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

What Planning Considerations are Involved in Anticipating the Need for Long-Term Nursing Home Care?

Introduction

Statistics indicate that there is an approximate 50% chance that a person over the age of 65 will at some time reside in a nursing home facility, the risk being slightly higher for men than for women, most probably due to the women's longer life expectancies. 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 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 2.3 years. However, for 15 percent of the population, the cumulative stay exceeds five years. Average costs of a long-term care resident vary considerably, both within urban and rural facilities, and from state to state. They can vary from approximately $5,000 per month to as much as $15,000 per month and be even higher for acute care. Thus, for an average cumulative stay, total expenditures can be from $138,000 to over $400,000.

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 resources (Medicaid, 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 rehabilitative Medicare benefits, this is principally through Medicaid benefits. Medicaid is not an entitlement program, but a "need based" and "medically needy" program, the cost of which is paid approximately 40% by the state government and 60% by the federal government.

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, the considerations involved in purchasing a long-term care insurance policy, and strategies to minimize efforts by the state to recover Medicaid benefits paid for LTC against the estate of the recipient or that of the recipient's surviving spouse. Particular emphasis is given to the importance of these techniques and strategies to farmers and ranchers.

Part One: Governmental Resource Planning for LTC

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 covered 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 be unnecessary.

However, Medicare's eligibility rules are quite restrictive. Medicare eligibility does not commence until one turns 65 years of age and has paid a sufficient amount in for Medicaid withholding to be eligible. 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, rehabilitative in nature, short term as opposed to long term, and care must be for skilled care (daily care from a licensed medical professional) as opposed to intermediate care (intermittent care by a licensed medical professional) 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, and can terminate during such period when rehabilitative benefits cease, after which period 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 population, the enormous costs of covering a rapidly aging population under Medicare would not be expected to be politically palatable.

Medicaid Eligibility Rules

One 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 and administered by the states. States are given some leeway in their eligibility requirements and enforcement. Once a person qualifies for Medicaid benefits in a Medicaid licensed facility, the individual or his or her financial representative pays all of their income (which due to the limited resources the person may have and qualify, as discussed below, normally only consists of social security and pension or annuity income) with the state picking up the difference between such income and the Medicaid reimbursement rate for that particular facility. Medicaid normally covers all costs for medical and other care in the facility, including medicine, except for the difference in cost between a private room and semi-private room, dental care, eyeglasses and hearing aids.

Unlike Medicare, eligibility for Medicaid LTC benefits requires a person to have a medical need for such care. 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. Such Nursing Facility Level of Care (NLFOC) varies somewhat from state to state and includes an individual's ability to satisfy certain activities of daily living (ADLs), such as eating, dressing, toileting and bathing.

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, 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), term life insurance having no cash value, a burial space, headstone and casket, and certain irrevocable pre-paid funeral and burial plan expenses ns within specified cost limitations. In addition, in some states such exemptions can include real and personal trade or business property, such as farm land and farm machinery operated by the recipient or other family member, and in other states such exemptions may also extend to "income producing property," principally limited to real and tangible personal property, when leased to third parties, not requiring any material participation by the recipient. To be exempt, such income-producing property must produce income commensurate with its usage. In Kansas, both exemptions apply. Thus, e.g., vacant real property would not be exempt, nor would rental property which is leased to family members at below market rent. Among other possible exemptions, such state

exemptions, like Kansas, may also extend to qualified retirement plans and IRA assets of the non-infirm or "community spouse" when determining whether the spousal "division of assets" test below.

The exemption for trade or business property provided for in a large number of states is of particular importance to farmers and ranchers as discussed below.

"Division of Assets" Medicaid Eligibility Test for Married Individuals

In addition to the requirement that the applicant only own non-exempt resources in order to qualify for Medicaid benefits, Medicaid eligibility for a married applicant also starts out with the concept that the assets of both spouses are "pooled" with respect to non-exempt resources in determining the eligibility of the applicant. Fortunately, under federal law there is an allowance for non-exempt assets owned by the other spouse in that regard. Under so-called "division of assets" provisions applicable only to 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 without disqualifying the eligibility of the infirm spouse for Medicaid benefits. To that end, federal law allows married couples to "divide" their resources such that the Medicaid applicant, the infirm spouse, retains only exempt resources (including up to $2,000 of otherwise non-exempt resources) and the well spouse is in possession of an amount of non-exempt resources that does not exceed a certain limit without disqualifying the infirm spouse for Medicaid benefits.

In states which have adopted the so-called 50% "division of asset" test, such as Kansas, one-half of the non-exempt resources (with a current minimum in 2019 of $25,284 and a current maximum of $126,420, both numbers being subject to subsequent periodic adjustments for inflation) as of the date the infirm spouse entered a long-term care setting (or the earlier date the infirm spouse went into a hospital, followed by going into LTC, or after being in a rehabilitation facility in the interim), the so-called "financial snapshot date," can be set aside or transferred to the well spouse (with the infirm spouse being allowed a maximum of $2,000 of otherwise non-exempt assets) without incurring any disqualifying transfer penalty by virtue of such transfer without having to count such non-exempt resources as a resource to the infirm spouse. On the other hand, in states which have adopted the alternative so-called 100% "division of assets" test for Medicaid eligibility, the well spouse may retain the full maximum amount of otherwise non-exempt assets irrespective of the amount of such non-exempt resources as of such "financial snapshot date" and consider such non-exempt resources to be exempt, without being limited to one-half of such non-exempt assets. Thus, if the couple's non-exempt assets under the 100% state option equaled to, or were less than, the maximum amount, all of such non-exempt assets may be held by the well spouse and considered exempt for such test. It is important to note, as will become evident below in this discussion of strategizing to maximize Medicaid benefits under either such option, that mortgages on property or the debts of the couple are not considered in valuing assets in applying the "division of assets test."

