LONG-TERM CARE PLANNING
in Kansas and Missouri

University of Kansas
Human Resources & Equal Opportunity

Financial Planning Awareness &
Pre-Retirement Planning Seminar
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Prepared and Presented By:

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ADMITTED TO PRACTICE LAW IN MISSOURI AND KANSAS

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Craig C. Reaves has been licensed as an attorney since 1978. The major emphasis of his law practice is in the areas of Estate Planning, Elder Law, Special Needs Trusts and planning for persons who have a disability. He practices law in both Kansas and Missouri.

Mr. Reaves was one of the first attorneys to become a Certified Elder Law Attorney (CELA)* by the National Elder Law Foundation, and has continued to be Certified since 1995. He is listed in Who's Who In American Law and Who's Who in America. He has been selected for inclusion on the Kansas and Missouri Super Lawyers list for every year since 2005 and has been included in the current editions of The Best Lawyers in America since 2007. He is an adjunct professor at three schools of law - the University of Kansas, the University of Missouri-Kansas City, and Stetson University in Florida.

Mr. Reaves received both a law degree (JD) and a Bachelor of Science in Business with an emphasis in Political Science from the University of Kansas. He also holds the Chartered Life Underwriter (CLU) and Chartered Financial Consultant (ChFC) designations.

Mr. Reaves is a sought after speaker and educator. He is involved with many professional and charitable organizations, some of which are listed below.

**Professional:**
- Past President of the National Academy of Elder Law Attorneys (NAELA)
- Fellow of NAELA
- Fellow of ACTEC (American College of Trust and Estate Counsel)
- Charter member of the Council of Advanced Practitioners (CAP) of NAELA
- Past President and Founding Board Member of the Missouri Chapter of NAELA and member of the Kansas Chapter of NAELA
- Member of the Special Needs Alliance, a national organization of lawyers dedicated to disability and public benefits law
- Member of WealthCounsel and Society of Financial Services Professionals
- Member of the Board of Directors of The Kansas City Estate Planning Symposium
- Former member of the Disciplinary and Ethics Commission of the Certified Financial Planner (CFP®) Board of Standards
- Member of the Kansas, Missouri, American and Kansas City Metropolitan Bar Associations, along with the Probate and Estate Planning Committees of each
- Admitted to practice law in the federal and state courts in Kansas, Missouri (Western District Federal), and the United States Tax Court

**Charitable:**
- Past President of LifeCare Planning, Inc., a non-profit organization that assisted parents of persons who have a disability to plan for future care of their children
- Past President of the Brain Injury Association of Kansas and Greater Kansas City
- Past Secretary of the Arthritis Foundation-Western Missouri/Greater Kansas City Chapter
- Past President of the Kansas City Chapter of the Fellowship of Christian Athletes
- Founding board member of Respite Care Services, Inc.

* Neither the Supreme Court of Missouri, nor the Missouri Bar reviews or approves certifying organizations or specialist designations.
About
Reaves Law Firm, P.C.
A Professional Law Corporation

Reaves Law Firm, P.C., was founded in 1988 by Craig C. Reaves for the purpose of providing creative, practical and effective legal solutions for persons with estate planning and related needs. That focus has evolved to also encompass the highly specialized needs of persons who are elderly and those who have a disability.

Mr. Reaves and the staff of Reaves Law Firm, P.C., take great pride in providing personal services to our clients by addressing each client’s needs on an individual basis. We concentrate our efforts in the complex areas of:

**Estate Planning:** Designing and preparing trusts, Wills, durable powers of attorney, and other documents to help our clients accomplish their estate planning goals while minimizing probate court involvement and taxes.

**Elder Law:** Helping persons who are elderly or have a disability to protect assets, qualify for public benefits such as Medicaid and SSI, and plan for long-term care.

**Special Needs Trusts:** Designing and preparing special trusts that allow assets to be used in ways that help the beneficiary without disqualifying him or her from Medicaid, SSI or other benefit programs. These can either hold assets that belonged to a parent or other person, or lawsuit settlements, inheritances or other assets that belong to the person who has the disability.

**Trust Administration, