FOULSTON SIEFKIN LLP

ATTORNEYS AT LAW

# *Foulston Siefkin Estate Planning:* MEDICAID AND LONG-TERM CARE PLANNING

Statistics indicate that there is an approximate 45% chance that a person over the age of 65 will at some time reside in a nursing home facility (33% of men; 52% of women). For married couples, there is an approximate 70% chance that at least one of the marriage partners over the age of 65 will spend some time in a nursing facility.

This high percentage is a result significantly from the impact of Alzheimer's disease, which accounts for approximately 60% of dementias, as well as similar mentally debilitating diseases. Approximately 5,000,000 Americans and 65,000 Kansans are afflicted with Alzheimer's. As Americans continue to live longer, a higher percentage of individuals will tend to incur mentally debilitating diseases related to age. For example, statistics indicate that 3% of Americans between the ages of 65 and 75 have Alzheimer's, 19% of those between 75 and 85 have the disease, and 47% of those over 85 are afflicted with this malady.

For those persons whose stay in a nursing facility is long-term and not rehabilitative in nature, the national average is a cumulative stay of 2.5 years. However, for 15 percent of the population, the cumulative stay exceeds five years. Average costs of a long-term care resident in Kansas now approximate $200.00 per day.

Kansas has ranked in the top ten states in about every age category with respect to the percentage of its citizenry over the age of 65. Despite the cost of nursing home care in recent years which outpaces the rate of inflation nationally, Kansas continues to rank below the national average in the cost of nursing home care. However, due to the high average age of its citizenry, the percentage of Kansas citizens residing in nursing facilities exceeds the national average and what statistics are available tend to indicate that the average long-term stay of a Kansas long-term care recipient will similarly tend to exceed the national average. This latter factor may be due to the relatively low cost of Kansas nursing home care in relation to the national averages and thus the inception of such care may not be deferred as much as it might be in other higher cost states. Given that nursing home costs in Kansas are averaging approximately $6,000 per month, the average long-term nursing home cost for a Kansas citizen would be expected to approximate $200,000.

Experts in long-term care have estimated that 80% of medical expenditures for people over the age of 65 are spent on long-term health care, either in nursing homes or in a private residence. There are three ways to pay for these expenses: out-of-pocket from one's own resources, government aid (Medicaid, Medicare, Veterans Administration), or private long-term care insurance. Over one-half of the residents in nursing homes are on some type of government assistance. Due to the limited availability and eligibility requirements of Veterans Administration (VA) benefits and the limited duration of Medicare benefits, this is principally through Medicaid benefits. Medicaid is a "need based" program, the cost of which is paid approximately 40% by the state government and 60% by the federal government. In Kansas, Medicaid payments and eligibility regarding long-term care benefits are administrated by the Kansas DCF, which is also given some leeway in interpreting federal law governing Medicaid eligibility determinations.

Discussed below are the long-term care coverage provided by governmental resources, estate planning techniques which can maximize their availability, the factors involved in determining whether long-term care (LTC) benefits not covered by governmental resources should be covered out of pocket, i.e., by being self-insured, or through the purchase of long-term care health insurance, and the considerations involved in purchasing a long-term care insurance policy.



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## MEDICARE BENEFITS INSUFFICIENT

Facing what could amount to a staggering cost for a long-term stay in a nursing home facility, individuals of advancing age face a dilemma in determining the proper approach in planning for such possibility. If Medicare substantially covers such costs, as many individuals mistakenly assume, a substantial commitment of one's own personal finances and the use of sophisticated estate planning strategies to protect assets would prove to be unnecessary.

However, Medicare's eligibility rules are quite restrictive. Medicare eligibility does not commence until one turns 65 years of age. Even then, coverage requires a hospital stay of at least three nights and the entering of a nursing home facility which participates in Medicare within 30 days of discharge from the hospital. Additionally, the stay in the nursing facility must be for the same condition for which hospitalization was required, be rehabilitative nature of Medicare benefits must be short term as opposed to long term, and such hospital care must be for skilled care (daily care from a licensed medical professional) as opposed to intermediate (intermittent care by a licensed medical professional, e.g., in rehabilitation) or custodial care (care not needing a licensed medical professional). Less than one percent of those residing in nursing homes receive skilled care. Even then, Medicare will only fully cover the first 20 days of such skilled care in full, requiring a co-payment of approximately $100 per day to cover the next 80 days, after which all Medicare coverage ceases.

There appears to be little likelihood that the federal government in the reasonably foreseeable future will significantly increase the benefits of LTC covered by Medicare. In a period of profound budgetary deficits and other fiscal restraints despite an aging political base, the enormous costs of covering a rapidly aging population under Medicare would not be expected to be politically palatable.

## MEDICAID ELIGIBILITY RULES

One possible LTC planning strategy is to simply resort to one's own funds in combination with an estate planning strategy maximizing benefits under the Medicaid "safety net." Medicaid benefits are provided by federal law. In Kansas, Medicaid LTC eligibility is administered by the Kansas Department for Children and Families (DCF). The Kansas Health Policy Authority (KHPA) is the state agency which governs the state interpretation to be given federal Medicaid provisions. This summary below is a discussion of the Kansas interpretation of Medicaid rules and thus would not necessarily be applicable to a resident of another state.

Unlike Medicare, eligibility for Medicaid LTC benefits requires a person to be financially "needy." First, there must be a medical need. The applicant is screened to determine whether residency in a nursing home facility is not only necessary, but also that there are no less costly alternatives available.

Secondly, there must be a financial need. Normally, Medicaid recipients may not have more than $2,000 in excess of certain exempt resources if they are to qualify for Medicaid. Exempt resources generally are a personal residence including contiguous acreage not broken by a public road (the value of a personal residence after deducting any mortgage liability that may be considered exempt being limited in Kansas, unless the spouse of the Medicaid recipient is living in the personal residence, to $552,000 (2015 indexed amount), by the federal Deficit Reduction Act of 2005), household furnishings, one car, household goods, personal keepsakes, personal effects, tools of one's trade, a very small amount of cash value of life insurance (death benefit limited to $1500), all term life insurance having no cash value, a burial space, headstone and casket, and certain pre-paid funeral and burial plans within specified cost limitations. In addition, for married individuals, the qualified retirement plan and IRA assets of the non-infirm or "community" spouse are exempt. Certain limited income-producing property other than cash (e.g., business assets or farmland which is leased out) may also be able to be exempted.

