News You Need to Use – Medicaid Law in 2011

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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.

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

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

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, long-term care insurance pays less than 5% of nursing home bills. Why are so few people buying LTCI? After all, everyone who has had to use LTCI is happy he or she bought it. A vigorous advocate for LTCI, Martin K. Bayne learned at age 45 that he was afflicted with Parkinson's disease. Fortunately, he had purchased an 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 LTC insurance 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. A lot of this comes from folks who have a vested interest in selling 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 the 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

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

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 and 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 is often 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 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, Medicaid or 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 long-term care patient, with no dependents, would be permitted no more than $2,400 in countable assets–$8,000 if "low-income." 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 Pennsylvania, the cost of care borne by the couple cannot be more than the patient's income, less $40. 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/, Title 55 of the Pennsylvania Administrative Code, and the policy manuals of the Pennsylvania Department of Public Welfare, only some of which are currently available either in print or on the internet.

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 an aged, blind, or disabled persons is $2,400 for a one-person household and $3,200 for a two-person. If a Pennsylvania couple were both in long term care, each could retain $2,400 in countable assets. The limit is increased to $8,000 for if the claimant's income is less than 300% of the SSI amount; i.e. $2,022.

There is no limit on excludable assets. A single, LTC resident could retain $2,400 in cash, plus a half million-dollar apartment building, if it qualified for the "homestead" exemption. [55 Pa. Adm. Code § 178.62.] 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 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 90 days of benefits, assets may be owned by either spouse. [NCH § 440.33.] After this time, the IS will be permitted no more than $2,400 in countable 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. The most important of these for families is the homestead, called "resident property." Pennsylvania asserts claims for reimbursement after the death of an MA recipient in a nursing home, but keeping the assets out of probate may avoid the state's reach. Avoiding estate recovery requires careful planning.

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 $2,400 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.

Retirement Funds of Community Spouse

Pension funds owned by the community spouse are not counted as a resource in determining the eligibility of the institutionalized spouse. [NCH § 440.4.] This extremely important exemption covers IRAs, 401Ks, and other deferred compensation, without regard to whether the community spouse is employed. The exemption applies to the principal and undistributed interest, even if the community spouse is receiving required minimum distributions, but distributions count as income to the community spouse.

Resident Property

The major exclusion for most families is the "resident property." [NCH § 440.52.] This exemption, also called homestead, is available for all persons, in all states, with community spouses or dependents. This exemption may be lost when the resident becomes a nursing home patient receiving Medicaid. However, the exemption continues for long term care patients who have spouses or dependents residing in the homestead. [NCH § 440.52.] If there is no spouse or dependent living in the home, the Pennsylvania nursing home patient or representative must state in writing that the patient intends to return to the home. [NCH § 440.52 at 23; 55 Pa. A.D.C. § 178.62(2).]

The patient or representative need provide the statement only once unless there is a "change in intent." At each redetermination, the worker will "review the client's intent to return home . . . in such a way as to avoid any hint of pressure or intimidation." [NCH § 440.52 at 24.]

The exclusion applies to "only the one property which is the principal residence of the client." A second home, even if it is built on the "same tract" is considered an available resource and counts against the countable assets limit. [*Id*.] However, this limitation conflicts with federal Medicaid regulations, which provide, part as follows:

> a. Land
>
> The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.
>
> Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.
>
> Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.
>
> b. Buildings
>
> **The home exclusion applies to all buildings on land excluded per a. above**. [SSA Program Operations Manual System, SI 01130.100 (emphasis added).]

The exclusion should apply to "all buildings," not just nonresidential buildings. Pennsylvania's rule regarding a second home on real property that qualifies for the homestead exemption is clearly subject to challenge.

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 CCA permits the transfer of a home and title to the spouse or a specified relative, without a penalty. 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. [42 U.S.C.A. § 1396p(c)(2)(A).]

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]

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.

Life Estates with Reserved Powers

While the resident property is exempt as long as the Medicaid recipient remains alive, this does not avoid a Medicaid claim on the probate estate. Prior to the passage of Act 2005-42 on July 7, 2005, estate recovery could be avoided through the use of a deed that retained a life estate in the Medicaid recipient and reserved the power to convey or change the remainder interest. Since the Medicaid applicant could transfer the remainder interest (who gets the property on the death of the life tenant) along with his life interest, this amounted to a power to sell, so there was no divestment. However, on death full title would pass to the grantees, while avoiding probate.