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 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 is no remaining disqualification period for any prior disqualifying transfers as discussed below.

Income Test for Medicaid Eligibility

In addition to the resource test, states may institute an income test for qualification for Medicaid. This is typically tied to a multiple of the applicable Supplemental Security Income (SSI). If the applicant's income exceeds such amount even though less than the Medicaid reimbursement rate for such facility in which the applicant resides, the applicant will not qualify for Medicaid benefits. Kansas does not have such test.

Fortunately, such problem normally can be avoided by creating an irrevocable trust to hold the applicant's income (so-called "Miller Trusts") which avoids the Medicaid cap. Generally, the applicant's income is assigned to the trust. The trust is allowed to return a minimum amount for a monthly needs allowance and for maintenance of the trust. The remaining income then is 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 facility's current reimbursement rate.

Although there is no income test for the applicant in order to qualify for Medicaid, if the total unprotected income of the Medicaid recipient 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 a most incidental needs allowance set by the state 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 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. As noted above, 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 2019 to a base of $2,057.50/month of total spousal income (plus shelter allowances to the extent that rent or mortgage expenses exceed $229 (up to a maximum of $1,033.50/month for excess shelter allowance), permitting a current maximum total of $3,090 per month in 2019 in such circumstances) after qualifying the infirm spouse for Medicaid. This is the so-called "division of income" test.

Unlike the "division of assets" test which must be met for an infirm spouse to qualify for Medicaid benefits, the "division of income" test is not a test which needs to be met for the infirm spouse to qualify for Medicaid. Adjusted in amount at least annually, 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 permitted income level.

For Medicaid qualifying recipients who are not receiving care in a long-term care facility but through what is termed Home and Community Based Services (or "HCBS"), i.e., who are medically needy but nonetheless living at home or in an assisted living facility, the protected monthly income level is $727 for an individual in 2019, which protected amount may be retained by the Medicaid recipient without adversely affecting HCBS benefits. This retained amount is intended to pay just for normal living aspects with Medicaid covering the level of care necessitated by the recipient's loss of ADLs. It has the same eligibility requirements as Medicaid. However, there are limitations on its availability depending upon the state and there can be long waiting lists. Kansas currently does not have a current limit.

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, there can be a Medicaid disqualification period. Such gifts must be disclosed on the Medicaid application form. Gifts to spouses are exempt from such disqualification rules because the resources of a spouse are still 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 others cause an additional per day or per month disqualification period based upon a transfer of each specific dollar amount. These periodically adjusted disqualification amounts are determined to approximate the current average daily/monthly nursing home cost in the applicable state. For example, if the state adopts a per month determination, there would be a one-month disqualification period for each disqualifying transfer amount of such determined monthly nursing home cost.

Normal routine gifts to charities typically are ignored by the state for disqualification purposes. So are routine small gifts to individuals. However, gifts of larger amounts are typically considered even if they were not made for Medicaid qualification purposes. Any waivers of such disqualification purposes due to an assertion that they were not made for Medicaid qualification purposes are in the discretion of the state, which can be approved or denied in its sole discretion.

For transfers made after February 8, 2006, the effective date of the Deficit Reduction Act of 2005, the disqualification rules applicable to such transfers changed substantially. The disqualification period no longer commenced from the

date of the gift, but from the date of application for Medicaid when the applicant has become "medically needy" (i.e., typically being in a long-term care facility and only possessed of non-exempt resources) so as to otherwise qualify for long-term care benefits provided by Medicaid except for any disqualifying gifts. This change dramatically reduced the efficacy in making transfers to enhance Medicaid eligibility prior to the transferor being in a long-term care facility, as the disqualification period no longer commenced at the time of the gift and thus prior to the transferor residing in such a facility, but in addition to being possessed of only exempt resources, also having applied for Medicaid benefits. Secondly, the look back period for disclosure of prior gifts was extended from thirty-six months on most transfers to sixty months (or five years) for all gifts, the so-called "look back" period.

These disqualification rules apply to all gifts for insufficient consideration, but only if an application is made for Medicaid benefits within five years of the transfer. For the applicant is not required to disclose any such gifts made prior to the look back period. Moreover, applying for Medicaid during the applicable look back period for prior disqualifying transfers continues to be a "trap for the unwary" and can greatly extend the applicant's disqualification period for Medicaid benefits. This is because if an application for Medicaid is made during the 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 applicable per day or per month disqualification amount in determining the number of days or months in which the transferor/Medicaid applicant will be disqualified from receiving Medicaid benefits. If the applicant instead waits to apply for Medicaid until after the look back period, there would be no disqualification period, assuming the applicant has otherwise qualified for Medicaid without consideration of any such disqualifying transfers.

