance (OASDI)[1] are eligible to receive the red, white and blue Medicare card. Disabled persons who have received OASDI for at least two years are eligible. The benefits and eligible group are uniform throughout the country, although there are different plans, depending on region. These plans are described on the Medicare website: http://www.medicare.gov/Choices/Overview.asp

Medicare Advantage, also known as Medicare Part C, does not always live up to its name. Plans have been opened for enrollment in areas where there are no plan doctors. Some plans do not provide the full 100 days of skilled care. Furthermore, appeal rights regarding a determination that skilled care is no longer needed may be diluted or hard to exercise. Clients should carefully review the options before making a plan choice. Unfortunately, the options are both numerous and complex and the information on the Medicare website may be wrong. Medicare enrollees are often forced to guess as to which plan is right for them.

Medicaid

Nursing home care is a terrifying subject for people who are at or beyond retirement age. There are two reasons for this: impending physical dependency and potential fiscal catastrophe. In the first place, a nursing home resident is extremely vulnerable and dependent. It is difficult for someone who is young and temporarily able-bodied to picture himself or herself as bed-ridden. However, as the infirmities of age creep up and become evident, it is not so hard to imagine a time when a nursing home stay may become inevitable. It is important to prepare for physical incapacity by executing a document that will appoint someone to be the agent for the patient. It is also crucial to arrange for regular -- daily

1 OASDI is commonly referred to as "Social Security." It may also be referred to as Retirement, Survivor's and Disability Insurance (RSDI).

if possible -- visits by someone who will oversee the quality of care and ensure that the care that the patient is due is properly performed.

Financial matters are also extremely important. Few have enough income to pay for care. This paper describes the government assistance that is available to assist middle-class Americans in avoiding poverty in paying for nursing home care -- Medicaid.

People assume that one must be a poverty case before qualifying for Medicaid. Fortunately for spouses and heirs who are dependent on nursing home residents this government program has many provisions that allow the nursing home resident to preserve substantial estates for their families.

I have often been criticized for assisting people in qualifying for Medicaid. There are people who think that the government should abandon those who are helpless and leave them to their families to take care of or to throw them on their own resources. I think that is an unreasonably heartless attitude. My Medicaid clients are not wealthy. They want to leave at least a small legacy to their families. They are workers and homemakers who have devoted their lives to their country and their families. Is it too much for the government to return a small portion of their investment to help them avoid destitution?

Medical Assistance or Medicaid (MA), is federally subsidized grant-in-aid for low-income individuals and families; i.e., welfare. It varies from state to state but generally covers medically necessary services and most prescriptions. For the uninsured nursing home resident, MA is the payer of last resort. There is no cap on covered services, but there are stringent eligibility requirements. The most important eligibility requirements concern assets. A single applicant with no dependents would be permitted no more $2,000 in countable assets. If married, a Community Spouse could keep a larger portion. But the couple would still be required to reduce their countable assets by at least half before qualifying for MA. On the other hand, once the nursing home resident qualifies for MA in Michigan, the cost of care borne by the couple cannot be more than the patient's income, less $60. If the

Community Spouse has low income, the Institutionalized Spouse's income can be diverted to support him or her.

Because Medicaid approval is such a great advantage, I will explain Medicaid eligibility and planning in some detail. I will also explain how the Medicaid rules allow almost anyone to preserve hundreds of thousands of dollars while qualifying for MA.

The long-term care industry and the LTCI associations promulgate their own interpretation of Medicaid policy. These explanations are generally intended to scare people into buying LTCI or paying privately for care and do little to explain the loopholes.

I assisted a client who had spent $200,000 -- nearly three quarters of his savings -- on his wife's care between 1993 and 1999. If I had advised him in 1993, he would still have all of his savings. He was eligible to keep his remaining $80,000, but the MA eligibility worker miscalculated the amount and demanded that he spend down to $60,000. That was straightened out, but it shows that families can receive unfair treatment even when they play by the agency's rules.

Avoiding Poverty through Medicaid

The following pages will explain Medicaid law and agency policy. The primary legal sources are the Social Security Act, found in Title 42 of the United States Code, http://www4.law.cornell.edu/uscode/42/, and the policy manuals of the Michigan Department of Human Services, the Bridges Eligibility Manual, at http://www.mfia.state.mi.us/olmweb/ex/bem/bem.pdf and the Bridges Administrative Manual, at http://www.mfia.state.mi.us/olmweb/ex/bam/bam.pdf.

Two key sections of the Social Security Act are §§ 1917 and 1924, which are 42 USCA §§ 1396p and 1396r-5, respectively. In this paper all citations will be to the Code. Section 1396p sets forth the rules that pertain to penalties for certain transfers and the treatment of trusts created by or for

Medicaid claimants; while § 1396r-5 governs the treatment of resources–both income and asset–of husbands or wives who are institutionalized.

Household Concept and Spousal Support

The Medicare Catastrophic Coverage Act of 1988 (CCA), 42 USCA § 1396r-5, requires the welfare agency to include all of the countable resources of both husband and wife in calculating Total Joint Resources (TJR). It makes no difference whether they are estranged or together. Furthermore, state law relating to community property or division of marital property is irrelevant.