## "DIVISION OF ASSETS" MEDICAID ELIGIBILITY REQUIREMENT FOR MARRIED INDIVIDUALS

Under the "division of assets" requirement applicable only for married Medicaid applicants, the "community spouse" (i.e., the non-infirm spouse estate planners often refer to in more common parlance as the "well spouse") is able to retain a certain amount of otherwise non-exempt assets and yet qualify the "infirm spouse" for Medicaid benefits. Federal law allows married couples to divide their resources for Medicaid purposes. In addition to exempt resources, one-half of the non-exempt resources (with a current minimum in 2015 of $23,448 and a current maximum of $119,220, both numbers being subject to subsequent periodic adjustments for inflation) as of the date the infirm spouse entered a long-term care setting can be set aside to the "well spouse" without having to count such divided non-exempt resources as a resource to the infirm spouse.

Thus, the infirm spouse will normally only qualify for Medicaid when: 1) there are no non-exempt assets in his or her name (which can be effectuated by transferring all non-exempt assets to the "well spouse," either by the infirm spouse or through a power of



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attorney authorizing such transfers if the infirm spouse has insufficient capacity to make such transfers, as transfers to a spouse do not incur any Medicaid disqualification period; 2) the non-exempt assets owned by the "well spouse" do not exceed the foregoing "division of assets" amount; and 3) there in no remaining disqualification period for prior transfers as discussed below.

## NO INCOME TEST FOR MEDICAID ELIGIBILITY

In addition to the resource test, there once was an income test for qualification for Medicaid. It was imposed by the 1991 Kansas legislature at $1,410.00 per month. However, pursuant to 1993 federal legislation implemented by Kansas Department of Social and Rehabilitation Services in 1994, an irrevocable trust could be created for the applicant's income (so-called "Miller Trusts") which would avoid the Medicaid cap. Generally, the applicant's income was assigned to the trust. The trust was allowed to return a minimum amount for a monthly needs allowance and for maintenance of the trust. The remaining income then was paid to the nursing home and Medicaid would then pick up the difference for nursing home costs between the income paid to the nursing home and the current reimbursement rate. In 1996, due at least in part to the ability of the applicant to circumvent the limitation using the foregoing technique, the income limitation was repealed by the Kansas legislature. Consequently, for over two decades, despite some public misconceptions, there has been no income eligibility rule governing the qualification of an applicant for Medicaid.

Although there is no income test for the applicant in order to qualify for Medicaid, if the total unprotected income exceeds the Medicaid reimbursement rate for the particular facility involved, the recipient will not qualify for Medicaid. In addition, once a Medicaid applicant meets the requirements to qualify for Medicaid, any monthly income of the Medicaid recipient (e.g., social security and any pension) in excess of $62 (an incidental needs allowance) normally must go to the facility, with Medicaid paying to the long-term care facility any deficiency between such unprotected income and the applicable Medicaid reimbursement rate for that facility.

Under both prior and current federal law, the income of a spouse is irrelevant to the applicant's ability to qualify for Medicaid. However, it is not sufficient for a married person simply to have met the resource test (i.e., only own non-exempt resources) and not have any remaining disqualification period resulting from disqualifying transfer in order to qualify for Medicaid benefits. A married Medicaid applicant must also meet the "division of assets" test, which limits the amount of non-exempt assets the applicant's spouse may own and still have the Medicaid applicant qualify for Medicaid.

## THE "DIVISION OF INCOME" SPOUSAL MEDICAID BENEFIT

In addition to being able to retain non-exempt resources equal to the "division of assets" amount, a well spouse is also currently entitled in 2015 to a base of $1,967.00 per month of total spousal income (plus shelter allowances to the extent that rent or mortgage expenses exceed $219 (up to a maximum of $992/month for excess shelter allowance), permitting a current maximum total of $2,981 in 2015 in such circumstances) after qualifying the infirm spouse for Medicaid. This is the so-called "division of income" law.

Unlike the "division of assets" test which can disqualify an infirm spouse who owns only non-exempt assets for Medicaid eligibility until the well spouse "spends down" to the "division of assets" amount, the "division of income" test is not a test which needs to be met in order for the infirm spouse to qualify for Medicaid. Adjusted at least annually, instead it allows the well spouse to in essence transfer income from the infirm spouse who qualifies for Medicaid (thus lowering the income of the infirm spouse otherwise going to the nursing home) to the well spouse in an amount necessary to bring the well spouse up to the minimum income level.

For Medicaid recipients who are not receiving care in a long-term care facility but through what is termed Home and Community Based Services (or "HCBS"), the protected monthly income level is $747 (subject to a reduction under current budget shortfalls) for an individual in 2015 which protected amount may be retained by the Medicaid recipient without adversely affecting HCBS benefits.

## GIFTING CAN RESULT IN A PERIOD OF MEDICAID DISQUALIFICATION

For those who gift assets (whether exempt or non-exempt) away to someone other than a spouse in an attempt to qualify for Medicaid, there can be a disqualification period. The reason gifts to spouses are exempt from such disqualification rules is that the resources of a spouse are considered under the "division of assets" test discussed above in determining the qualification of a Medicaid applicant for Medicaid eligibility. Such gifts for insufficient consideration (i.e., the amount paid is less than the value of the property transferred) to someone other than a spouse caused a disqualification of one month for every $2,000 given away for applications made for Medicaid prior to July 1, 2001. For applications for Medicaid on or after July 1, 2001, the $2,000 amount was increased to $3,000 (irrespective of when the transfer occurred). Effective April 1, 2007, for gifts made on or after February 8, 2006, the disqualification period is now calculated on a per day basis. That amount currently is $172.36 day, or approximately $5,170 for a 30-day month if viewed on an average thirty day monthly basis. These periodically adjusted disqualification amounts are considered to be the current average daily/monthly nursing home cost.



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There normally is a "cap" on such disqualification period, irrespective of the amount of the disqualifying transfer. That normal maximum disqualification period prior to February 8, 2006, the effective date of the federal Deficit Reduction Act of 2005 in Kansas, was thirty-six months (although gifts involving trusts could cause the maximum disqualification period to be extended to sixty months), provided an application for Medicaid was not made within thirty-six months of the date of transfer, the "look back" period in which transfers prior to the date of the Medicaid application had to be disclosed. For transfers made after February 8, 2006, the effective date of the Deficit Reduction Act of 2005 in Kansas, the rules changed substantially. First, the disqualification period no longer commences from the date of the gift, but from the date of application for Medicaid when the applicant has become "medically needy" (i.e., was in a long-term care facility and only possessed non-exempt resources) so as to otherwise qualify for long-term care benefits provided by Medicaid except for such gifts. Secondly, the "look back" period has been extended to sixty months (or five years) for all gifts.

