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PAYING FOR NURSING HOME CARE: A GUIDE TO MEDICAID PLANNING

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PAYING FOR NURSING HOME CARE: A GUIDE TO MEDICAID PLANNING

The decision to place a loved one in a nursing home is often accompanied by an incredible amount of anxiety and stress. Whether the need for long-term care is brought on by a sudden accident or by a long-term, progressive illness, this is likely an unhappy time for both the person entering the nursing home and those who are helping with the transition.

The last thing most people want to do during this time is to deal with the question of how to carry the often overwhelming financial burden associated with nursing home care. However, it is critical to make good financial choices during this period, because these decisions can have far-reaching consequences. Fortunately, there are options for alleviating the burden, and help is available to guide you through this unfamiliar process.

This guide is designed to address some common financial issues that come up during the process of transitioning a loved one to a nursing home.

According to federal government statistics, as of the year 2000, approximately 13 million Americans needed some form of long-term care. This figure is expected to grow to 27 million by the middle of this century. The transition from living independently to living in a long-term care facility, such as a nursing home, is one involving great difficulty for many people. It means giving up a certain amount of control over your own life. No longer are you in your own home, with all the privacy and independence that entails. Even in the best of nursing home situations, there are significant adjustments that need to be made, both by the person receiving care and by those family members or loved ones helping with the transition.

Besides the upheaval involved in moving to a nursing home, there is also the stress of figuring out how to pay for nursing home bills that can total $7,000 each month.

COVERING THE COST OF NURSING HOME CARE

Aside from choosing the right facility, the number one concern for many families is how to pay for long-term care in a nursing facility. The most common means of paying for care fall into the following categories:

- **Out of Pocket.** With the average monthly nursing home bill coming in at $6,996, only those with substantial income or savings are able to pay for all of their long-term care from their own funds. However, this is the initial payment method that many families have to use until other benefits take effect.

- **Reverse Mortgage.** For families who don't have enough savings or income to cover the entire bill for long-term care, reverse mortgages are becoming an increasingly popular option. Homeowners who have reached a certain age can qualify for a reverse mortgage, draw on the equity in their home, and not have to worry about the loan coming due as long as they reside in the home. This option works for some people, but it is not a good choice for those who are single, or those who want to pass their homes on to their heirs.

- **Private Insurance**. Long-term care insurance is a relatively new option that is gaining popularity, but it is not yet a common method of paying for care. Policies can be confusing, and insurance only pays for a set amount per day for a certain number of years.

- **Medicare.** Medicare is the federal health insurance program that is available to people 65 and over. It provides limited, short-term coverage of some costs associated with long-term care.

- **Medicaid.** Medicaid is a needs-based medical assistance program that is jointly funded by the federal and state governments. It pays medical expenses for those who can't afford their own care, and can pay a large portion of long-term care costs for those who meet certain requirements.

The focus of this report is Medicaid coverage, and, to a lesser extent, the coverage offered by Medicare.

THE LIMITS OF MEDICARE

Medicare provides limited benefits for long-term care. The program makes a distinction between "skilled care" and "custodial care." Custodial care is assistance with basic daily tasks like getting in and out of bed, eating, and taking care of personal hygiene, and is not covered by Medicare. Skilled care is for things like injections and physical therapy that require the assistance of nurses or rehabilitation staff. Medicare provides some coverage for this type of care, but it is very restricted.

If you need skilled care and qualify for Medicare, then the program will pay for your first 20 days in a skilled nursing facility. For days 21 through 100, the program will pay a portion of the costs, but you will be responsible for a substantial deductible. After day 100, Medicare does not pay any of the costs of skilled care. Furthermore, because of additional restrictions, Medicare benefits are often terminated well before the 100-day limit.

If you have a private supplemental insurance policy, then it may cover the Medicare deductible for days 21 through 100. If you have a Medicare managed care plan, then your deductible will be covered as long as you meet the plan's strict eligibility requirements.

Under any scenario, however, you are limited to 100 days of Medicare coverage per "spell of illness." A "spell of illness" is defined as treatment requiring skilled care for a period of 60 consecutive days. Once you have been discharged from skilled care, your benefit period continues for 60 days. This means that if you once again need skilled care within 60 days after discharge, then the new treatment period is tacked on to the period of care you have just received, until the two total 100 days and coverage is terminated. On the other hand, if you are discharged from skilled care and need treatment again after 60 days have elapsed, a new "spell of illness" begins, and both your deductibles and your 100-day period of coverage begin again. There is no limit to the number of "spells of illness" Medicare will cover.