Limits on *Countable* Assets–No Community Spouse

Assets are countable or excludable. Countable assets are subject to limitation. The limit for aged, blind, or disabled groups is $2,000 for a one-person group $3,000 for two. If a Michigan couple were both in long term care, each could retain $2,000 in countable assets. However, there is no limit on most excludable assets. Even if single, an MA applicant could retain $2,000 in cash, *plus a car and up to $500,000 in equity in the homestead*. This is an extremely important piece of the puzzle. Asset limits will be explained in the next few pages, but the limits do not apply to certain excluded property.

Limits on *Countable* Assets–Community Spouse

Married couples may take advantage of more liberal asset allowances. The first step is to determine "total joint resources" (TJR) on the day one spouse enters LTC. This is commonly referred to as the "snapshot." Half of this amount, with a maximum TJR of $219,120, may be retained. The Community Spouse, or CS, may retain a minimum of $21,912. Thus, if a couple have $25,000 in countable assets when one spouse enters a nursing home, the CS may still retain $21,912 and the Institutionalized Spouse, or IS, $2,400. The IS may transfer assets to the CS to bring the assets up to the spousal share, not exceeding $109,560. Therefore, if they have $220,000 in countable assets when the IS, the CS may only retain $109,560 and the IS $2,400. Once the IS is approved for MA, the CS's assets are no longer counted.

As the graph shows, there is no incentive to be thrifty during the spend-down phase. The asset limit of half of $219,120 at the time of institutionalization--$109,560--remains the same, regardless of the rate at which savings are depleted. Therefore, increased spending only moves the date of eligibility up.

Presumptive Eligibility

Once the combined assets are less than the Protected Spousal Amount, MA should be approved. During the first year of benefits, assets may be owned by either spouse. This is referred to as the "Presumed Asset Eligible period." The policy manual states, "Applicants eligible for the processing month and recipients eligible for the first future month are automatically asset eligible for up to 12 calendar months." The purpose of this period is to allow the institutionalized spouse to transfer assets to the community spouse. After the Presumed Asset Eligible Period, the Institutionalized Spouse will be permitted no more than $2,000 in countable assets. However, the manual directs the worker to count "only the client's assets, not the spouse's assets."

This presents a problem for "Brady Bunch" families. Depending on whether Carole or Mike is the community spouse, one set of children or the other may be cut out. Medicaid law has absolutely no respect for pre-nuptial agreements. However, where all of the couple's assets can be preserved, a coordinated estate and Medicaid plan may provide something for everyone.

Post-Eligibility Asset Treatment

Once the Institutionalized Spouse has qualified for Medicaid, the Community Spouse's assets are no longer counted. This is required by the language of the federal statute's use of the "first continuous period of institutionalization (beginning on or after September 30, 1989)" with regard to the asset assessment of the Community Spouse. 42 USCA § 1396r-5(c)(1)(A). *There is no second*

assessment of the Community Spouse. Therefore, it is to the couple's benefit to transfer all of the assets to the Community Spouse as soon as possible after the Institutionalized Spouse is determined to be eligible for Medicaid.

Exempt Property

Items of property that are not counted in determining eligibility may be retained or purchased with countable funds. Asset exemptions are generally independent. For example, the value of the resident property or home has no effect on the availability or value of the motor vehicle exemption. However, care should be exercised with regard to final arrangements and exempt insurance, which have some cumulative aspects. The most important of these for families is the homestead. Michigan asserts no claim for reimbursement after the death of a MA recipient, even though it is a federal requirement. Therefore, the homestead can be retained for eventual inheritance. If this changes, plans may need to be revised.

Income Exclusion

Medicaid is approved for the entire month if the claimant's assets are within the asset limitation on any day. Barring divestment, the claimant's assets on any other day are of no consequence.

Income is what the claimant receives after the first moment of the first day of the month and before the first moment of the next month. Income is *not considered part of the assets* for the month in which it is received. This is a fact that many workers will ignore. I advise persons applying for single clients to keep the countable assets less than $1,000 at all times. I advise community spouses to reduce the countable assets to a figure that is at least $2,000 less than the permitted amount. That way, monthly receipts will not push the total funds over $2,000 and the worker will not deny the case.

There is often a two-, four-, or six-month wait for the Medicaid worker to act on an application. It is crucial to keep the countable assets below the asset limit throughout this time. When the worker processes the application, eligibility for the month in which the worker is processing the application is

assessed first. Only if the applicant meets the asset limitation does the worker determine the next prior month. The worker stops this backward progression at any month in which there is no asset eligibility. This seems to be in conflict with "Presumptive Eligibility" discussed below. But until the wrinkle is smoothed out, it is necessary to keep the assets well below the limit until Medicaid has been approved.

IRAs & Other Qualified Retirement Accounts

The treatment of qualified retirement accounts varies from state to state, depending on how the state views the interplay between SSI and Medicaid rules. Some states, for example Colorado, Michigan and New Jersey, consider IRA and § 401(k) funds accessible, and therefore countable. If the state's annuity rules permit the annuitization of excess funds, this may provide a workaround. Ohio, Pennsylvania and Wisconsin, which have very restrictive Medicaid rules in other respects, exempt retirement accounts if they are owned by the community spouse. In Michigan a retirement fund is only considered unavailable if the participant must leave his or her job in order to make a withdrawal.