In response, the legislature amended the public welfare law to give the Medicaid agency the power to require the exercise of the right to convey or to change the remainder beneficiaries of the deed. The new provision reads as follows:

> Section 441.6. Treatment of Life Estates, Annuities and Other Contracts in Determining Medical Assistance Eligibility.
>
> (a) As a condition of eligibility for medical assistance, every applicant or recipient who owns a life estate in property with retained rights to revoke, amend or redesignate the remainderman must exercise those rights as directed by the department. The acceptance of medical assistance shall be an assignment by operation of law to the department of any right to revoke, amend or redesignate the remainderman of a life estate in property. [62 P.S. 441.6 (July 7, 2005).]

The new rules make it important to plan for the necessity of applying for Mediciad before long-term care is imminent. It is still possible to preserve the home or "resident property" by putting it in joint tenancy with the intended beneficiaries, as long as the deed is executed and recorded five years before it is necessary to apply for Medicaid. Transferring the home to others with a reserved life estate will also work, as long as the grantor does not retain the right to convey the remainder interest to third parties; but federal tax law is unclear on whether a reserved life estate will confer a basis step-up on the

(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).

death of the grantor after 2009. See the section on joint tenancies on page 26 for further discussion of possible problems with this tactic.

Since § 441.6 applies specifically to remainder interests, it may be possible to transfer the resident property reserving a life estate and the right to sell the property. There would be no penalty for such a transfer because the grantor retained the right to sell, while the statute does not give the Department the power to force the sale. Estate recovery would be avoided because such a deed would avoid probate. The Department is challenging any deed that excludes a Medicaid recipient as either a life tenant or remainder person, so at least an administrative hearing will be necessary if the family tries to avoid estate recover using a deed.

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. [NCH § 440.43.]

Real or Personal Property Used in Trade or Business

Real property not excluded as a home may be excluded if it is a property used in a trade or business essential to self-support. [NCH § 440.532; 55 Pa. Adm. Code § 178.64.] Neither the code nor the handbooks explain what is meant by this, but this exclusion could include rental property that produces a reasonable return.

Funeral and Burial Arrangements

An irrevocable burial reserve is a fund held in trust or under contract with a financial institution or a funeral director under a written agreement providing that the funds cannot be withdrawn before the death of the beneficiary. If a burial reserve is in an irrevocable form, it is not a countable resource. However, interest earned on the burial reserve is counted as income if it can be and is withdrawn before the death of the applicant or recipient. Excess funds after the burial expenses become a part of the deceased recipient's estate.

The transaction establishing the irrevocable burial reserve shall be reviewed to determine whether the fair consideration requirements were met. Fair consideration is established if the irrevocable burial reserve is not exorbitant in relation to the average cost of burial in the locality where the person lives. To allow for future increases in the cost of burial, an irrevocable burial reserve is not considered exorbitant if it does not exceed the average local costs by more than 25%.

There is no limit on the amount of the burial reserve, but the Agency may review the amount to determine whether the amount is exorbitant for the person's situation. A higher amount may be justified for items such as:

> (A) The cost of transport of the body because burial is to be in a community many miles away.
> (B) The person arranged for a priest, minister or rabbi who is a close friend or relative and lives some miles away to conduct the memorial services with the cost of travel, food, lodging and honorarium to be paid from the irrevocable burial reserve.
> (C) A reasonable gift to the church or synagogue for the use of the facilities for the services. [55 Pa. Adm. Code § 178.5.]

Burial Space

Conventional grave sites, crypts, burial drawers, mausoleums, urns and other repositories customarily used to deposit the remains of deceased persons may be exempt. [55 Pa. Adm. Code § 178.2.] Burial space may be purchased for the client, the client's child or stepchild, sibling, parent or adoptive parent, and the spouse of any of them. [NCH § 440.6.]