Since Medicare provides spotty coverage at best, most people who are facing the need for long-term care must look to other sources to pay for their care.

THE NEED FOR MEDICAID

Unlike Medicare, the Medicaid program provides long-term coverage for nursing home stays, and it covers custodial care as well as skilled care. There are strict eligibility requirements for Medicaid, including caps on income and assets. Despite these strict requirements, it is not necessary to be impoverished in order to receive Medicaid benefits for nursing home care. Medicaid planning, when done properly, is a legal and ethical way to qualify for benefits while still retaining your family's financial security.

The rules surrounding Medicaid are convoluted and can be confusing, making it necessary to seek professional guidance for the process of Medicaid planning. There are stiff penalties for failing to follow the rules concerning qualifying for coverage, such as making improper transfers of assets in an attempt to qualify. On the other hand, you want to make sure that you only spend as much as you absolutely need to, so that your loved ones can remain financially stable.

WHAT ASSETS CAN YOU KEEP?

Medicaid is a need-based program, meaning that your eligibility is determined by whether you have low enough income and few enough assets. Under the rules, your assets are divided into two categories: exempt assets and countable assets. Countable assets are those included in the calculations that will determine whether you are within the qualification limits. Exempt assets are those that are not counted toward your limit. Exempt assets include:

- One home (as long as it is your primary residence), with equity up to $585,000
- One personal vehicle
- Your personal belongings, furniture, and other household goods
- A burial fund for you and your spouse with a total value of up to $1,500
- A life insurance policy valued at less than $1,500

Most other assets are considered countable, including:

- Cash, including checking, savings, and money market accounts
- Stocks, bonds, and mutual funds
- Real estate other than your primary residence
- Vehicles other than your one exempt car or truck
- Livestock and farm equipment
- Revocable prepaid funeral contracts
- Certain trusts
- Oil, gas, and water leases or rights

As a basic rule, a single person can qualify for Medicaid if he or she has only exempt assets, plus no more than $2,000 in cash. There are special rules that apply to married couples when only one spouse is in need of nursing home care.

MARRIED COUPLES

When Medicaid was first enacted, the eligibility requirements for single people and married couples were the same. Over time, it became apparent that this was a flaw in the system. Under the original rules, if one spouse developed a need for nursing home care while the other spouse remained well, the assets of both spouses had to be reduced in order to meet the eligibility requirements. This meant that the spouse who remained well was forced to live in poverty, and would ultimately need government assistance.

In 1988, the federal government changed the eligibility rules for married couples. These provisions are commonly referred to as Division of Assets, and they apply when one spouse needs to go into a nursing home, while the other spouse, the Community Spouse, remains at home.

There are two components involved in division of assets: The Community Spouse Resource Allowance and the Minimum Monthly Maintenance Needs Allowance.

To determine the Community Spouse's Resource Allowance, the couple's countable assets are totaled. The assets are then divided in half, and the Community Spouse is allowed to keep half of the assets, up to a maximum of $126,420. The couple then has to "spend down" the assets assigned to the spouse who needs nursing home care until those assets are no more than $2,000.

To make sure the Community Spouse not only gets to retain some of the couple's assets, but also has money coming in each month, there is also the Minimum Monthly Maintenance Needs Allowance. Under this allowance, the spouse who remains at home is entitled to keep an income ranging from $2,057 to $3,160 each month. The government uses a complicated formula to determine the exact amount of the allowance. If the Community Spouse's income does not reach

this level, then a portion of the ill spouse's income is diverted away from paying for the nursing home and given to the well spouse to reach the amount of the allowance.

Consider the situation of Bob and Elaine, a married couple. Elaine has Alzheimer's and has been admitted to a nursing home, while Bob remains in the couple's family home. Bob receives $1,200 per month in social security, and Elaine's social security check is $900 per month. Bob's Minimum Monthly Needs Allowance has been calculated at $2,100. After accounting for his social security income, he has a monthly shortfall of $900.

$2,100	Minimum Monthly Needs Allowance
-$1,200	Bob's Social Security income
$ 900	Bob's monthly shortfall

In order for Bob to receive his full allowance, $900 of Elaine's social security (all of it) is allocated to Bob each month.

Although the basic rules can paint a bleak picture, with proper planning many people are able to have Medicaid pay for nursing home care, while keeping a substantial portion of their income and assets.

COMMON QUESTIONS ABOUT MEDICAID PLANNING

The complexity surrounding this constantly changing area can be confusing. Here are a number of common questions and answers to assist in your research.

ARE JOINT ACCOUNTS CONSIDERED COUNTABLE ASSETS?