Homestead

The major exclusion is the homestead, which is available for all persons, in all states, with community spouses or dependents. Michigan continues the homestead exemption for long term care patients, even absent a spouse or dependent. The exclusion applies to the house and adjoining land, but not if the property is in any kind of trust. Possessed by whimsy that day, whoever wrote the policy stated that a homestead is countable if it is in a trust.

The homestead may be occupied by others during the patient's absence. The home may also be rented, but income derived from the homestead must be reported. Net rental income is added to the amount the client must pay for care.

The Medicare Catastrophic Coverage Act permits the transfer of a home and title to the spouse or a specified relative. The permitted relatives include a dependent child or a child who resided in the

home for at least two years, whose care enabled the person to remain in the home, or a sibling with an equity interest who resided in the home for at least a year.

Under the Deficit Reduction Act there is a $500,000 cap on home equity, unless there is a Community Spouse or disabled or minor child residing in the home.[2] The Program Eligibility Manual was revised to provide as follows:

> MA will not pay the client's cost for:
> • Home Help services
> • Home Health services
> • Home and Communtiy based services (MIChoice Waiver)
> • LTC services
> When the equity in the cilent's homestead exceeds $500,000.

PEM Item 400(19) (January 1, 2008).

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2 This amendment to the Social Security Act is codified as follows:

(f)(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if--

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

42 U.S.C.A. § 1396p(f).

However, the manual directs the worker not to "apply the home equity limit to the client if the spouse, child under 21, or the client's blind or disabled child is residing in the home." Id.

Household and Personal Goods

Household goods and personal goods comprise another major exclusion. Household goods are *customarily* found in the home and used in conjunction with maintenance or occupancy. Personal goods are incidental items intended for personal use by a household member. Excluded household and personal goods generally are not reported on the application. As a rule of thumb, it is important not to report information on the application that is not required. The worker may attempt to count items reported even if the items are properly excludable.

Personal goods held for investment purposes may not be excluded. Items with ready market value which are not used in day-to-day living would probably be counted.

Motor Vehicle

One motor vehicle of any value is excluded. If more than one vehicle is owned, the most expensive may be excluded. An additional vehicle may also be excluded if it serves as the homestead, or if it is necessary for self-support.

Income-Producing Real Property and Assets Used in Trade or Business

Income producing real property (IPRP) and personal property used in a trade or business are excluded assets. However, BEM Item 400 limits the equity in IPRP to $6,000, the same as the SSI limit. The annual income of real property must be at least 6% of the group's equity interest.

Whether the exemption for "assets used in a trade or business" will be useful remains to be seen. Its utility will probably be limited to situations where a Community Spouse has a small business.

Funeral and Burial Arrangements

There are four separate exemptions for final arrangements. Any combination of investments is permitted, except that certain combinations of life insurance, life insurance-funded funeral and burial

fund cannot exceed $1,500. Medicaid policy must be carefully analyzed with regard to each investment and with regard to each combination. I advise bringing items that are thought to be excluded to the worker's attention early in the application process to get a determination of which investments will be excluded.

1 Irrevocable Funeral Contracts

Up to $11,393[3] may be tied up in an irrevocable funeral contract. The Department's form, DHS-8A, must be used and the Department must certify the agreement. The Department does not consider the irrevocable funeral contract an excluded resource prior to the date it is certified by the Department. Therefore, it should be submitted when the application is filed.

Only “guaranteed-price” contracts may be certified. Some funeral agreements include non-guaranteed-price items, such as grave opening and closing. This will cause the Department to reject the irrevocable funeral contract.

1 Burial Fund

Up to $1,500 per person may be set aside in a separate fund for burial expenses. Burial expenses are generally those related to preparation of the remains for final disposition. This can be a bank account, certificate of deposit, bond or other type of fund. It may be in the client's name or in another's. To be exempt, the burial fund must be "clearly designated" for that purpose. This requires a signed statement from the client stating the value and ownership of the asset, the name of the person for whose burial the funds are set aside, the type of account or investment in which the funds are held, and the date the fund was set aside. The $1,500 maximum per person is reduced by the face amount of life insurance policies owned by the person.

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3 As adjusted June 1, 2010. Department of Human Services, Program Administrative Manual, Item 805(4) (July 1, 2010).

This exclusion may be claimed *ex post facto*. It can be used when a stray savings account has turned up after the month for which Medicaid is needed. The burial fund designation can be signed with an earlier "effective" date to exclude the account back to the desired month.

1 Life Insurance

The cash surrender value of life insurance is excluded when the total face value of all policies one owner has for the same insured are $1,500 or less. Term insurance policies are not considered at all.

1 Life Insurance Funded Funerals

Life insurance policies may be excluded if the proceeds will be used for funeral expenses. The life insurance proceeds must be assigned for funeral expenses and the ownership of the policies may be transferred to a trust, funeral director or other third party. If the proceeds are assigned and the ownership transferred, there does not appear to be a maximum exclusion. This type of arrangement has no *ex post facto* effect.