Life Insurance

The cash surrender value of life insurance is excluded when the total face value of all policies are $1,500 or less. Term insurance policies are not considered at all. If the total face value is more than $1,500, total cash surrender value in excess of $1,000 is a countable resource. [NCH § 440.42.]

Annuities

Annuities that are being paid out in installments and that meet the test of being "actuarily 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." Annuities must be purchased from commercial annuity companies; private ones are not permitted.

Despite several losses in federal court, the Department claims that the income stream from an unassignable, irrevocable, non-commutable, immediate annuity may be purchased on a secondary market. J.G. Wentworth and its subsidiary, 321 Henderson, provide the Department quotations of the amount they will pay for even the most iron-clad annuities. In most cases these offers are less than 70% of the amount of the outstanding payments and are disguised loans, not purchases; but the Department relies on these quotes to deny Medicaid based on the alleged "market value" of the asset. This policy has been overturned in both state and federal court.[insert link to annuity discussion beginning on 26]

Jointly Held Liquid Assets

The Department will consider jointly held liquid assets to be totally available to the MA applicant or recipient. Assets over which the applicant has unrestricted access and control are countable in determining his SSI and MA eligibility. Therefore, most joint liquid assets will be considered totally available.

If he or she 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 unavailable and are 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–given away–when the funds are removed.

The Administrative Code states, in part, as follows:

> (f)(2) A bank account owned jointly by a husband and wife is not entireties property unless a contrary intent is clearly shown or the account predates September 1, 1976. A bank account may be held in many forms. The legal rights of the parties are not wholly determined by the title of the account. The account title or caption determines the rights of the account in relation to the bank and not their rights in relation to each other. The CAO shall apply the following rebuttable presumptions to determine the availability of bank accounts:
> (i) The person whose name appears on the account title is the owner.
> (ii) Persons who own an account jointly--for example, "and," "or," "and/or"--own the account in proportion to their contributions.
> (iii) If contributions cannot be determined, each owner of a joint account owns an equal share.
> (iv) If an account is titled "in trust for," the account is a tentative trust, unless a written trust document exists. A tentative trust is owned by the trustee, and the beneficiary has no legal rights before the death of the trustee. 55 Pa. A.D.C. § 178.4 (f)(2).

Despite the Code, the Department considers joint bank accounts to be completely available to a Medicaid applicant whose name appears on the account.

Jointly Held Real & Personal Property

Assets which cannot be divided, such as parcels of real property or vehicles, may be considered unavailable if held jointly with rights of survivorship. 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." NCH § 440.3. 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 $40 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 $491[3]. If the total shelter cost exceeds $525, this "Excess Shelter" is added to the CS's Minimum Monthly Maintenance Needs Allowance of $1,712 to derive the "Total Allowance" of up to $2,610. 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 $45 incidental needs and health insurance premiums. The resulting figure is the Patient Pay Amount.

The new policy severely limits the amount of income and resources that can be transferred by the IS to the CS. According to the Operations Memorandum, if the CS's income, including imputed interest from the Community Spouse Resource Allowance, is less than the CSMMNA, the IS's income is used to make up the difference. Only if the IS has insufficient income to make up the difference does the Department permit the Community Spouse to keep additional assets. In that case, the CS is directed to produce three commercial annuity proposals to cover the shortfall, protecting only a

3 The figures used in this paragraph are adjusted annually for increases in cost of living and are current as of January 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.

minimal amount of assets above the CSRA. These rules are also found in the Pennsylvania Administrative Code at 55 Pa. A.D.C. § 181.452.

This forces the CS to rely on income that will terminate on the death of the IS. The spouse's dilemma is illustrated by Mrs. McClusky on Desperate Housewives. She stashed her late husband in the freezer and did not report his death to continue to collect his Social Security and pension.

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.

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.

Preserving Funds with an Annuity–Not!

In most states, a Medicaid applicant may place funds in a Medicaid-sheltered annuity. In order to serve this purpose, the annuity must be irrevocable, unassignable, and there must be no possibility of a lump-sum settlement. 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.

There are three 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. For example, a male at age 80 has a 9.11-year life expectancy. 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 have been considered to have divested the payments for the last 11 years. Finally, the installments must be equal.