Example: The Medicaid applicant/transferor transfers $300,000 to his children. 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 an assumed $200/day disqualification amount, an approximate fifty-month disqualification period would result. Had the Medicaid application not been made until more than five years had expired following such transfer, such transfer would have been outside the five-year look back period and thus not have to have been required to be disclosed on the Medicaid application. In such latter situation, no disqualification period would have resulted from the $300,000 transfer.

If such a disqualifying transfer is made to avoid such assets being considered to be a resource for Medicaid purposes or be subject to an estate recovery claim even if otherwise exempt, it is preferable for the individual not to transfer such assets outright to other family members, but to gift them into an irrevocable trust for the benefit of such family members, except for the grantor/transferor possibly reserving an interest solely as an income beneficiary. This estate planning strategy provides flexibility for the grantor, as trust provisions can enable the grantor to change trustees to a party other than the grantor, alter the disposition of the trust estate among family members upon the transferor's death, and in the absence of any such change, leave the assets to children in the same manner as under their own revocable trust, such as in asset protection trusts for their benefit.

Such retention should not alter the commencement date of the five-year lookback period beyond the transfer of property to the trust. Such ability of the grantor to alter the disposition of the trust estate or the retention of trust income also causes the trust estate to be includible in the estate of the transferor/grantor such that any appreciated assets will be includible in the estate of the transferor and be eligible, except for "income in respect of a decedent" items such as IRAs, for a "step up" in income tax basis at the transferor's date of death. Given the very high current applicable exclusion amount for federal estate tax purposes, such inclusion in the vast majority of situations would not result in any federal estate tax liability. Such potential "step up" would not be the case for assets gifted to children. In that situation, the children's income tax basis in the gifted assets would be the income tax basis of the parent for purposes of gain and the lesser of its fair market value or parent's income tax basis for purposes of a subsequent loss sale.

The trust provisions can also permit transfers to children as beneficiaries during lifetime to enable them, but not require them, to voluntarily use such distributions to provide support to the transferor parent should the parent be in need of LTC during such lookback period or be in need of care not provided by Medicaid. Finally, the trust can be structured as a so-called "grantor trust" such that the income of the trust is taxed to the transferor/grantor (which would be the case in any event if the transferor was an income beneficiary) in the same manner as if the grantor remained the owner, even though the property is in the trust and the transferor may not even be a beneficiary. This result can have substantial

income tax advantages in a Medicaid planning context. First, it often permits the income of the assets in the trust to be taxed at lower brackets than it would have been if the income from the property was taxed to children. Second, it permits the proceeds of the sale of the grantor/transferor's personal residence by the trustee to be excludible from federal income taxation if it would otherwise be exempt if sold by the grantor. Finally, LTC costs paid by the grantor will remain deductible against the income of the trust if paid out of the grantor's account resulting from assets voluntarily being given back to the grantor by trust beneficiaries.

From an administrative and asset protection standpoint, transferring assets to such trust instead of outright to children avoids the property being subject to a divorce claim of a child's spouse or the claims of their creditors, avoids problems in seeking contributions for the parent's care from children individually should the spouse be in need of LTC during the five year lookback period, particularly in circumstances where a child may have predeceased the parent, and avoids the disposition of the property gifted to a child to someone whom the parent does not wish to benefit should the child predecease the parent.

Medicaid Planning Strategies

The foregoing federal law changes have constricted Medicaid planning opportunities. Nonetheless, there remain several viable strategies. Prior to discussing such strategies, the author acknowledges that some individuals may find these strategies, in addition to those enunciated above, to be personally objectionable. However, attorneys as legal counselors have an ethical and professional obligation to advise their clients regarding 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, maximizing Medicaid eligibility through strategies which fully comport with all legal and regulatory requirements is an available legal option in meeting an LTC need. 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 aware of these strategies used by citizens to maximize Medicaid eligibility, and analogously as well, to minimize federal income taxation. In the event Congress at any time should 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 utilize any legally permissible strategy such individual should find objectionable.

A primary strategy in maximizing Medicaid eligibility is asset restructuring, i.e., making purchases and payments that do not constitute disqualifying transfers to others and assist the Medicaid applicant 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 five-year disqualification period should Medicaid subsequently be needed to assist in LTC. The earlier that LTC is anticipated to be needed, the lesser this strategy will be efficacious, for it will be then more at risk to take place during the five-year and require private pay until the period expires to avoid having to disclose the transfer on a Medicaid application, thereby possibly resulting in a disqualification period beyond the look back period. Moreover, in that situation, under the provisions of the Deficit Reduction Act of 2005 discussed above, as noted above, with respect to transfers during the five-year look back period, such disqualification period will not even commence until the transferor is possessed of only exempt resources, is "medically needy," and normally also residing in a long-term care facility.