Due to provisions of the Deficit Reduction Act of 2005, the normal maximum disqualification period is now five years for transfers made on or after February 8, 2006, the effective date of the Act, irrespective of whether a trust was involved in the transfer. However, notwithstanding this normal longer maximum disqualification period, applying for Medicaid both during both the disqualification period and "look back" period continues to be a "trap for the unwary" and can extend the otherwise applicable disqualification period. This is because if an application for Medicaid is made during the five year "look back" period in which disqualifying transfers must be disclosed on a Medicaid application, the disqualification period is determined in the usual manner, i.e., by dividing the amount of the transfer by the current $172.36 per day amount in determining the number of days in which the transferor/Medicaid applicant will be disqualified for Medicaid benefits. If the disqualification period under such calculation extends beyond five years, then that becomes the applicable disqualification period.

Thus, it is important to understand that the five year "look back" period does not put a "cap" of five years on the period of disqualification resulting from the transfer if a Medicaid application is made during the "look back" period. Once a disqualifying transfer is required to be disclosed, i.e., an application for Medicaid is made during the five year "look back" period, the number of days in which the Medicaid applicant/transferor will be disqualified for Medicaid benefits is based strictly upon the actual amount transferred. Example: The Medicaid applicant/transferor transfers $300,000 to his children on or after February 8, 2006. Within sixty months of such transfer, the transferor applies for Medicaid. As all transfers within such five year "look back" period prior to the Medicaid application must be disclosed on the application, the $300,000 transfer will be required to be disclosed thereon. Thus, by dividing the amount of such transfer by the $172.36 per day amount, an approximate fifty-eight month disqualification period will result. Had the Medicaid application not been made until more than five years had expired following such transfer, such transfer would be outside the five year "look back period" and thus not be required to be disclosed on the Medicaid application. In such latter situation, no disqualification period would result from the $300,000 transfer. Consequently, normally it is important not to apply for Medicaid when: (a) there is either a remaining disqualification period or the disqualification period as a result of the transfer has not even commenced; and (b) the disqualifying transfer was made during the five year "look back" period. This is because the Medicaid applicant will not qualify for Medicaid in that situation (the disqualification period has not expired) and there will be no five year "cap" on the disqualification period if the amount of the disqualification period would otherwise extend beyond five years due to having to be disclosed on the Medicaid application.

Also, as noted above, other provisions of the federal Deficit Reduction Act of 2005 of perhaps even greater importance provide that the disqualification period for disqualifying transfers made on or after February 8, 2006, which are required to be disclosed within the five year "look back" period will no longer commence from the date of the transfer, but when the Medicaid applicant otherwise qualifies for Medicaid, i.e., is possessed of only exempt resources not considering any prior transfers and the transferor meets the "medically needy" test for long-term care (i.e., normally requiring the transferor to be in a long-term care facility). This change will dramatically reduce the efficacy in making transfers to enhance Medicaid eligibility prior to the transferor being in a long-term care facility, as the disqualification period will no longer commence prior to the transferor residing in such a facility, being possessed of only exempt resources and having applied for Medicaid.

## MEDICAID PLANNING STRATEGIES

The foregoing rules and recent federal law changes limit Medicaid planning opportunities. Nonetheless, there remain several available strategies. Prior to discussing such strategies, the author acknowledges that some individuals may find these strategies to be personally objectionable. However, attorneys as legal counselors have an ethical and professional obligation to advise a client with regard to all relevant legally permissible options which can achieve the client's estate planning goals. Clients should expect nothing less. It is then up to the client to choose those options with which the client is most comfortable and deems appropriate. In LTC situations,



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maximizing Medicaid eligibility through the use of qualification strategies which fully comport with all legal and regulatory requirements is an available legal option in meeting an LTC need. Obviously, an individual is not legally required to expend any more of an individual's assets for long-term care than the law requires prior to qualifying for Medicaid benefits. In much the same manner an individual is not legally required to pay more in taxes to federal, state and local governments than required by governing tax statutes. The laws Congress enacts establish public policy. Congress and its highly knowledgeable and experienced policy staff are well aware of most strategies used by citizens to maximize Medicaid eligibility and minimize federal income taxation. In the event the members of Congress at any time deem such governmental resource or tax strategies to no longer be acceptable, whether from an altruistic public policy, or merely political, point of view, Congress can, and frequently does, enact modifying legislation. In the interim, any individual is certainly free for any reason to choose not to use or maximize any legally permissible strategy such individual finds to be objectionable.

A primary strategy in maximizing Medicaid eligibility is through asset restructuring, i.e., converting non-exempt resources into exempt resources. Such purchases do not constitute disqualifying transfers and will assist in reducing the Medicaid applicant's non-exempt resources in order to meet the resource test. Secondly, one may gift assets to children or other parties and then "wait out" the applicable disqualification period. Under the provisions of the Deficit Reduction Act of 2005 discussed above, however, unless the five year "look back" period has not expired following the disqualifying transfer, the disqualification period does not commence until the transferor is possessed of only exempt resources and is "medically needy," i.e., the Medicaid applicant must normally be residing in a long-term care facility.

Although the new law has some ambiguities, it may also permit what has been termed a "half a loaf" strategy to be implemented in accelerating Medicaid eligibility. Under this strategy, a Medicaid applicant who is already in a long-term care facility would make two separate and distinct transfers upon becoming "medically needy." These transfers would leave the applicant with only exempt resources so as to start the disqualification period (the transfers being aggregated and divided by the applicable $172.36 per day amount to determine the applicable period of disqualification). After making both transfers, one of the transfers would then be returned by the transferee to the applicant. Under Medicaid eligibility rules, the period of disqualification arguably should be reduced to the extent of such re-transfer amount. Such re-transfer amount then could be utilized to pay for long-term care during the period of disqualification caused by the other transfer. Unfortunately, it appears the current Kansas DCF position is that this technique is ineffective to reduce the transfer period.

With respect to married Medicaid applicants, Medicaid eligibility strategies for the infirm spouse may be employed to reduce the period of time necessary for the "well spouse" to meet the "division of assets" test. Under such strategies, the "well spouse" may purchase exempt assets with non-exempt assets (e.g., buying an exempt irrevocable pre-paid funeral plan and burial plot, paying off a mortgage on the principal residence, making improvements in the principal residence, purchasing a vehicle, purchasing household furnishings, and purchasing "income producing" assets which are exempt resources) in an amount necessary to reduce the couple's exempt assets to the "division of assets" amount such that the "infirm spouse" may qualify for Medicaid.