This is a useful device to preserve funds for the community spouse. If the TJR is $200,000 when one spouse enters the nursing home, the community spouse may retain $100,000. If the excess funds were put into an annuity, the institutionalized spouse could be immediately eligible. Pennsylvania’s new policy attempts to prohibit using non-qualified funds to purchase annuities to preserve excess assets. A qualified annuity–meaning an annuity in an IRA or purchased as an IRA roll-

over--of an applicant/recipient that names DPW as the beneficiary in the first position will be counted as income to the applicant or recipient.

The Operations Memorandum states, in part, as follows:

> Any provision in an annuity or similar contract for the payment of money owned by an applicant, recipient or spouse of an applicant or recipient, limiting the right to sell, transfer or assign the right to receive payments or restricting the right to change the beneficiary will not be recognized by DPW. *It will be presumed that any annuity or similar contract to receive money is marketable.* OM at 2, 6.

This policy was nominally effective March 1, 2007 and was applied in two cases that were recently, *Ross v. Department of Public Welfare*, 936 A.2d 552 (Pa. Cmwlth. 2007) [link to rosscmnwlthopnion.pdf], and *James v. Richman*, 547 F.3d 214 (3rd Cir. 2008). [link to jamesthirdcircuitopinion.pdf] In each case, the community spouse purchased an annuity with excess assets and DPW denied Medicaid. The denial was based on a valuation of the annuity by JG Wentworth stating that it would pay a lump sum for the stream of future payments. John Payne, the attorney for the appellant in *Ross*, and Matthew Parker, in *James*, contested JG Wentworth's valuation, demonstrating that the annuity issuer would not permit an assignment.

However, in each case the court decided that federal law did not require the community spouse to sell the annuity. Since the annuity stream is an item of income and the community spouse's income is not available for the care of the institutionalized spouse federal law protects such annuities. Therefore, annuities are a way to preserve the Community Spouse's financial security—*with no limit as to amount*.

The Pennsylvania DPW Operations Memorandum includes two examples of permissible annuities:

Example 1: Non-qualified Annuity of Applicant Meets DRA Requirements

1. Mr. Jones, an 86-year-old widower, was admitted to a nursing facility and applied for Medicaid/LTC on March 1, 2007. Mr. Jones requested that Medicaid/LTC benefits be effective the day of his admission.

2. Mr. Jones purchased an annuity for $50,000 on July 15, 2006. The annuity:

- Is irrevocable and non-assignable;
- Is actuarially sound;
- Provides for equal monthly payments with no deferral or balloon payments; and
- Names DPW as the beneficiary in the first position of any funds remaining due at the death of Mr. Jones not to exceed the amount of medical assistance paid by DPW on his behalf.

3. The CAO determines that the annuity is a transfer of assets for FMV and considers the payments from the annuity as income to Mr. Jones.

4. The CAO will include the gross income generated by the annuity in calculating Mr. Jones' payment towards his cost of care.

Example 5: Non-qualified Annuity of CS – Income Less Than or Equal to CSMMNA

1. Mr. Rock, a 75-year-old married man, was admitted to a nursing facility on May, 1, 2007.

2. On May 15, 2007, Mrs. Rock submitted a Resource Assessment indicating that on the day of admission, the couple had $20,000 in total countable resources. Total resources were below the minimum CSRA, currently $20,328. Therefore, all of the resources are protected for the CS.

3. On June 15, 2007, Mrs. Rock completed an application for her husband and requested Medicaid/LTC benefits be effective May 1, 2007.

4. The application indicated that on April 15, 2007, Mrs. Rock, age 78, purchased an annuity for $200,000. The life expectancy of Mrs. Rock is 10.10 years (see Policy Clarification PMN 13293440). The annuity:

- Is irrevocable and non-assignable;
- Is for a ten-year term and is therefore actuarially sound ;
- Provides for equal monthly payments with no deferral or balloon payments over the ten-year period; and
- Names DPW as the beneficiary in the first position of any funds remaining due at the death of Mrs. Rock, not to exceed the amount of medical assistance paid by DPW on behalf of Mr. Rock.

5. Mr. Rock's total gross monthly income is $893.50 from Social Security. Based on his income, he will be able to retain $8,000 in resources for himself ($2,000 resource allowance + $6,000 resource disregard = $8,000).