With respect to married Medicaid applicants, Medicaid eligibility strategies for the infirm spouse may be employed to reduce the period necessary for the well spouse to meet the "division of assets" test so that the infirm spouse may qualify for Medicaid. Under such strategies, the well spouse may pay down bills (e.g., credit card debts and mortgages) or pay taxes due but not owing (e.g., current year's property taxes and estimated federal income tax payments) or make improvements on exempt property or purchase exempt assets with non-exempt assets (e.g., buying an exempt irrevocable pre-paid funeral plan and burial plot, purchasing a more expensive vehicle, improving the residence, purchasing desirable household furnishings and more energy efficient appliances, and purchasing "income producing" assets which are exempt resources under state law) in an amount necessary to reduce the couple's exempt assets to at least the "division

of assets" amount such that the infirm spouse may then qualify for Medicaid benefits.

Additional strategies which maximize the "division of assets" eligibility test in 50% option states such as Kansas for married Medicaid applicants include borrowing assets prior to the so-called "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 (the amount of cash) 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, thereby already limiting the "division of amount" to the maximum amount, employing this borrowing strategy will increase the amount of non-exempt assets which may be retained by the well spouse for the infirm spouse to 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 returning to the financial status quo prior to the loan, thereby reducing the amount of assets held by the infirm spouse to a much higher "division of assets" amount that qualifies 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 not previously available. Under the Act, a well spouse may purchase a "Medicaid compliant annuity" as defined in such Act, which converts a non-exempt asset used to purchase the annuity (i.e., cash) into an "income stream" to the well spouse which is not considered a Medicaid resource. As noted above, the income of the well spouse has no adverse impact in qualifying the infirm spouse for Medicaid. A "Medicaid compliant 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 "Medicaid compliant annuity," the state 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." Thus, the most effective strategy in this regard is for the period of such "qualified annuity" to be quite short, say one year or less, 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 state for Medicaid reimbursement to the infirm spouse's benefits. This is an effective method of significantly reducing the amount of the non-exempt assets of the couple to a much lesser "division of assets" amount qualifying the infirm spouse for Medicaid benefits. Following such qualification, the amount of the well spouse's non-exempt assets is irrelevant to the infirm spouse's continuing qualification for Medicaid benefits.

Although a single person could use the same approach in purchasing a "Medicaid compliant annuity" to convert a non-exempt asset into an "income stream," such strategy has significantly less advantages and may be of no advantage at all 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 normally would have to be paid to the state as beneficiary to the extent of any Medicaid benefits paid.

Thus, the only apparent way to use a "qualified annuity" for a single person both to accelerate Medicaid benefits and to preserve assets from having to go for long-term care is to make a disqualifying transfer of an amount and contemporaneously purchase a "Medicaid compliant 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, thereby commencing the disqualification period resulting from the transfer. The annuity would be structured such that the term of the even annuity payments would extend till the end of the disqualification period and approximately equal the LTC payment needed during the disqualifying period. Such amount would vary from individual to individual based upon the individual's income and the cost of LTC in the subject facility. A simple mathematical formula can determine the amount of the transfer and remaining amount of non-exempt assets needed to purchase the annuity for the full term of such disqualification period such that the disqualification period for the disqualifying transfer amount and the period for which the annuity will satisfy the annuitant's care are approximately contemporaneous events. Consequently, once the disqualification has expired, the Medicaid applicant should then be eligible for Medicaid. The amount transferred then could be retained by family members not needed for any future need of the Medicaid applicant not satisfied by Medicaid benefits and not otherwise have to be "spent down" for LTC needs prior to the transferor being qualified for Medicaid benefits under the resource test.

It is also important to note that under the same DRA 05 provisions, a promissory note can be structured in the same

manner as a Medicaid compliant annuity in converting what would otherwise be a resource into income. That is to say, the promissory note must provide for level payments which do not exceed beyond the life expectancy of the promissee. There is an additional requirement that the note must preclude cancellation of the indebtedness on the promissee's death. Thus, if an otherwise disqualifying transfer is couched as a loan with a qualifying promissory note, there should be no disqualification period as a result of the transaction. Moreover, the promissory note technique has an advantage over a Medicaid qualifying annuity in avoiding commissions and other attendant costs in its implementation, and the state, should the promissor die during the term of the note, is not entitled to any remaining amount owing on the note to the extent of reimbursing the state for Medicaid benefits paid to the well or infirm spouse.

The remaining planning alternatives for married couples who nonetheless desire to possess the maximum amount of non-exempt resources in excess of the "division of assets" limit while having 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, under state law, as in Kansas, it may have no effect on Medicaid eligibility under governing state law. 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. However, if the divorce is too one-sided in favor of the property set aside to the well spouse by agreement of the parties, the state may consider the excess to be a disqualifying transfer to a former spouse.

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 party may then provide for the other at death through the Medicaid trust technique discussed below. However, whether a separate maintenance decree will be honored in the same manner as a divorce with respect to avoiding any assets of the infirm spouse from being considered an asset of the infirm spouse is dependent upon state law, which at this time is highly uncertain.

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, and less opportunities for a single person, to accelerate Medicaid eligibility using the foregoing Medicaid planning strategies.

Important Note: Several states, including Kansas, Ohio and Pennsylvania, have attempted in the past to attack the efficacy of Medicaid qualified annuities in converting an otherwise non-exempt resource to an income stream for Medicaid purposes, notwithstanding they are sanctioned under federal law. Thus, their acceptance is not assured and the possibility of a state challenge is always present. Consequently, such strategy, like all Medicaid planning strategies, should not be implemented without the advice of an experienced Medicaid estate planning attorney who can assess the current state's position as to the viability of such strategy.