Additional strategies which maximize the "division of assets" eligibility test for married Medicaid applicants include borrowing assets prior to the "financial snapshot date." As the "division of assets" eligibility test does not consider liabilities of either spouse, such borrowing will have the effect of increasing the numerator of the "division of assets" amount prior to dividing such amount by two in determining the "spend down" amount necessary to qualify the "infirm spouse" for Medicaid. Thus, unless the amount of non-exempt assets of the couple is already in excess of twice that of the maximum "division of assets" amount, employing this borrowing strategy will increase the amount of non-exempt assets which may be retained by the "well spouse" and still have the "infirm spouse" qualify for Medicaid. Once the "infirm spouse" has entered a long-term care setting, the debt incurred to increase the "division of assets" amount may be paid off, thereby reducing the amount of assets held by the infirm spouse to a much higher "division of assets" amount to the amount qualifying the "infirm spouse" for Medicaid benefits.

However, although generally reducing Medicaid eligibility strategies in other respects, the provisions of the Deficit Reduction Act of 2005 ("DRA 2005") do provide an additional planning opportunity. A "well spouse" should be able to purchase a "qualified annuity" as defined in such Act and Kansas DCF regulations, which converts a non-exempt asset used to purchase the annuity (cash) into an "income stream" which is not a resource. As noted above, the income of the "well spouse" has no adverse impact in qualifying the "infirm spouse" for Medicaid. A "qualified annuity" must be irrevocable, non-assignable and actuarially sound, i.e., it must be ratably paid over a period not exceeding the annuitant's life expectancy. In addition, in order to be a "qualified annuity," the State of Kansas must be named the beneficiary to the extent of Medicaid benefits paid to the "infirm spouse" should the "well spouse" predecease the payment of all annuity benefits to the "well spouse," although it is permissible for the State of Kansas to be named a beneficiary



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after the "infirm spouse," should the "infirm spouse" survive the "well spouse," as well as after a minor or disabled child of the "well spouse." The most effective strategy in this regard is for the period of such "qualified annuity" to be quite short, say two years, thus reducing the risk that there would be any remaining annuity payments at the death of the "well spouse" having to be paid to the "infirm spouse" (which would first have to go to the long-term care facility do to such payments being income of the "well spouse") or to the State of Kansas. This is an effective method of reducing the amount of the non-exempt assets of the couple to the "division of assets" amount in order to qualify the "infirm spouse" for Medicaid benefits.

Although a single person could use the same approach in purchasing a "qualified annuity" to convert a non-exempt asset into an "income stream," such strategy may have very little advantage unless carefully structured. First of all, the income from the annuity, plus the other income of the Medicaid applicant such as social security and any pension, could exceed the Medicaid reimbursement rate for that facility, thereby disqualifying the Medicaid applicant from Medicaid benefits. Secondly, such annuity payments, as they constitute income, would nonetheless go to the long-term care facility during the lifetime of the Medicaid recipient and any remaining benefit would have to be paid to the State of Kansas as beneficiary (after any minor or disabled child) to the extent of Medicaid benefits paid. Thus, the only apparent way to use a "qualified annuity" to accelerate Medicaid benefits for a single individual is to make a disqualifying transfer of an amount and purchase a "qualified annuity" with the remaining amount, such that at the time of filing the Medicaid application, the Medicaid applicant would otherwise qualify for Medicaid benefits but for the disqualifying transfer, so as to be able to commence the disqualification period as a result of the transfer. The annuity would be structured such that the term of the annuity payments would extend till the end of the disqualification period and approximately equal the LTC payment needs during the disqualifying period as determined by DCF. Once the disqualification expired, the Medicaid applicant should then be eligible for Medicaid. The amount transferred then could be retained by family members and not have to be "spend down" for LTC needs.

The alternatives for married couples who nonetheless want to possess non-exempt resources in excess of the "division of assets" limit and still have the infirm spouse qualify for Medicaid are quite limited. Although a pre-marital agreement may waive the legal obligation of one spouse to support the other financially and protect separate property status at death and in the event of a divorce, it has no effect on Medicaid eligibility. This leaves married couples with the sole option of obtaining a divorce or decree of separate maintenance in order for property otherwise exceeding the "division of assets" limit to be set aside to the well spouse and not be considered a resource to the well spouse for Medicaid eligibility. For personal and tax reasons, the couple often will prefer a decree of separate maintenance to a divorce. Although property and debts are divided in a decree of separate maintenance in the same manner as in a divorce, the couple can remain legally married. Each may then provide for the other at death through the Medicaid trust technique discussed below.

In summary, the Medicaid eligibility rules are both restrictive and complex. Nonetheless, even after the DRA 2005, as discussed above, there remain significant planning opportunities for a married individual to accelerate Medicaid eligibility. Further, as noted initially in this section, some individuals may have personal objections to utilizing some of these techniques.

Important Note: The Kansas regulatory authority governing Medicaid eligibility rules, the Kansas Health Policy Authority (KHPA) in 2008 reversed its prior stance regarding the efficacy of Medicaid qualifying annuities and took the position that although the purchase of a Medicaid qualifying annuity will not constitute a transfer of assets causing a disqualification period, the annuity nonetheless will be a non-exempt resource. The DCF position was that some person or company (such as those that purchased structured settlement payments) would purchase the annuity despite its non-assignability, thus making it a resource. If such position was correct, which is dubious given the clear wording of DRA 2005 as to what constitutes a "qualified annuity," there would be no benefit in purchasing a Medicaid qualifying annuity in meeting Medicaid resource eligibility requirements. Fortunately, DCF subsequently loosened its position to accept such qualified annuities, as long as three letters were produced by reputable companies in the industry indicating such qualified annuity was not marketable. However, may still challenge otherwise large qualified annuities which they consider abusive, e.g. annuities of hundreds of thousands of dollars. Thus, such strategy like all Medicaid planning strategies, should not be implemented without the advice of an experienced Medicaid planning attorney who can accurately determine DCF's current position and the viability of such strategy.

## MEDICAID ESTATE PLANNING CONSIDERATIONS

Estate planning considerations are also important in maximizing Medicaid eligibility. Statistics indicate that one-third of the time a well spouse will predecease his or her infirm spouse residing in a nursing home. In the Medicaid context, traditional estate planning techniques such as joint tenancy ownership or simple Wills giving all assets to the surviving spouse are normally inappropriate. Either



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of these approaches will cause the infirm spouse to own all of the spousal property upon the death of the well spouse. All non-exempt resources would then have to be spent down before the infirm spouse would qualify (or remain qualified) for Medicaid. In addition, if the infirm spouse were incapacitated, unless the infirm spouse has executed a durable power of attorney prior to becoming incapacitated, a conservator may need to be appointed by the probate department of the district court to manage the infirm spouse's property. Finally, if the infirm spouse had insufficient legal capacity to execute a Revocable Trust or use other probate avoidance devices, probate of any remaining property not needed for the surviving spouse's care would probably be required on the infirm spouse's death.