Annuities

Annuities that are being paid out in installments and that meet the test of being "actuarially sound" do not count as assets. This is because they are an income stream, not a fund that can be liquidated. By placing assets into an annuity or "irrevocable sole-benefit annuity trust" assets can be taken out of the pool of "countable" assets and become "excludable."

There are four requirements for an annuity to shelter funds: irrevocability, unassignability, actuarial soundness, and a beneficiary designation naming the state the beneficiary for Medicaid payments expended on behalf of the annuitant or the Institutionalized Spouse if the annuitant is a Community Spouse.

The rule reads as follows:

Converting countable resources to income through the purchase of an

annuity or the amendment of an existing annuity on or after 09/01/05, is considered a transfer for less than fair market value unless the annuity meets the conditions listed below:
• Is commercially issued by a company licensed in the United States and issued by a licensed producer, (a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance), and
• Is irrevocable, and
• Is purchased by an applicant or recipient for Medicaid or their spouse and solely for the benefit of the applicant or recipient or their spouse, and
• Is actuarially sound and returns the principal and interest within the annuitant's life expectancy, and
• Payments must be in substantially equal monthly payments (starting with the first payment) and continue for the term of the payout (no balloon or lump sum payments).
• An annuity purchased or amended on or after February 8, 2006 must name the State of Michigan as the remainder beneficiary, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits provided. The naming of the State in the first or second position must be verified at application or redetermination. BEM Item 401(4) and (5) (January 1, 2009)

Jointly-Held Liquid Assets

The Agency will consider jointly-held liquid assets to be totally available to the MA applicant or recipient. Assets over which an institutionalized person has unrestricted access and control are countable in determining his SSI and MA eligibility. Therefore, most joint liquid assets in which he is a joint tenant will be considered totally available to him.

If he is made a joint tenant for estate planning, but has neither a current claim of right in the funds, nor unrestricted access, the assets are supposed to be unavailable and not counted. The policy provides that jointly held assets which are capable of division, such as bank accounts, are *presumed* to be entirely available to the applicant or recipient. The other joint owner may rebut the presumption by showing that the a portion of the funds do not belong to the recipient. This, however, is extremely difficult.

Joint accounts are considered divested when the funds are removed. There is an example in the manual to illustrate this point. It states as follows:

> **Example:** Mr. Jones is applying for MA. In 1990, he added his sister's name to his bank account. Each is free to withdraw as much money as desired so adding the sister's name did not affect the client's ownership or control. On September 1, 1993, the sister withdrew $10,000 and deposited the money in her own bank account. Mr. Jones is considered to have transferred $10,000 on September 1, 1993, the day he no longer had ownership and control of his money.

This reinforces the strong presumption that all funds in joint accounts bearing the institutionalized person's name are deemed to belong to him or her. It also points out that the transfer is not deemed to have occurred when the name is added to the account, but when funds are withdrawn.

All joint accounts bearing the applicant's name, except one, should be dissolved. Withdrawal of a portion of the funds, it could be argued, is evidence of ownership of those funds by the joint tenant. Since the policy refers to assets held at the time the worker is determining eligibility, if a joint account was broken up before the application was filed, the assets now held individually by the former joint tenant would only be counted with regard to the applicant if it is determined that divestment occurred.

Jointly Held Real & Personal Property

Assets which cannot be divided, such as parcels of real property, securities, or vehicles, may be considered unavailable if held jointly with rights of survivorship. The institutionalized person would have to show that his share could not be sold without the consent of the other owners and that the other owners do not consent to the sale.

The policy says that joint assets are not considered transferred until the other joint owner refuses to sell. It may be wise to have the joint owner sign an intent letter shortly after the property is put in joint tenancy.

Creating a joint tenancy may be divestment since it reduces the client's ownership or control of the asset. However, assets which have been joint since before the look-back period calculated for divestment, as explained in the next section, should be neither available nor disqualifying. Any problem with such an asset would arise on sale or other disposition, or on the death of the claimant.

The topic of joint tenancies in the context of estate planning deserves extended discussion beyond the scope of this paper. One of the most important considerations is basis step-up on death. A gratuitous joint tenancy does *not* impair the basis step-up on the death of the grantor-joint tenant. Other factors that must be addressed are problems that could arise if there are numerous joint tenants and someone dies out of order or if the original owner wants to sell the property. Even though the basis step-up on death is not affected, the IRC § 121 capital gains exclusion for sale of a primary residence only applies to the portion of the home owned by the seller. These are just a few of the complications that must be addressed if the deceptively simple strategy of putting the home in joint tenancy is used to avoid probate or estate recovery. For a comprehensive treatment of capital gains issues in estate planning see "The Curious Case of the Persistent Step-Up" on the home page of this website.

Community Spouses

Bill and Marian retired recently. Each receives social security and pension of approximately $1,200 per month. Their assets include a $200,000 house with a $30,000 mortgage, a car, checking, savings, and CDs totaling $50,000, a stock portfolio worth $100,000, and a piece of real property in Arizona worth $10,000. For MA purposes, stocks, bonds, certificates of deposit, passbook accounts and cash are all considered countable liquid assets. Real estate other than the "resident property" is also countable.