State Recovery of Medicaid Benefits

As an important Medicaid consideration, a 1993 federal law mandates all states institute legislation providing for estate recovery against the probate estate of an individual for Medicaid benefits paid to such individual or such individual's predeceased spouse. States are also authorized under federal law to pursue the non-probate disposition of property by individuals to convey property at their deaths, such as through joint tenancy, beneficiary designations or under the provisions of a revocable trust. Many states have enacted such expansive provisions. Kansas has adopted such extended recovery on such probate avoidance decrees.

However, no estate recovery is permitted until the death of a surviving spouse, or when a child of the decedent is under 21, blind or disabled as determined under social security disability criteria. It also cannot be pursued with respect to a personal residence if a sibling lived in the residence at least one year prior to the Medicaid recipient going into a LTC facility and has continuously lived in the residence since or a child of the recipient lived in the residence at least two years prior to the recipient entering LTC and provided care to such recipient sufficient for them to avoid LTC. Finally, with respect to an estate recovery claim against the personal residence of the Medicaid recipient, there is a hardship exception to such estate recovery claim, e.g., a child resides in the residence and has no means of living elsewhere.

Careful estate planning can minimize if not avoid the impact of this claim. In states not having such expansive estate

recovery provisions, disposition of property through probate avoidance devices not subject to estate recovery can be implemented. Moreover, having property subject to an estate recovery claim pass through probate makes it much easier for the state to pursue such a claim. Probate estates are normally legally required to give notice to the state of a potential estate recovery claim if the decedent or the decedent's predeceased spouse were in receipt of Medicaid benefits. When probate avoidance devices are utilized instead to convey property at death, there is no probate procedure requiring such notice be given to the state. The state must initiate its own more cumbersome separate judicial procedure to make such estate recovery efforts, which then include determining what property the decedent owed and to whom it passed to as a result of the decedent's death. This makes it somewhat less likely the state will pursue such efforts and increases the possibility of a more favorable settlement against the parties receiving such property subject to such estate recovery efforts.

Due to the fact that the assets of a deceased individual who was on Medicaid at date of death would likely only consist of exempt assets and the state would be aware of such property and that the Medicaid recipient has died and would likely have to be notified in any event with respect to any potential Medicaid claim, estate recovery is likely only to be avoided by using probate avoidance devices such as beneficiary designations on the property of the estate which the state would not be permitted to recover if recovery in such state is limited strictly to probate assets. Minimizing estate recovery of Medicaid benefits is thus likely to be much more feasible with respect to the assets of a surviving spouse of a Medicaid recipient who was not on Medicaid. In that situation, the state may not be aware of such death if the surviving spouse was not receiving Medicaid benefits, for the state would have had to initiate tracking procedures to make such determination. Moreover, the surviving spouse will often have a much larger estate due to the "division of assets" when the predeceased spouse qualified for Medicaid or which the surviving spouse inherited or earned following the predeceased spouse's death. The surviving spouse would thus best use probate avoidance devices for the disposition of property at death, for as noted above, if the surviving spouse's assets pass through probate, normally the state would need to be notified of such potential claim. However, in the event the surviving spouse was in a state having expanded estate recovery against non-probate assets, the surviving spouse could also consider transferring assets away during the surviving spouse's lifetime either outright to family members or to an irrevocable trust discussed above under Section F so as to preclude the efficacy of any estate recovery claim the state might nonetheless assert provided such transfers could only be set aside if made by a Medicaid recipient. Under the provisions of such trust, the surviving spouse could be an income beneficiary, have the authority to change the trustee to a party other than the grantor/transferor, and even have the authority to change the disposition of the trust estate upon the surviving spouse's death. In default thereof, the trust estate would pass in the same manner as any other remaining assets of the surviving spouse's revocable trust.

Federal` law under certain circumstances permits states, which Kansas has exercised, to file a lien on the personal residence of a Medicaid recipient while living to ensure reimbursement to the state for Medicaid benefits paid upon the death of the Medicaid recipient (or the death of a surviving spouse, if married). Such lien may be filed if the Medicaid recipient has been residing in an LTC facility for six months and the state can demonstrate that there is little possibility of the recipient returning to the personal residence. However, such lien may not be placed on a personal residence if a surviving spouse, or child under 21, or is blind or disabled is living in the residence. States are also permitted to file liens in lieu of, or in addition to filing a probate estate claim, on property owned by a Medicaid recipient following death or by a recipient's surviving spouse to secure a Medicaid estate recovery claim for benefits paid to the predeceased spouse. Kansas has also adopted such lien procedures. Lien resistant strategies include placing such real property into a limited liability company, which would convert real property into personal property.

It is important to keep in mind that even if the state 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 normally only consist 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 could still be a substantial economic benefit conferred by Medicaid eligibility. This is because the Medicaid reimbursement rate paid by the state to the nursing home or other long-term care facility is typically less than the private pay rate. Consequently, only if such estate recovery claim exhausted the estate would there not have been a benefit in that situation in qualifying for Medicaid. Moreover, there is no interest charged by the state on the amount of such payment.