Generally, unless the spousal assets for estate tax purposes approach or exceed the applicable exclusion amount (in which event marital estate tax deduction techniques discussed in this booklet may need to be employed), this adverse consequence may be avoided by the well spouse placing all spousal assets in the well spouse's Revocable Trust. Should the well spouse predecease the infirm spouse, the Trustee of the Revocable Trust would be authorized to make discretionary distributions for the infirm spouse's health, support, and maintenance, without the trust assets being considered a resource to the surviving infirm spouse for Medicaid eligibility purposes. Such trust would pay for those benefits Medicaid may not pay for, such as dental care, personal incidentals and any additional amounts required for a private room. Due to Medicaid benefits being immediately available (if they weren't already due to meeting the "division of assets" test) on the well spouse's death, the spousal assets would not only last much longer in providing for the infirm spouse's care, but provide for a higher degree of care. The final benefit of this estate plan is that there would be no probate on the infirm spouse's death, as the Trustee, pursuant to the terms of the trust, would distribute any then remaining trust assets to the remainder beneficiary of the trust (usually children or their issue). Note: The implementation of this strategy requires a highly skilled attorney knowledgeable both in Medicaid law and the utilization of highly sophisticated drafting techniques. Due to the limitations under Medicaid law for a Revocable Trust to provide this benefit as opposed to a Will, the provisions of the Revocable Trust must be utilized in conjunction with a carefully drafted Will (by authorizing the Trustee to make a distribution to the estate of the Grantor of the Revocable Trust whose Will incorporates the same provisions) in order to effectuate the intended result. Moreover, this strategy also has become both more tenuous and limited as a result of a 2003 Kansas Supreme Court decision which held that the amount of inheritance that a surviving spouse would be entitled to under Kansas elective share statutes (even if waived) remains an available resource to the surviving spouse for Medicaid purposes following the death of the Grantor.

If there is an increased probability of incapacity of a spouse, implementation of the above estate plan is normally advisable from the outset. If not, separate Revocable Trusts for each spouse (each holding approximately one-half of the spousal assets) could be created, thereby sheltering all assets owned by the predeceased spouse from having to be spent down for Medicaid purposes before the surviving spouse qualifies for Medicaid. Even if Revocable Trusts are not desired presently, each spouse may give the other spouse a durable power of attorney to allow transfer of all spousal assets to the well spouse should either spouse later become incapacitated. In that event, the well spouse could then transfer all spousal assets to a Revocable Trust that the well spouse would execute, which Revocable Trust would implement the foregoing Medicaid trust provisions for the benefit of the surviving spouse. Without a previously executed and properly drafted durable power of attorney, however, the implementation of this strategy following the incapacity of a potential Medicaid recipient may not be possible.

## ESTATE RECOVERY OF MEDICAID BENEFITS

As a final Medicaid consideration, the 1992 Kansas legislature passed a statute giving DCF a claim against the estate of a Medicaid recipient and the estate of a Medicaid recipient's surviving spouse in order to recoup any Medicaid expenditures made for the benefit of the Medicaid recipient. Careful estate planning can minimize or avoid the impact of this claim. For example, although such claim law was effective against probate estates and financial institution accounts having a "POD" designation, it did not appear that the present claim law applied to assets held in joint tenancy, property owned in Revocable Trusts, or personal property (other than "POD" accounts) having a beneficiary designation. Although the 1997 legislation allowing "TOD" beneficiary designations on real property made such designations subject to the Medicaid claim law, the Medicaid claim statute, which did not literally apply to such "TOD" designations, was not amended. Consequently, there was a serious question whether such "TOD" designations on real property were subject to the Medicaid claim law. Under a bill passed into law by the 2004 Kansas legislature, applicable to those persons receiving Medicaid benefits after July 1, 2004, the Medicaid claim law has been expanded to include all property interests of a Medicaid recipient (or Medicaid recipient's surviving spouse) passing at death, whether through probate or outside of probate, such as through joint tenancy, beneficiary designation, or under the provisions of a revocable trust.

Nonetheless, the Medicaid recovery claim is most easily made by the State of Kansas filing a Medicaid claim against a probate estate (by simply filing a claim in the probate estate). With regard to assets that are not going through probate (e.g., joint tenancy, beneficiary designation property and property held in a revocable trust), the State of Kansas must pursue the claim by filing a lawsuit against the



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recipients of the property. This is a much more cumbersome procedure, requiring DCF to open a probate estate within six months of the recipient's death, and thus enhances the prospects of either such claim not being made or such recipients being able to settle any such claim for an amount less than the face amount of the claim. However, recent Kansas legislation has authorizes DCF to file a lien against real property to recoup such benefits up to one year following the death of a Medicaid recipient or the death of his or her surviving spouse.

Moreover, just as the timing of transfers is important in qualifying for Medicaid, it is equally important in avoiding the Medicaid claim. The Medicaid claim statute permits DCF to set aside transfers by a Medicaid recipient for purposes of asserting a claim against transferred property. To date, DCF has not interpreted this statute to permit DCF to set aside transfers made prior to the time a recipient was receiving Medicaid. Thus, a surviving spouse, the assets of which would otherwise be subject to a Medicaid claim upon the death of the surviving spouse regarding Medicaid benefits paid to the predeceased spouse, should be able to avoid the Medicaid claim by transferring such assets prior to any time the surviving spouse would otherwise have been eligible for Medicaid benefits. Finally, as part of the 2004 Kansas Medicaid legislation, DCF is permitted under certain circumstances to file a lien on the real property of a Medicaid recipient to ensure reimbursement to the State of Kansas for Medicaid benefits paid upon the death of the Medicaid recipient.

It is important to keep in mind that even if DCF successfully recoups payments made to a Medicaid recipient following the death of the Medicaid recipient from the exempt assets of the Medicaid recipient (which would have to consist only of exempt assets if the Medicaid recipient qualified for Medicaid benefits up to date of death) or the assets of the surviving spouse of a Medicaid recipient, there was still a substantial economic benefit conferred by Medicaid eligibility. This is because the Medicaid reimbursement rate paid by DCF to the nursing home or other long-term care facility is significantly less than the private pay rate. Moreover, there is no interest charged by DCF on the amount of such payment and only the long-term care costs, not other Medicaid costs, are revocable. In addition to these benefits, there are also probate avoidance and asset holding estate planning strategies which make it more difficult for DCF to assert the Medicaid claim. These strategies, which have other estate planning benefits, tend to effectuate a reduction in the amount DCF is able to recoup regarding Medicaid benefits paid.