What would happen if Marian went into a nursing home? The home and one automobile are not counted, so Bill and Marian have countable assets of $160,000. This means that Marian can get

MA when she has less than $2,000, and Bill has less than $80,000. Not all of the excess has to be spent on Marian's care, but the person who applies for her must account for it.

Once Marian enters LTC and Bill's spousal share has been established by filing an application for MA with the Department of Social Services, Bill can start to "spend down". He pays a couple of months of LTC, pays off the mortgage, buys a new car and pays for remodeling. If the countable assets are now less than $80,000, Marian can qualify for MA. The important counseling point is that increased spending advances Medicaid eligibility. Note that Bill would have ended up with a lower spousal allowance if they had paid off the mortgage and made the other expenditures before Marian went into the nursing home.

The two significant dates are the date the institutionalized spouse enters LTC and the date the couple's assets fall below the Protected Spousal Amount or Spousal Share. The LTC date is the day of admission for the first continuous period of institutionalization beginning on, or after, September 30, 1989. The date of admission is the date the patient entered a hospital or other facility prior to admission to the long-term care facility. Therefore, the hospital stay does not provide an opportunity for pre-admission planning.

The first date, the snapshot, is determined by entry into LTC. The second date is not fixed. It is dependent on the rate the assets are expended.

Income Transfer

Bill may also be entitled to some of Marian's income if he meets certain needs tests. Although most of Marian's income will probably go to the nursing home, he will be able to keep all of his income. If the spouse who has most of the income goes into a nursing home, the spouse at home may have a difficult time maintaining his or her standard of living.

The income calculation is directed at determining the "Patient Pay Amount." This is the amount that must be paid out of the Institutionalized Spouse's income for his or her care. After adding

up the Institutionalized Spouse's OASDI, pensions, net rental income, and annuity payments (dividends and interest from other assets do not count), health insurance premiums and $60 for incidental needs are deducted. If there is a community spouse and the Institutionalized Spouse is willing to assign the income, the Community Spouse Income Allowance (CSIA) may also be deducted.

To determine the CSIA, the Community Spouse's needs must be determined. To the mortgage, taxes and assessments, home insurance and rent is added a heat and utility allowance of $550.[4] If the total shelter cost exceeds $547, this "Excess Shelter" is added to the CS's Minimum Monthly Maintenance Needs Allowance of $1,822 to derive the "Total Allowance" of up to $2,739. The CS's income is added up and subtracted from the Total Allowance, which gives the CSIA to be deducted from the IS's income, net of the $60 incidental needs and health insurance premiums. The resulting figure is the Patient Pay Amount.

Community Spouse Example

The timing of certain expenditures is important. Married persons may take advantage of more liberal asset allowances if one spouse will not be in long term care. The amount of assets which the community spouse may retain is based on TJR, as of the date of institutionalization. It may be wise to establish a high TJR on the date the spouse enters long term care.

For example, assume that Al and Ann Ayers the assets shown in Table A. The countable assets would be $100,000. The community spouse would be able to keep $50,000.

4 The figures used in this paragraph are adjusted annually for increases in cost of living and are current as of July 1, 2009. For reasons known only to faceless bureaucrats, the heat and utilities allowance and the maximum total allowance are increased on January 1, but the excess shelter standard and the basic allowance are increased on July 1.

TABLE A	AL & ANN BEFORE PLANNING			
	Fair Market Value	Countable Liabity	Exempt Liabity	Total Joint Resources
Homestead	$100,000			
Mortgage				
Savings	90,000			$90,000
Car	25,000		($15,000)	
Boat	30,000	$20,000		10,000
Total	$245,000	$20,000	($15,000)	$100,000
Net Worth	$210,000			

However, with a mortgage against the home (not counted), the TJR could be increased to 160,000, as shown in Table B.

TABLE B	AL & ANN AFTER PLANNING			
	Fair Market Value	Countable Liabity	Exempt Liabity	Total Joint Resources
Homestead	$100,000			
Mortgage			($60,000)	
Savings	130,000			$130,000
Car	25,000		(15,000)	
Boat	30,000			30,000
Total	$285,000		($75,000)	$160,000
Net Worth	$210,000			

Then, when the mortgage is paid off after one spouse goes into the nursing home, as in Table C, the institutionalized spouse very quickly becomes eligible.

TABLE C	AL & ANN AFTER INSTITUTIONALIZATION			
	Fair Market Value	Countable Liabity	Exempt Liabity	Total Joint Resources
Homestead	$100,000			
Mortgage				
Savings	70,000			$70,000
Car	25,000			
Boat	30,000	$15,000		15,000
Total	$225,000	$15,000		$85,000
Net Worth	$210,000			

Only the equity of countable assets is used in determining eligibility. This means that the indebtedness is a deduction for MA purposes. On the other hand, unsecured debt, or mortgages on exempt property are not taken into account. This is the reason that the manipulations outlined above reduce the amount that must be spent so impressively.

Planning for married couples often must be done in two or more stages. The assets retained by the community spouse are at risk if that spouse then requires nursing home care. This calls for careful analysis of the assets, the likelihood that the second spouse will need LTC in the near future, and Medicaid policy.

Divestment

If The Institutionalized Spouse or the Community Spouse disposed of assets for less than fair market value on or after a look-back date, they would become ineligible for certain benefits. They would lose MA for nursing home care, for home health services, and for certain other services for a number of months. The number is determined by dividing the amount divested by the monthly cost of nursing home care for a private-pay patient. Despite the penalty, they would be considered "eligible for MA." However, nursing home and home care costs would not be paid.

Look-Back Periods

The look-back period is measured from the "Baseline Date." The Baseline Date is the first date that the client is eligible for Medicaid and in a long-term care facility or approved for waiver, home health, or home help services. The baseline date does not change even if the client leaves long-term care or is no longer approved for waiver services. The look-back period is 60 months, except for certain transactions before February 8, 2006.

DRA 2005 applies the 60-month to any disposal of assets on or after February 8, 2006. This is extremely confusing to workers and clients, alike because the five-year look-back applies to transactions in 2007, but when an application is filed, the look-back, as it pertains to any transaction before February 8, 2006, is truncated. For example, if an application is filed on October 5, 2007, only transactions after October 5, 2004 are subject to scrutiny. However, workers are demanding five-years'

bank statements and tax returns even in the summer of 2007. This is overreaching except for transactions involving trusts.

When applications are filed after February 8, 2009, the effective look-back will begin to stretch. So, for an application filed on March 8, 2009, the look-back will cover any transaction dated February 8, 2006, or later; so the look-back will be three years and one month. The look-back will not be fully effective at 60 months until February 8, 2011.

The 60-month look-back applies to payments, even those that pre-date the DRA, from a revocable trust that are not made to the Institutionalized Spouse or Community Spouse and any portion of an irrevocable trust from which no payment could under any circumstances be made to them. Because there is some applicability of the 60-month look-back, Medicaid workers have a basis to demand five years of financial records. It is better to avoid revealing a transfer that is before the look-back date. Many workers will try to apply a penalty to a large transfer, even if it is technically not within the look-back. Therefore, resist demands for documentation that exceed the period the worker has the right to count.

If the last transfer was more than 36 months (or 60 months, if applicable) before the date of application, there is no disqualification. If the claimant applies too early, he or she cannot apply again later and avoid a disqualification period that exceeds the look-back period. The Baseline Date remains unchanged despite denials and re-applications. The look-back period is measured from the first application date. Therefore, when there has been a divestment it is crucial to calculate penalty periods and look-back dates *before* filing an application.

Application of Pre-DRA 60-Month Look-Back

The policy promulgated by DHS was simplistic. The 60-month look-back period applied to payments from a revocable MA trust to someone other than the client or spouse. It also applied to

assets *in* an irrevocable MA trust. However, assets distributed *from* an irrevocable trust to someone other than the client were only subject to the 36-month look-back period.

Penalty Period

According to DHS's divestment rules, the penalty period starts when the individual is receiving long-term care, MIChoice waiver, or home help or home health services eligible for Medicaid and is eligible for Medicaid but for the divestment penalty.

The disqualification period may be shorter than the length of time that it would have taken to expend the assets. The amount divested is divided by an amount that approximates the monthly nursing home bill. If the Baseline Date (application) is in 2010, the divisor is the state average private-pay nursing home rate, $6,618. This gives the length of the disqualification. Since there will be monthly income received during the disqualification period, the amount that must be retained to pay for care while disqualified can be reduced by the anticipated income.

The problem with the new policy is that the penalty does not start until "the individual is eligible for Medicaid and would otherwise be receiving institutional level care LTC," or one of the other Medicaid LTC benefits, but for the penalty–that is, out of assets. How does the Medicaid applicant get through the penalty period when he or she has nothing to pay for care?

Under Pre-DRA Medicaid policy, the penalty started when the gift was made. This permitted the potential Medicaid applicant to give away half of his or her assets. The half retained would nearly always cover the cost of care during the penalty. Under the new regime, this plan–known as half-a-loaf–must be modified. Instead of giving away half and retaining the other half to pay for care, the person must impoverish himself or herself, but arrange for payment for care during the resulting penalty.

A simple method would be to give all of the assets to a family member on condition that this person will cover the cost of care during the penalty, but on July 1, 2008 the Department set forth new policy that does not permit partial returns to reduce the penalty. According to the Department's new rule, the property must be returned in its entirety to cure the penalty. This area of Medicaid policy is extremely perilous and any gift is hard to cure. The application of this new policy is still being worked out, but it appears that it will be possible to give away half the assets and buy an immediate annuity or long-term care policy to cover the nursing home in an amount that is approximately the same as the gift. Another alternative is to give away half and loan the other half to a family member under a special DRA-compliant promissory note.

For example, let's assume that Myrtle has $100,000 and wants her daughter Dotti to keep as much as possible of her money. Myrtle gives Dotti the entire amount and applies for Medicaid in 2010. The penalty divisor is $6,618. Myrtle's income is $1,100 and the cost of care is $6,600 per month. Myrtle's gift results in a 15.11-month disqualification that cannot be cured, except by returning the entire $100,000.

A better strategy would be for Myrtle to give Dotti $54,000, resulting in a nine-month penalty. The remaining $46,000 would probably cover the cost of Myrtle's care during the penalty if placed in a short-term annuity or loaned to Dotti on a DRA-compliant promissory note. Myrtle will have paid $46,000 for her care and Dotti will be able to retain $56,000.

Permitted Transfers

The transfer of a home to the spouse and certain qualified donees is permitted. Special attention should be paid where a child or sibling of a potential MA applicant resides in a home in which the applicant has an ownership interest.

A transfer is not divestment if the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or that the assets were transferred exclusively for a purpose other than to qualify for medical assistance. Transfers between spouses, in any amount, are expressly permitted at any time.

A disqualification may also be avoided if all assets transferred for less than fair market value are returned to the patient. As noted, return of a portion of the assets will shorten the disqualification period *pro rata*.

Disclaimers and Will Elections

The Agency does not yet have an estate recovery program, but Michigan is overdue on compliance with the federal mandate to establish it. As previously stated, real property and other probate assets may become subject to the state's Medicaid claim in a few years.

Disclaimers and will elections present two different problems. A disclaimer is defined as a transfer for less than full consideration. The policy specifies "refusing an inheritance" as a divestment. Therefore, if someone left The Institutionalized Spouse some money and he refused the inheritance, he would be subject to an MA divestment penalty.

On the other hand, failing to elect against a will is not an act. It is an omission. Michigan Medicaid policy generally does not penalize omissions.

Let me try to make this understandable. If the Community Spouse died before the Institutionalized Spouse and left everything to her children, he would have the right to "elect against the will." This would give him a portion of her estate. If he failed to elect against her will, this might make him ineligible for Medicaid. However, he should be ineligible only for the period the election is available. This ineligibility is different from a divestment penalty. It derives from the welfare

requirement that the recipient take all reasonable steps to utilize available resources. There is no set period of ineligibility. As soon as the opportunity to elect lapses, eligibility should be restored.

This is all theoretical. It does not appear that the Agency applies a penalty for disclaiming an inheritance or closed a case for failure to elect against a will.

Conversion

Converting an asset from one form to another, such as using cash to purchase stock of equal value, would not be divestment, even if the new asset is exempt. The new law recognizes divestment when any action is taken that reduces or eliminates the claimant's ownership or control of an asset, not necessarily when names are added to the claimant's account. Since a joint account is totally available to each joint account holder, no divestment occurs when names are added to the account.

Conversion is permitted at any time. This is because the value that is returned to the person is equal to the value that is given away. It is this principle that allows a person to purchase an annuity or income-producing real property. If an institutionalized person pays $100,000 for an annuity and the value of the future payments is $100,000, he or she has not made a gift. Since there is no gift, there is no penalty. Likewise, if he or she pays $100,000 for a car, jewelry, or an addition to his home, he or she receives property of equal value for the money transferred. There is no gift, no penalty, and no waiting period before applying for MA.

Undue Hardship

Federal law requires the state to recognize an exemption from the divestment rules where application of the disqualification would result in an "undue hardship." The definition in Michigan's policy manual is problematic. There are two elements of undue hardship:

- necessary medical care is *not* being provided, **and**

- the client needs treatment for an emergency condition. [emphasis in original]

Undue hardship must be substantiated by the statement of a treating physician. The condition must require immediate treatment to avoid death or permanent impairment of health, but the definition of emergency does not include sudden onset of illness.

It is also very difficult for a nursing home resident to satisfy the first element. If treatment is being provided, there is no emergency.

This definition could be difficult to meet if The Institutionalized Spouse miscalculated the divestment disqualification and were in a nursing home when his money ran out. The Agency would refuse to recognize that an undue hardship existed until he was out on the street.

Trusts

Funding a trust or other device from which payments may be made to the patient or spouse does not result in a penalty, but any amount of income or corpus that could be distributed *under any circumstance* is considered a resource. That is, any portion that *could* be distributed is treated as cash in hand. The patient is considered to have established a trust even if the assets are placed in trust by a person, including a court or administrative body acting on his behalf or at the direction of the spouse. If a trust contains assets of a person other than the patient or the patient's spouse, the resource rules do not apply to those assets. These new rules even apply to trusts established by others for aged and disabled individuals unless the state is assigned the residue on the death of the individuals and certain other conditions are met.

Creating an irrevocable trust should not constitute divestment, provided the Institutionalized Spouse or the Community Spouse is the only beneficiary during his or her life. The Social Security Act

provides that a transfer does not constitute divestment if resources are transferred to another (i.e. in trust) for the sole benefit of the spouse of the claimant.

Income-Only Trusts

Income-only trusts may preserve corpus for a Medicaid recipient's heirs. However, entrustment of assets to such a trust would result in a period of disqualification.

Preserving Funds with an Annuity

A Medicaid applicant may place funds in an annuity. Once the funds are "annuitized," that is, once periodic payments have commenced, the principal or corpus of the annuity cannot be returned to the annuitant. Because the corpus cannot be returned, it is no longer considered an "asset." The annuity is just considered an income stream for Medicaid budgeting.

This is a useful device to preserve funds for the community spouse. Consider the first "Al & Ann" spreadsheet. Because TJR is $100,000 when one spouse enters the nursing home, the community spouse may retain $50,000. If the excess funds were put into an annuity, the institutionalized spouse could be immediately eligible.

There are four limitations on the use of an annuity. First, the owner and annuitant must be the Medicaid applicant or the applicant's spouse. Second, any period of guaranteed payments must end within the annuitant's actuarial life expectancy, according to the actuarial tables in the Medicaid manual. For example, a male at age 80 has a 9.11-year life expectancy, according to these tables. If an 80-year-old, male applicant or spouse put money in an annuity and annuitized it with guaranteed payments for 108 months, there would be no divestment. However, if the annuity had guaranteed payments for twenty years, the applicant would be considered to have divested the payments for the last 11 years. The policy manual does not explain whether or how present value is calculated.

Third, the payments must be equal, although payments for life are not required. Finally, as noted above, "an annuity purchased or amended on or after February 8, 2006 must name the state of Michigan as the remainder beneficiary, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits provided."

Irrevocable Annuity Trusts

Another useful device is the irrevocable annuity trust. This trust works exactly like an annuity. There are three requirements:

- The arrangement must be in writing and it must be legally binding on the parties.
- The arrangement must ensure that none of the resources can be used for a beneficiary other than the Medicaid applicant or the applicant's spouse during the person's life, except for trustee's fees.
- The arrangement must require that the resources be spent for the person at a rate that will use up all the resources during the person's life expectancy.

An advantage to an annuity trust over a commercial annuity is that the state is not required to be the beneficiary after the Community Spouse.

Income Eligibility

As discussed above, the applicant must establish asset eligibility by showing that his or her total countable assets are lower than the asset limit. Income is not an eligibility criterion in Michigan. DHS calculates the amount the applicant is obligated to pay based on his or her income and other circumstances. This is called the Patient Pay Amount. If the applicant's Patient Pay Amount is less than the monthly MA payment rate for that nursing home, plus other medical expenses, the applicant

can receive MA for the difference. If there is no deficit, the applicant receives no benefit because there is no need for assistance.

Other DRA Changes

The Deficit Reduction Act made changes in the way low-income Community Spouses are allowed to augment their income, the treatment of Continuing-Care Retirement Community entrance deposits, and the rules for establishing that loans are not gifts. Finally, the Act created a minimum period of residence for life estates purchased by Medicaid applicants.

Income-First

Under the DRA, states are required to apply an income-first rule with regard to the income of Community Spouses. This is a complicated rule that allows community spouses to get some of the income of the Institutionalized Spouse to bring him or her up to a poverty standard or needs allowance. Formerly, most states would allow the community spouse to keep additional assets to bring the income up to the needs allowance. "Income-first" means that the institutionalized spouse's income must be applied first to make up the deficit before additional assets can be kept. This is unfavorable to community spouses because pensions on which they must rely under the income-first rule often end when the institutionalized spouse dies.

Continuing Care Retirement Community Contracts

The DRA requires that entrance deposits or fees for continuing-care retirement communities (CCRCs) be considered available and be used to pay for care before the resident can apply for Medicaid for nursing services. A CCRC is a retirement community that has a continuum of living arrangements, usually apartments for independent living, assisted living units or rooms, and a nursing

facility. The advantage to this type of facility is that the transition to greater levels of assistance does not require the resident to leave the campus.

The rule is easy to apply in the case of a single resident, but many couples move into CCRCs. There is no explanation of how the entrance deposit is to be treated if one spouse remains in the retirement apartment when the other spouse needs nursing care. It can be inferred that the entrance deposit would be considered part of the assets that the community spouse would be allowed to keep under the spousal anti-impoverishment rules. However, the largest amount the community spouse can keep in 2007 is $101,880 and many CCRC entrance deposits are $150,000 or higher. This is extremely problematic and the new law does not provide guidance or relief for community spouses.

Notes & Loans

Persons who apply for Medicaid after loaning money come under strict rules. Loans that do not meet the requirements are treated as gifts. The repayment must be "actuarially sound." That means equal payments with no deferral. No balance may be cancelled on the lender's death.

Life Estates

Once the DRA becomes effective, the purchase of a life estate in another's home is considered a gift unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

Conclusion

There are three current devices to avoid having all of one's savings used to pay for nursing care: divestment, investment in the homestead, and annuities. These devices, used separately or in combination, can preserve substantial wealth. If you consult a knowledgeable Medicaid attorney, the attorney can assist in avoiding unnecessary poverty for yourself, your spouse, or your heirs.

As the discussion above explains, there will be dramatic changes in Medicaid for nursing home residents. Before purchasing an annuity or making a gift, anyone over 60 should consult an Elder Law attorney to determine possible Medicaid consequences in case the person or the person's spouse ever needs care in a nursing home.