Estate Planning to Maximize Medicaid Eligibility

Maximizing Medicaid eligibility is an important estate planning consideration. Statistics indicate that approximately

one-third of the time a well spouse will predecease an infirm spouse residing in long-term care. In the Medicaid context, traditional estate planning techniques such as joint tenancy ownership or simple wills giving all assets to the surviving spouse upon the death of the predeceased spouse are normally quite counterproductive. Either 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 surviving spouse is lacking sufficient mental capacity to execute any estate planning devices such as a financial power of attorney or manage financial affairs, a conservator would likely need be appointed by a court to make such decisions, with its attendant costs. Finally, probate of any remaining property owned outright by the infirm spouse and not having a valid beneficiary designation not needed for the surviving spouse's care would probably be required on the infirm spouse's death. State or federal law may then require that notice of the decedent's death be given to the state in the event the decedent or decedent's predeceased spouse was receiving Medicaid benefits. The state almost always would then file a claim against the probate estate of the decedent to recover such Medicaid benefits paid to the decedent or the decedent's predeceased spouse under estate recovery provisions discussed above.

Even worse for Medicaid planning purposes is a couple executing a joint revocable trust to hold the assets of both spouses, the provisions of which authorize either spouse to amend or revoke the trust or direct the distribution of trust assets for their singular benefit. This results in all assets in the trust being deemed to be fully available to both spouses for Medicaid purposes during their lifetimes, maximizing the spend down requirements for each spouse before either spouse would become eligible for Medicaid benefits. In states having expanded estate recovery statutes for Medicaid benefits paid to either spouse upon the death of the surviving spouse through a probate avoidance device, the entire trust estate is likely to be subject to such estate recovery provisions.

Generally, unless the spousal assets for estate tax purposes approach or exceed the applicable exclusion amount (in which event marital estate tax deduction techniques may need to be employed), this adverse consequence may be avoided by the well and infirm spouse placing or transferring all spousal assets to 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 supplementary to government resources, 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 also provide a higher degree of care, such as paying for a private room not covered by Medicaid benefits. In addition, 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 beneficiaries of the trust (usually children or their issue). Finally, if the well spouse predeceases the infirm spouse, there would be no assets in the infirm spouse's estate for the state to recover for Medicaid benefits paid to the infirm spouse.

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 in the event the state should challenge such benefit under the provisions of a revocable trust.

Note: 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 spousal rights claim that a surviving spouse would be entitled to under Kansas elective share statutes (even though having been waived during lifetime) remains an available resource to the surviving spouse for Medicaid purposes following the death of the predeceased Grantor. Other states have similarly deemed such survivorship rights to be a resource, whether legally pursued or not, although apparently not in the context of having been waived under a premarital agreement or the consent to the will of the decedent. Nonetheless, this anomalous position of the Kansas Supreme Court in holding the elective survivorship right of a surviving spouse to be a resource notwithstanding it did not exist at the predeceased spouse's death due to having previously been waived by the surviving spouse, might possibly be adopted in other states. Nonetheless even if adopted, if the infirm spouse has been receiving Medicaid benefits prior to the death of the predeceased spouse, such benefits should not be subject to any

estate recovery for Medicaid benefits paid, as the trust estate of the predeceased spouse are not assets owned by, or disposed of, by the surviving spouse.

Although the Kansas position may disqualify Medicaid benefits, continuing for the surviving spouse notwithstanding the predeceased spouse having left all spousal assets in a "supplemental needs" Family Trust until "spend down" to the elective share spousal survivorship right, all prior Medicaid benefits paid to the surviving spouse should not be subject to a Medicaid lien or estate recovery against the surviving spouse's assets, for the surviving spouse under that scenario owns no assets.

If there is a probability of incapacity of one spouse, implementation of the above estate plan by transferring assets to the well spouse's revocable trust 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. In the event one spouse subsequently should incur a disability or have the expectancy of such an incurrence, revocable trust provisions could then permit the transfer of the assets from the revocable trust of the spouse anticipating a disability to the revocable trust of the other spouse, thereby maximizing both Medicaid eligibility under the "division of assets" test and also in the event the well spouse should predecease the infirm spouse during the pendency of such disability.

Even if revocable trusts are not desired presently, each spouse may give the other spouse a durable power of attorney authorizing the transfer of all spousal assets to the well spouse should either spouse later become incapacitated precluding them from having the capacity to execute such transfers in their individual capacity. 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 Family Trust provisions for the benefit of the surviving spouse. Without a previously executed and properly drafted durable power of attorney authorizing such transfers, however, the implementation of this strategy following the incapacity of a potential Medicaid recipient may not be feasible.

Important Final Comment: The state may possibly not consider assets that are otherwise exempt for Medicaid eligibility to be exempt if held in a revocable trust. This is true in Kansas. Thus, should that be the case, such exempt assets such as the personal residence would need to be held in the individual name of a single Medicaid applicant or the married Medicaid applicant's spouse to retain its exempt status. The owner would then name his or her revocable trust as beneficiary on such property at the owner's death to avoid probate in states permitting beneficiary designations on the subject properties.