## FEDERAL LAWS OSTENSIBLY PROHIBITING MEDICAID PLANNING TECHNIQUES

Provisions of the Kennedy-Kassebaum Bill, which were enacted into law in 1996, imposed criminal misdemeanor penalties of up to one year in jail and up to a $10,000 fine for "making or causing to be made false statements or representations." Although it is understandable that criminal penalties would ensue if one makes false statements to secure Medicaid benefits for which one was otherwise ineligible, that Bill contained another provision which passed Congress without any significant public input and apparently with respect to which most members of Congress were unaware was even included in the bill. Under the heading of making or causing to be made false statements or representations is a provision including someone who "knowingly and willfully disposes of assets...to become eligible for [Medicaid]...if disposing of the assets results in the imposition of a period of [Medicaid] ineligibility....".

This provision created a furor among senior citizens and elder law practitioners who had no knowledge such a provision was even pending, let alone passed. It was inconsistent with the heading it was under and with other provisions in the law. Other provisions of the law, as discussed above, permit transfers but impose an ineligibility period as a result of the transfer. By imposing criminal penalties, this provision seemingly negated what was otherwise legally permissible under other provisions of the law. It was also ambiguous as to whether it would cover someone who made a transfer but did not apply for Medicaid until the period of ineligibility had expired. If not, the provision would be totally nonsensical, for it would criminally penalize someone who simply prematurely applied for Medicaid, even though there would still remain a period of Medicaid ineligibility. Moreover, these provisions of the law did not appear to cover the conversion of non-exempt assets into exempt assets. Given that criminal statutes are strictly construed against the government and can be voided by the courts for vagueness, ambiguities or inconsistencies, to the extent the government intended to enforce this provision, such provisions appeared to be in for "rough sledding" in the courts.

Transfers after January 1, 1997 were affected by the new law. However, due to flack over this law, dubbed the "Granny Goes to Jail Law," it was partially repealed by provisions of the Taxpayer Relief Act of 1997. It now only applies to those who "for a fee" give advice with respect to making transfers which would have been a violation of the old law. On March 11, 1998, Attorney General Janet Reno wrote House Speaker Newt Gingrich and notified him that the Department of Justice considered the law unconstitutional (violative of free speech) and would take no enforcement action against "violators". Further, in the first judicial challenge of this new law in 1998, a Federal Court in New York concurred, holding the new law unconstitutional and issuing a restraining order prohibiting governmental agencies from enforcing it. To date, no attempt has been made to enforce the law in Kansas.



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## LIMITATIONS OF THE MEDICAID SAFETY NET

As discussed above, the Medicaid rules permit maximizing eligibility through several methods, including purchasing additional exempt resources (or improving an already exempt resource, such as the personal residence), transferring assets to family members and waiting out the disqualification period, and for married couples, using proper estate planning techniques to ensure that assets owned by the predeceased spouse are left at death in a "supplemental to Medicaid" trust for the surviving spouse. Moreover, a divorce or decree of separate maintenance is available as a means of last resort to protect additional assets thereby set aside to the well spouse from Medicaid "spend down" requirements. However, the bottom line is that for a single person or married couple who are both in need of LTC, couple may own only $3,000 of non-exempt resources. For married couples in which only one member currently is in need of LTC, the well spouse may only retain non-exempt resources up to the "division of assets" limit if the infirm spouse is to qualify for Medicaid.

Even for those individuals who feel that proper estate planning within the Medicaid eligibility rules minimizes their financial risk to an acceptable level such that consideration of long-term care insurance is deemed unnecessary, such eligibility rules are subject to change in the future. Current and possible future fiscal restraints could compromise the ability of the federal and state governments to continue to fund LTC at current care levels. Much of recent sessions of Congress have been devoted to this issue and there has been proposed legislation which would provide "block grants" to the states giving them more flexibility in setting Medicaid eligibility rules. Also, there is some uncertainty as to the quantity and quality of nursing homes which will accept Medicaid residents in the future.

## LONG-TERM CARE INSURANCE

For individuals who are not satisfied with the combination of self-insurance and estate planning techniques maximizing Medicaid eligibility, or who are concerned that Medicaid only covers skilled nursing care and not assisted living or custodial care, long-term care (LTC) insurance is probably the only viable alternative. Certainly, the restrictions placed on disqualifying transfers as a Medicaid qualifying technique under the Deficit Reduction Act of 2005 give an additional impetus to the consideration of LTC insurance. Historically, at least 65 companies have offered LTC policies in Kansas. LTC policies in Kansas are governed by the Long-Term Care Insurance Act (the Act), which became effective January 1, 1988. Under the Act, all individual LTC policies must have a thirty-day "free look" period, during which time the policyholder may cancel the policy for any reason and receive a full premium refund. In addition, the Act essentially mandates that issued policies be renewable, as cancellation based solely upon the age or deteriorating physical or mental health of the insured is prohibited.

The key to proper evaluation of LTC policies is threefold: the policy itself, the company issuing the policy, and the person from whom it is being purchased. In evaluating the policy, the most important criterion is not the amount of the annual premium, but the value received for that premium. That is, one should evaluate the total overall benefit received for the amount of premium paid.

Evaluating different policy benefits is not an easy task. Different policies have various exclusions, elimination periods, daily benefits, benefit maximums and "triggering events" for coverage. A policy exclusion is a condition which is not covered by the policy. Generally, policies exclude benefits if services are needed for intentionally inflicted injuries, treatment already paid for by the government, illnesses caused by acts of war, alcohol or drug addiction, and mental and nervous disorders, other than Alzheimer's disease. It is important that these exclusions be carefully reviewed to ensure that needed benefits will not be excluded under the terms of the policy.

The elimination period is the period the insured must receive care before benefits "kick in." Generally, policy options offer an elimination period from zero to 100 days. Daily benefits may be couched in terms of a fixed daily benefit or a "floating amount" which covers the full cost of care up to a ceiling. The maximum benefit is normally reached when payments have been made for the maximum benefit period allowed under the policy. The most common benefit period is three years, although some companies offer policies for shorter and longer maximum benefit periods. Another factor to consider is whether to purchase a policy covering home health care and facility care at separate maximums or an integrated policy providing for a single maximum which can be utilized for either home health care or facility care. Under a separate maximum policy, once the maximum for home health care has been utilized, benefits would cease unless the insured was moved to a nursing facility for which continued coverage was provided. The trend is toward integrated policies. These policies are especially preferred by individuals who do not desire placement in a nursing facility under any circumstances.