6. Mrs. Rock receives $1,800 gross monthly income from the annuity. Mrs. Rock also receives $293.50 gross monthly income from Social Security and $25 monthly interest from her CSRA. Mrs. Rock's total gross monthly income is $2,118.50 ($1,800 + $293.50 + $25 = $2,118.50).

7. The CAO determined the CSMMNA for Mrs. Rock to be $2,200 due to a mortgage and excess shelter costs. Mrs. Rock's total gross monthly income of $2,118.50 is less than her CSMMNA of $2,200/month.

8. The CAO will treat the purchase of the annuity as a transfer of assets for FMV and will treat the annuity payments to Mrs. Rock as income.

9. Since we are counting the annuity as income, the CSRA does not have to be amended.

10. Mrs. Rock is entitled to $81.50 from Mr. Rock's income to bring her income up to her CSMMNA of $2,200/mo.

11. The CAO determined Mr. Rock eligible for Medicaid/LTC.

These examples will have very limited application. The first will only provide relief where a very small annuity is purchased. The second is based on an unusual set of facts–the Community Spouse is relatively young, there are high shelter costs, and the combined income is very low. However, federal law prohibits the Department from imposing limits on the amount of excess resources. Therefore, if the couple have $400,000 in excess assets, like Mr. and Mrs. Ross, all of the excess can be preserved for the community spouse through a Medicaid annuity.

Estate Recovery

Converting countable assets to exempt assets is a useful strategy for creating Medicaid eligibility, as long as the value received equals the value transferred. However, it is not a perfect strategy. When the nursing home patient who is receiving Medicaid benefits dies, the Department of Public Welfare may demand repayment for Medicaid expenditures.

This problem requires special scrutiny in Pennsylvania. The estate of a an individual who was 55 years or older at the time that MA was received is liable to repay the Department for the amount of MA paid for all nursing facility services, home and community based services and related hospital and prescription drug services provided from the time the individual was 55 years of age and thereafter. Only MA services provided on or after August 15, 1994, are subject to estate recovery. [NCH § 440.62.] Furthermore, non-probate property generally escapes the Department's grasp. Joint tenancies, life insurance that is paid to individuals, accounts that pay on death to specific beneficiaries, and other property that passes automatically on death avoid estate-recovery. [55 Pa. Adm. Code § 258.3.]

Medicaid claims against the decedent's probate estate are postponed for the life of a surviving spouse or dependant, but do not necessarily go away. [55 Pa. Adm. Code § 258.] To preserve assets for the surviving spouse and the surviving spouse's heirs it is desirable to bypass probate on the death of the institutionalized spouse. Avoiding estate recovery is tricky. Planning around estate recovery is made even more difficult by divestment rules. If the wrong type of transaction is used, the Department may disqualify the nursing home resident from receiving Medicaid benefits for months or years based on a claim that resources were transferred for less than fair consideration, also known as divestment.

Divestment is explained in the following paragraphs. Many transactions that would be useful in avoiding probate and estate recovery will carry a penalty. The interplay between estate recovery and divestment rules are intended to limit the nursing home patient's ability to preserve assets. However, an experienced Medicaid attorney will help to preserve as much as possible.

Divestment

If a Medicaid applicant or spouse disposed of resources--assets or income--for less than fair market value on or after a look-back date, both could become ineligible for certain benefits. They would lose MA for nursing home care, for home health services, and for certain other services for a penalty period. The period is determined by dividing the amount divested by the daily cost of nursing home care for a private-pay patient, currently $222.17. 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 date that my father is an MA applicant or recipient and in nursing care. [NCH § 440.91.] The look-back period for transfers before February 8, 2006 is 36 months, except for certain transactions involving trusts. For all transfers on or after February 8, 2006, the look-back period is 60 months.

If the last transfer was more than 60 months before the date of application, there is no disqualification. If the person 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.

Penalty Start Date and Length of Disqualification

A gift results in a Medicaid penalty that begins when the person who made the gift is otherwise eligible for Medicaid. This is a drastic and restrictive limitation on the ability of elder citizens to dispose of their property. To see how this works, let's assume that Rosco, a widower, is in good health when he gives his grandson $25,000 for college. After the gift, he still has $75,000 in savings. Three years after he made this gift, he suffers a stroke and enters a nursing home. His cost of care as a private-pay patient is $6,500 per month and his income is $1,200, so he has to withdraw $5,300 per month to pay for his care. Four years and three months after the gift, he runs out of money. Under the new rules he cannot get assistance with his nursing home bill for a number of months computed by dividing the $25,000 gift by a number that represents the average cost of private-pay care in a nursing home. Since the Commonwealth uses an average private daily rate of $237.89, the penalty would be for as 105 days--three and one half months.

This penalty provision applies without regard to the reason for a gift. Donations to one's church, one's alma mater, or one's younger, opposite-sex caregiver are all penalized. It would be the same whether Rosco gave his daughter money because she wheedled it out of him or because she needed help paying for a liver transplant.

Under this new rule, the penalty for a gift cannot start until the applicant has made an application for Medicaid and been determined to be eligible, based on the applicant's assets. Then,

unless there is another period of ineligibility running, the penalty is applied. What is Rosco to do if he is penalized *after he has run out of money?* More to the point, what is Rosco's nursing home to do when Rosco cannot pay? The nursing home can discharge him for not paying his bill, but only if they can find another appropriate placement. How likely is that, if he is broke and Medicaid will not pay the bill?

All gifts are required to be lumped together to establish a penalty period, even if the gifts consist of small amounts in successive months. The states are directed not to round down or disregard fractional months. However, Pennsylvania as adopted a "threshold" disregard of $500 per month in gifts.

The new law has an "undue hardship" waiver, as did the previous law. However, the terms under which the waiver may be granted are so limited that it is a dead letter.

Transfers That Are Not Penalized

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.

Transfers to the MA applicant's minor child are also permitted, as are transfers to blind or disabled children, regardless of age. Furthermore, no transfer to a spouse is penalized unless the spouse then transfers the resource to a third person. Transfers between spouses--in any amount and at any time--are expressly permitted.

A transfer is not divestment if there is a "satisfactory showing" that 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. It is virtually impossible to meet the Department's standard of proof. In "Explanation of an Undue Hardship Waiver Request," it states, in part:

> DPW takes the position that any transfer of assets made for less than FMV within the applicable look-back period was made for the purpose of qualifying for Medicaid/LTC Services. You must present documentation or other evidence to the Income Maintenance Caseworker that you are entitled to an undue hardship waiver.

The Department is not interested in quibbles about why a transfer might have been made. If there was a transfer, the penalty will only be waived if there is undue hardship.

It is important for the client to retain assets in his or her own name needed to pay for any disqualification period. Assume that Oscar has $100,000 of countable assets and wants to preserve the maximum amount for his children. If his children promised to pay for care during the disqualification period, and the cost of care is $5,000 per month, $72,000 might be expended during an 18-month disqualification period, assuming that the Oscar's income is $1,000 per month. If Oscar gave or entrusted $58,000 and put $42,000 into a Medicaid annuity to cover care during the penalty period, the disqualification would only be nine months. The $42,000, plus income, might cover the cost of care, leaving the children with $58,000, rather than $28,000.

A disqualification may also be avoided if all assets transferred for less than fair market value are returned to the patient. Return of a portion of the assets will shorten the disqualification period pro rata. However, a new application is required to trigger a recalculation.

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 policy 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.

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." Undue hardship exists when applying a penalty would deprive the client of medical care endangering of life or health. It also exists if the penalty would deprive the client of food, clothing, shelter, or other necessities. The County Assistance Office has “flexibility” in deciding whether “funds in trust are not counted under the transfer requirements because of undue hardship.” [NCH § 440.98.] The Handbook provides little guidance, but the client has the right to appeal an adverse decision.

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 rules apply to trusts established by others for aged and disabled individuals with the disabled individual’s assets unless the state is assigned the residue on the death of the individuals and certain other conditions are met.

Creating a revocable trust should not constitute divestment, provided my father or his wife 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. [42 U.S.C.A. § 1396p(c)(2)(B).]

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.

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.