Federal Law Ostensibly Prohibited Medicaid Planning Techniques

Provisions of the Kennedy-Kassebaum Bill, subsequently known as the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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, such 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 then only applied 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, the author is unaware of any subsequent efforts to enforce it.

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 benefit of the surviving spouse. Moreover, a divorce or possible 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: a single person may own only $2,000 of otherwise non-exempt resources to qualify for Medicaid; a married couple who are both in need of LTC may own only $3,000 of otherwise non-exempt resources and qualify for Medicaid; and for married couples only one of whom is currently 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, it is important to realize that such eligibility rules are subject to change in the future. Current and possible future fiscal restraints may well compromise the ability of the federal and state governments to continue to fund LTC at current care levels. There has been past discussion in Congress and 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 long-term care facilities which will accept Medicaid residents in the future.

Part Two: Particular Importance of Medicaid Estate Planning to Farmers and Ranchers

For a variety or reason, Medicaid estate planning is extremely important for farmers and ranchers. Unlike other individuals, they often have a significant estate but only a small percentage of which consists of assets which are not exempt resources in qualifying for Medicaid benefits. There is typically only a modest amount in IRAs, stocks and bonds, and cash. Thus, unless the individual has LTC insurance, this could require the sale or mortgaging of farm or ranch assets to pay for their care unless qualified for Medicaid benefits.

Second, the bulk of their assets are in their home and contiguous acreage and other business real and personal property, such as farmland, cattle, farm machinery and equipment. A large number of states, in addition to the personal residence, exempt such property from being considered a resource for Medicaid eligibility purposes. These include such large agricultural producing states as Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, North Dakota, Oklahoma, South Dakota and Wisconsin. This presents a great opportunity for Medicaid eligibility planning unavailable to most other estates. With proper Medicaid estate planning, and resorting to conversion of non-exempt assets to exempt assets, or if necessary, purchasing Medicaid compliant annuities or loans to reduce the non-exempt assets to the "division of assets" amount, despite the estate being of substantial value, the "division of assets" test often can be rather easily met so as to qualify an infirm spouse for Medicaid.

Third, agricultural families tend to place a substantial non-monetary value on farm and ranch land that other individuals do not with respect to their investment holdings, having a great importance on its retention in the family as a trade or business or simply for family legacy purposes. In addition to minimizing estate taxation in such preservation efforts,

farmers and ranchers thus understandably desire to avoid needing to sell or mortgage agricultural property in order to pay for long-term care.

Unfortunately, the estates of farmers and ranchers, not unlike those of many non-agricultural families, are typically ill-prepared to both maximize Medicaid eligibility and minimize exposure to state estate recovery efforts. Even when they have attorney assistance in their estate plans, Medicaid planning is often not even a consideration. Consequently, their assets are often held in joint tenancy ownership with a spouse, name their spouse as beneficiary, or provide in their wills that all property at their death go to their surviving spouse. As a consequence, should either spouse go into long-term care, assuming their estate even otherwise meets the "division of assets" test, one-half of the income from their agricultural property, along with their other income, such as social security, would go to the LTC facility, thereby either disqualifying them from Medicaid due to such income exceeding the Medicaid reimbursement rate for the facility or substantially reducing the Medicaid benefits that would otherwise have been paid had such property not been held in joint tenancy by reducing the amount Medicaid is required to pay.

Although such exempt and non-exempt property in that circumstance could be transferred to the well spouse without incurring any disqualification period, this may not be possible if the infirm spouse does not have sufficient competency to make the transfer and has not previously executed a comprehensive financial power of attorney authorizing such transfer to be made on his or her behalf. Under the laws of most states, a general durable power of attorney for financial decisions needs to specifically authorize gifts for such authority to be reposed in the attorney in fact. Further, under such type of estate plan all spousal assets will be owned by the surviving spouse. Should the surviving spouse be the well spouse and subsequently be in need of LTC, all non-exempt assets would need to be "spent down" to qualify for Medicaid benefits and the exempt agricultural property would be subject to estate recovery by the state for Medicaid benefits paid to the predeceased spouse. Should the surviving spouse be the Medicaid recipient, the same result ensues. In either situation, as noted above, the income from the entirety of the exempt property may exceed the Medicaid reimbursement rate for that facility, thereby denying Medicaid eligibility.

Even if the couple employs a revocable trust to avoid probate, it is often a joint revocable trust permitting either spouse to revoke or amend the trust, or withdraw assets, in favor of themselves in their individual capacity. Such trusts are the absolute worst estate planning device for Medicaid benefits. Even if exempt assets held in the joint revocable trust are still considered to be owned by the grantors of the trust and thus remain exempt, which may not be the case under some state laws such as Kansas, all assets in the trust are an available resource for Medicaid eligibility purposes to either or both spouses and in states which provide for estate recovery against non-probate assets held in a revocable trust, the entire trust estate remains available to estate recovery upon the death of the surviving spouse.