The daily benefit and maximum benefit must be sufficient to underwrite the risk for which LTC insurance is being purchased. This may not necessarily be full coverage either on a daily or total benefit basis. The policy may only be intended to partially cover the



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LTC risk, with self-insurance and the Medicaid safety net being intended to cover the balance. In short, a policyholder should insure that amount of the cost of LTC it is determined the insured cannot afford to self-insure. It is an interesting observation that although most individuals routinely insure casualty risks, those same individuals are often reluctant to insure for LTC, even though the risks and costs of LTC can be much higher.

With regard to policy "triggering events," most reputable companies have long moved away from a "medically necessary" definition for eligibility to an "activities in daily living" (ADL's) test. Medical definitions are not only often subjective and uncertain; they ignore the reality that many individuals in need of nursing facility care are not technically "ill." All LTC policies in Kansas are statutorily prohibited from using a "medically necessary" definition, although policies are permitted to require that the care be ordered by a physician due to illness, injury or infirmity. Focusing on ADLs places the emphasis where it should be, i.e., on the inability of the insured to attend to daily needs. ADLs look to the inability to be self-assisted in daily care needs such as bathing, dressing, walking and moving about, eating and the taking of medication. It is important to review what those ADLs are under the LTC policy and how many are required in order for the LTC policy to cover home health care or facility care. For example, one or two triggers may be required for home care and two or three for facility care.

Policies which offer a variety of options, rather than rigid mandatory benefits, are normally preferable. This is particularly true if the mandatory benefits are unlikely to be utilized or are otherwise not desired or needed. Most policies, however, automatically include such normally desirable benefits as one-time alteration expenses necessary to adapt a dwelling for home care, a respite benefit to allow family members to take a break from care-giving, and a bed reservation payment necessary to retain a bed in a nursing facility should a brief hospitalization be required. Moreover, long-term care insurance benefits may include "assisted living" and opposed to "nursing home" care, a benefit which is generally not available under Medicaid benefits. Inflation adjustment riders are normally desirable, particularly for younger insureds. However, such inflation riders can add between 25% and 40% to the cost of the policy. Another often desirable provision is a waiver of premium once LTC benefits become payable under the policy.

Readily accessible resources are available to assist the consumer in evaluating LTC policies from the Kansas Insurance Department, the Kansas Department of Aging, and the Kansas State University Sedgwick County Extension Education Center in Wichita. The KSU Extension Center is a particularly good resource, as it compiles information from a variety of sources, including the Kansas Insurance Department's, the National Association of Insurance Commissioners' and AARP's "Shopper's Guides." The Kansas Insurance Department's shopper's guide can be accessed at www.ksinsurance.org, and that of the AARP at www.aarp.org. Yet other good resources are LAN (Life Association News) magazine, which annually publishes charts comparing plans offered by most leading insurers, and Consumer Reports, which has periodically addressed long-term care insurance issues. A final source is the Health Insurance Association of America. Its phone number is 1-877-582-4872 and its web site is www.hiaa.org.

In evaluating a long-term care insurance company, it is important to look at its insurance industry rating. Various rating systems determine the insurer's financial ability to meet the demands of covering policy benefits to its policyholders. The rating categories include superior (very little risk), excellent (slightly higher risk), good (high claims-paying ability) and adequate (less protection against risk). Any company not having a rating in the above four categories should be considered unacceptable. All other factors being equal, a company having a higher rating should be preferred over a company having a lower rating.

LAN, in its annual publication, usually provides the A.M. Best, Standard & Poor's, and Moody's ratings of LTC insurers. These ratings are also available directly by calling A. M. Best at (900) 420-0400, Standard & Poor's at (212) 208-1527, and Moody's at (212) 553-1653.

Ratings of an insurer's financial stability do not address such factors as an insurer's longevity in the business, its record in paying claims, or its history of premium increases to its policyholders. Nor do they address the size of the company related to other insurers, as normally the larger the pool of insureds, the greater the stability of the insurer and corresponding insurance premiums. Most, if not all, of this information can be obtained from a reputable LTC specialist. In selecting a LTC specialist, one should inquire as to years of experience in LTC insurance, the percentage of the specialist's time devoted to LTC insurance, the variety of insurers represented, and professional and client references. If the specialist represents only one insurer or a limited class of insurers, it may be desirable to comparison shop to ensure one is getting the best overall policy value for the premium expended.

There are additional monetary and tax incentive considerations in determining whether an individual should purchase a LTC policy. For example, Kansas law has provided monetary incentives for individuals to purchase LTC policies in an attempt to lower Medicaid costs. First, there is a dollar-for-dollar offset against amounts otherwise recoverable under the Medicaid claim law against assets in the applicant's or applicant's spouse's estate for amounts paid for the applicant's care under LTC policies. For example, if a LTC



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policy has provided $20,000 toward the LTC of an applicant and DCF subsequently provided $30,000 for LTC under Medicaid once the policy limits expired and the applicant met the Medicaid eligibility requirements, the amount of the Medicaid claim against the estate of the applicant or the estate of the applicant's surviving spouse would be $10,000, as the otherwise applicable $30,000 claim amount would be reduced by the $20,000 provided under the LTC policy. To the extent the applicant's estate consisted of minimal exempt assets or the estate of the applicant's surviving spouse was planned in a manner discussed herein such as not to be subject it to the application of the Medicaid claim law, such Medicaid claim "offset" would be of little or no benefit.

As a second monetary benefit, Kansas law extended the amount of exempt assets for Medicaid purposes to include the amount of premiums the Medicaid applicant paid for LTC insurance. That is to say, a Medicaid applicant may possess an amount which would otherwise not be exempt equal to the amount of LTC premiums paid, without having an adverse impact upon the applicant's Medicaid eligibility. Third, under the "long-term care partnership" program enacted under the Deficit Reduction Act of 2005, which was statutorily affirmed by the Kansas legislature in 2008, there is a "dollar for dollar" offset for "Partnership" policy benefits paid in terms of increasing the amount of non-exempt assets that would otherwise not be able to be retained in order to qualify for Medicaid benefits. This additional benefit would normally be expected to be an amount greatly in excess of the Medicaid premiums paid on the policy deemed to be exempt under prior law.