In general, when more than one name is on a cash asset like a bank account, savings bond, or CD, the entire amount is considered a countable asset. The only exception to this rule is a situation where you can prove that a portion of the money in the account was contributed by a joint account holder other than you or your spouse. In this situation, the portion that was contributed by the other person is not counted for Medicaid purposes.

CAN I MAKE MYSELF ELIGIBLE BY GIVING AWAY MY ASSETS?

Part of Medicaid planning may involve giving away some of your assets; however, this has to be done with extreme caution. There are tough penalties for simply giving away your assets to meet the eligibility requirements.

Every $6,996 worth of assets that you give away within five years prior to applying for Medicaid will make you ineligible for one month. What's worse, the ineligibility period does not begin until you have already spent down your other assets and you are in a nursing home. Furthermore, if

it's found that you committed fraud in trying to qualify for Medicaid, not only will you be ineligible for benefits, but you'll have to repay whatever benefits you've already received.

Because the rules are strict and the penalties are harsh, it is critical that you seek the advice of an experienced elder law attorney before you attempt to give away any assets.

CAN'T I GIVE AWAY $15,000 PER YEAR PENALTY-FREE?

This is a common misconception about Medicaid that results from confusing federal tax laws with Medicaid rules. Under the federal gift tax exemption, you are allowed to give away up to $15,000 per year without paying gift tax. There is no such blanket Medicaid exemption. If you want to make gifts to your children for estate planning purposes, you may be able to do this through a properly established gifting program. However, it's important to consult a qualified elder law attorney before you consider giving away any assets.

HOW CAN MEDICAID PLANNING HELP A MARRIED COUPLE?

In a situation where one spouse needs nursing home care, while the other spouse remains healthy, proper Medicaid eligibility planning can mean the difference between "spending down" a significant portion of the family's assets and keeping those assets for future needs.

For example, Jim and Joanne have been married for 53 years. Six months ago, Joanne had a stroke. Jim has been struggling to take care of her at home, but it's just too much, and he has finally made the decision to place her in a nursing home. They're not rich by any stretch of the imagination, but over the years, they've managed to accumulate $100,000 in savings and other assets, plus they own their home, which is worth about $110,000, free and clear.

Their combined income is $2,000 each month, with Jim receiving social security and a pension totaling $1,450, and Joanne receiving $550 in social security. The couple has no long-term care insurance, and paying out-of-pocket for Joanne's nursing home care would mean that they would run through their savings in just a few short years, leaving Jim in poverty.

Jim decides that the best option is to apply for Medicaid so the cost of Joanne's care will be covered. If he simply follows state guidelines without seeking any Medicaid planning advice, then he'll be able to keep the house and about half of their other assets, plus his income and a portion of Joanne's income. However, this means "spending down" the other half of their assets, or about $50,000.

On the other hand, with proper planning, Jim may be able to convert the "spend down" amount into an income stream that will provide for his needs, while at the same time avoiding any waiting period before Joanne is eligible for Medicaid. He'll have to seek good advice, and be very careful to stay within Medicaid rules. Any transfers of either spouse's assets, if not properly made, can trigger a period of ineligibility.

The strategies that work in one family's situation may not work in another family's situation, so Jim will have to seek individualized advice – he can't just do what worked for a neighbor or friend. However, using the services of a qualified elder law attorney can help in determining the best course of action.

I HAVE A DISABLED CHILD; IS THERE A WAY TO PROVIDE FOR MY CHILD AND QUALIFY FOR MEDICAID MYSELF?

Parents of disabled children face a special set of circumstances when it comes time for one spouse to be admitted to a nursing home. Many people find themselves in a situation where it appears that, in order to become eligible for Medicaid, they'll have to spend down a significant portion of their assets or savings. When a family has a disabled child who needs this money, the situation can look very bleak.

Often, establishing a Special Needs Trust can help with this scenario. If the "spend down" amount is placed in a properly established Special Needs Trust with the disabled child as the trust beneficiary, then Medicaid eligibility can be achieved while still providing for the child's needs.

As with any other Medicaid planning strategy, it is essential that you have the guidance of an experienced attorney when setting up a Trust. Even one mistake can result in noncompliance with Medicaid guidelines, and you could end up losing eligibility and repaying benefits.

DOES RECEIVING MEDICAID MEAN I'LL LOSE MY HOME?

For many of us, our home is our most significant asset, and it can be the bulk of the estate that we plan to pass on to our children. For purposes of qualifying for Medicaid, a home with equity of less than $585,000 is considered an exempt asset; so in most situations, you can keep your home when you enter long-term care and still be eligible for Medicaid.