It is thus critical that Medicaid estate planning be accomplished when both spouses are living and competent to sign legal documents to maximize such planning. As discussed above, single persons such as surviving spouses have quite limited options to both maximize Medicaid planning with their assets and limit the exposure of their estates to state estate recovery for Medicaid benefits paid to them or their predeceased spouses. Such planning should include comprehensive financial powers of attorney which include provisions authorizing the attorney in fact (agent) to transfer assets to a spouse (assuming there are no second marriage considerations, such as children from prior marriages) for "division of assets" purposes.

Thus, it is normally desirable for each spouse to create a separate revocable trust as part of the estate plan pursuant to which the assets held in the trust would pass at the predeceased spouse's death to a "supplemental needs"/Family Trust arrangement discussed above, providing discretionary distributions for the health, education, maintenance and support needs of the spouse, and possibly children as well, supplemental to Medicaid benefits. The surviving spouse may serve as a trustee of such trust up until the time of a disability or death. This avoids adding additional assets to the surviving spouse's estate for Medicaid eligibility purposes and the income of exempt assets left for the benefit of the surviving spouse from having to be spent for LTC, it also minimizes the exposure of exempt assets such as farm and ranch property to estate recovery upon the death of the surviving spouse for Medicaid benefits paid to either spouse. Finally, to further maximize such benefit, what is termed a "reciprocal general power of appointment" provision can be included in each revocable trust, pursuant to which the predeceased spouse has the right to appoint the assets in the surviving spouse's revocable trust to the trustee of the predeceased spouse's revocable trust, which then places such appointed trust estate along with the other trust assets of the predeceased spouse into a Family Trust arrangement benefiting the surviving spouse supplementary to Medicaid benefits.

For a surviving spouse of a Medicaid recipient under a traditional estate plan who as a consequence owns all spousal assets, minimizing estate recovery efforts against such property for Medicaid benefits paid to the predeceased spouse involves consideration of a transfer of farm and ranch property to a comprehensive irrevocable trust discussed above in Section F to both avoid such Medicaid claim and maximize the surviving spouse's eligibility for Medicaid benefits, subject to a disqualification period resulting from the transfer should the surviving spouse be in need of Medicaid benefits within the five year lookback period following the transfer.

Part Three: The Role of Insurance in LTC Planning

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. Many companies offering such policies went out of business due to grossly underestimating their exposure in relation to insurance benefits paid. Some states also provide for a "free look" period, e.g., 30 days, during which time period the policyholder may cancel the policy for any reason and receive a full premium refund. State laws may also essentially mandate that issued policies be renewable and cancellation based solely upon the age or deteriorating physical or mental health of the insured may be 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 in relation to 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 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 both 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) 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." State laws may require that all LTC policies in that state 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 ADL places the emphasis where it should be, i.e., on the inability of the insured to attend to daily needs. ADL 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 LTC 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" as 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 state universities, county departments of aging, state insurance departments, as well as nationally in the National Association of Insurance Commissioners' and AARP's "Shopper's Guides," and 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 the 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 is normally desirable to comparison shop to ensure one is getting the best overall policy value for the premium expended.

There also can be 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 policy has provided $20,000 toward the LTC of an applicant and KDHE 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 re-

duced 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 that ultimately resulted in the estate of the applicant being not subject to the application of the Medicaid claim law, such Medicaid claim "offset" would have been of little or no benefit.

As a second monetary benefit, some states have extended the amount of exempt assets for Medicaid purposes to include the amount of premiums the Medicaid applicant paid for LTC insurance. In that case 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 can be statutorily affirmed by state legislatures, 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 have to be considered in qualifying for Medicaid benefits.

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 certain amounts 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.

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 10% of the payor's adjusted gross income. It has been made more difficult due to the $24,000 standard deduction enacted in the 2017 federal tax legislation. 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 an 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 an 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 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 against the Medicaid recipient's estate as well as that of the 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, at age 75, a comprehensive policy with good inflation protection might cost twice as much as the same policy at age 65. 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 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 those from different companies.

Foulston's Estate Planning and Probate Group

Foulston Siefkin LLP, the largest Kansas law firm having offices exclusively in the state of Kansas, has nearly 90 attorneys and is headquartered in Wichita, Kansas. The firm has additional offices in Kansas City and Topeka. The firm's Estate Planning and Probate Practice Group currently consists of attorneys who collectively practice in all significant estate planning, probate and trust areas. Viewers are invited to click here for information on the Group's practice areas and attorneys, law summaries of estate 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.

This estate planning law summary above was authored by the firm's Estate Planning and Probate Practice Group. Provided as a service to viewers, the strategies discussed therein are not designed to be an exhaustive discussion of the subject matter. Moreover, the discussion is often Kansas law specific, and are subject to varying and changing federal and state laws. This document has been prepared by Foulston Siefkin LLP for informational purposes only and is not a legal opinion, does not provide legal advice for any purpose, and neither creates nor constitutes evidence of an attorney-client relationship.

For Further Information

Foulston Siefkin regularly counsels clients on issues relating to Estate Planning and Probate. If you are interested in additional information regarding these matters, please visit our website at **www.foulston.com** or if you would like to discuss specific ways in which Foulston can help you, contact Tim O'Sullivan at 316.291.9564 or **tosullivan@foulston.com**, or Stewart Weaver at 316.291.9736 or **sweaver@foulston.com**, or Matt Bish at 316.291.9729 or **mbish@foulston.com**.

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