In terms of tax incentives for the purchase of a LTC policy, the premium costs and benefits received have been made tax-advantaged. Due to the so-called "Kennedy-Kassebaum bill" passed by Congress in 1996, up to $200.00 per day of LTC benefits are excludible from income taxation, provided the policy meets certain specified criteria in providing "qualified LTC services". Further, on such "qualified" policies, to the extent the plan offers a full refund of premiums paid whether or not any benefits are paid out, the refunds are tax-free. In addition to other requirements, a "qualified" policy must provide payment for personal care services required by a chronically ill individual. This same legislation provides that premium payments by individuals on such "qualified" policies are also now deductible for income tax purposes in the same manner as other health insurance. With respect to "C Corporations," premium payments for "qualified" policies on the employee, employee's spouse, or children are fully deductible with no corresponding inclusion in the employee's income. For self-employed individuals, partnerships, limited liability companies (LLCs) and what are termed "S Corporations," the deduction for premium payments on health insurance premiums, which now includes payments on "qualified" policies, is normally 100%. Otherwise, such payments are deductible to the extent itemized on Schedule A (subject to amounts over 7.5% of AGI limitation).

Thus, unless paid out of a "health saving account" (HSA) which permits payment of LTC premiums, in order to achieve any federal income tax benefit on the portion of the LTC premium payment which is subject to itemization, the payor must be able to itemize. Medical itemized expenses such as LTC premium payments are only deductible to the extent total medical expenditures exceed 7.5% of the payor's adjusted gross income. Even then, there are maximum annual cumulative deduction limitations on premium payments for such policies which are dependent upon the age of the insured. Consequently, inquiry should be made prior to purchasing a LTC policy whether the policy satisfies the statutory requirements as a "qualified policy" necessary for favorable federal income tax treatment. If so, a determination should be made as to whether the premium will be deductible based upon the foregoing criteria, as well as the amount of the deduction.

## ACCELERATED DEATH BENEFIT LIFE INSURANCE

Many life insurance companies are now offering policies which provide for accelerated death benefits in the event LTC should become necessary. The provisions of the life insurance policy providing this benefit for LTC should be viewed as a LTC policy. Consequently, these policies should be evaluated upon the same basis as LTC policies discussed above. As would be expected, amounts paid for LTC normally reduce the amount paid at death.

Obviously, having a death benefit irrespective of whether LTC is ever needed does not come without an added cost. The insurance company is providing additional insurance over and above that provided by LTC insurance alone. Thus, consideration should be given as to whether the additional cost required for a guaranteed death benefit if LTC is never required merits the purchase of the policy. Further, if a death benefit is desired for other estate planning factors, e.g., liquidity to pay taxes or debts, such liquidity would be compromised if the death benefit was needed during lifetime to cover LTC. Consequently, in that circumstance, either the amount of the death benefit purchased should be sufficient after taking this contingency into account or there should be additional guaranteed death benefit options under the policy which could be exercised should such eventuality later arise.

As it did with LTC policies, the Kennedy-Kassebaum Bill of 1996 also extended favorable income tax treatment to these types of policies as well. Benefits received for LTC through life insurance providing an accelerated death benefit are normally treated as paid



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by reason of death and are therefore excludible from income in the same manner as death proceeds.

## CONCLUSION

LTC estate planning, particularly estate plans involving Medicaid eligibility rules, is without a doubt one of the most highly technical areas of estate planning. It involves very complex and frequently changing Medicaid eligibility rules, sophisticated estate planning techniques, and often technical income tax issues as well. Thus, Medicaid estate planning should in no circumstance be deemed a "do it yourself" proposition. Those who attempt to implement a Medicaid estate planning strategy without the assistance of a highly qualified and experienced LTC estate planning attorney incur a substantial risk of suffering significant, if not dire, adverse financial consequences.

In short, a highly experienced and reputable LTC estate planning attorney should be sought at the outset to assist in implementing an estate plan involving Medicaid considerations. Normally, a very high "cost versus benefit" ratio will thereby be achieved with respect to balancing the costs of such Medicaid planning advice with the attendant resource savings. A well-devised estate plan will maximize the availability of Medicaid as either the primary or secondary (after LTC insurance) source of payment while minimizing the exposure of assets to a Medicaid estate recovery claim following the death of the Medicaid recipient as well as any surviving spouse of such recipient.

In addition, there are many additional benefits to be secured by a well devised Medicaid estate plan. Such benefits include the preservation of family harmony, providing for the inexpensive and proper management of assets during a legal disability without having to resort to an expensive and often contentious judicial proceeding, and the distribution of any remaining assets at death in a manner which not only avoids the costs, bother and public exposure of probate proceedings, but also which distribute the decedent's remaining assets to the intended beneficiaries in the desired amounts or proportions. A well devised LTC estate plan also will provide for an agent to make all personal and health care decisions during a legal disability, including home health care and any nursing facility determinations which become necessary.

If the financial risk of the costs of LTC following implementation of Medicaid estate planning strategies is deemed insufficient as the sole LTC planning strategy, LTC insurance should be considered. In purchasing LTC insurance, it is important to engage a qualified and reputable LTC insurance specialist to assist in the evaluation of various policy benefits, attendant costs and the financial stability and consumer reputation of the various insurers offering such policies. The final determination of the LTC insurance policy to be purchased involves properly balancing the cost of the policy against the LTC financial risk which is being insured.

If it is decided that the purchase of LTC insurance is a preferable component of the desired LTC estate planning strategy, insurability and premium costs become significant factors. The longer one waits, the greater the risk that one's health could deteriorate to the point LTC coverage is unavailable. Further, as risk increases with age, the longer one waits the higher the annual premium cost. For example, for a person aged 65, a comprehensive policy with good inflation protection might cost $2,000 per year. At age 75, that same policy may cost two and a half times the age 65 premium. As an additional example, a policy purchased at age 55 may have an annual premium of only one-sixth of its cost at age 75. In waiting to take out a policy a considerable risk is incurred that a person may become uninsurable. Approximately 15% - 20% of the population over age 65 are uninsurable for LTC coverage.

In sum, only through a comprehensive approach developed with an experienced LTC estate planning attorney and a reputable LTC insurance specialist can an informed and proper decision be made with respect to comprehensively implementing appropriate LTC planning strategies in one's estate plan. An LTC estate plan is incomplete unless it has considered all of the financial, property management, estate planning and health care decision-making needs which may arise should LTC become necessary. Any LTC insurance policy component of such strategy should be purchased from a reputable LTC insurance professional, cover only the risk that needs covering, be a good overall value for the premium cost, be purchased from a company whose insurance rating indicates that the coverage is likely to be available should the need arise, and only be purchased after properly comparing the costs and benefits of similar LTC policies, both from the same company and different companies.

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planning areas of special interest, regional and national estate planning articles authored by Group attorneys, related links and other estate planning information which may be of interest.

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