The potential problem is that there is another law dealing not with Medicaid eligibility but with recovery of the value of Medicaid payments. Under this 1993 law, after the Medicaid recipient dies, (and after his or her spouse passes away, if the recipient was married), the state can try to recover the Medicaid benefits that were paid. This amount is recovered from the recipient's probate estate, and in some cases, from his or her non-probate estate. Since the family home is most people's most valuable asset, the state often attempts to make the required recovery by forcing the sale of the home.

Again, for most people, this does not mean that you'll have to sell your home in order to qualify for Medicaid, but it might mean that, after your death, your home could be sold to pay back the state for the benefits you received. Medicaid rules are highly specific and are constantly changing, so it is important to seek the advice of an expert if you have questions about your particular situation.

CHOOSING AN ATTORNEY

Navigating the Medicaid system can be an incredibly complex and convoluted process, and most people find that, in order to receive the best results, they need the help of someone who knows the rules and has the experience necessary to guide them through a difficult situation.

Medicaid planning generally falls within the expertise of elder law attorneys, but all elder law attorneys are not created equal. How do you go about finding the right attorney for you?

A good place to start is to ask for recommendations from friends or family members who have dealt with nursing home issues. Find out who helped them and what kind of assistance they received. Other good sources of recommendations include clergy members, hospital social workers, or financial professionals.

It is not enough just to go with whomever is recommended; it's important talk to several attorneys, and to carefully investigate the credentials of any attorney you're considering.

When you interview an attorney, find out what portion of their practice is devoted to Medicaid planning. In general, the more time an attorney spends in this area, the more up-to-date he or she is likely to be on the regulations and the strategies you'll be dealing with. Other questions to ask when you talk to an attorney include:

- Whether he or she is involved with any organizations that deal specifically with Medicaid or nursing home planning.
- Whether he or she lectures to other attorneys on the topic of nursing home planning.
- Whether he or she has published any books or articles on the subject.
- How many annual hours of continuing legal education he or she receives in the area.

In addition to experience and credentials, it is important that you find an attorney you'll be comfortable interacting with during this difficult period in your life. When you interview an attorney, pay attention to whether or not he or she really listens to you and responds to your concerns. You want someone who makes an effort to understand the specifics of your situation and who is able to answer your questions.

Choosing an attorney is a highly individual decision. Ultimately, your goal is to find someone who is knowledgeable and experienced, and with whom you feel comfortable.

ABOUT THE ACADEMY

This report reflects the opinion of the American Academy of Estate Planning Attorneys. It is based on our understanding of national trends and procedures, and is intended only as a simple overview of the basic estate planning issues. We recommend you do not base your own estate planning on the contents of this Academy Report alone. Review your estate planning goals with a qualified estate planning attorney.

The Academy is a national organization dedicated to promoting excellence in estate planning by providing its exclusive Membership of attorneys with up-to-date research on estate and tax planning, educational materials, and other important resources to empower them to provide superior estate planning services.

The Academy expects Members to have at least 36 hours of legal education each year specifically in estate, tax, probate and/or elder law subjects. To ensure this goal is met, the Academy provides over 40 hours of continuing legal education each year. The Academy has also been recognized as a consumer legal source by *Money Magazine, Consumer Reports Money Adviser* and Suze Orman in her book, *9 Steps to Financial Freedom*.

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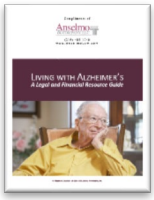
7 Things You Need to Know Before You Choose a Nursing Home

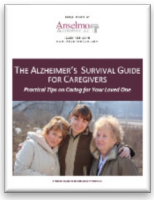


Living with Alzheimer's: A Legal and Financial Resource Guide

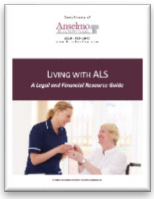
Plan Today for a Secure Tomorrow: Medicaid Planning with an Income-Only Trust

A Nursing Home Resident's Rights: Ensuring You Get the Care You Deserve

Medicaid Planning for Married Couples: Solutions to Paying for Nursing Home Care



The Alzheimer's Survival Guide for Caregivers: Tips on Caring for Your Loved One



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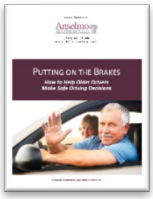
A Family Guide on Medicaid Planning: What it is, How it Works, & Why You Need a Plan



Putting on the Brakes: How to Help Older Drivers Make Safe Driving Decisions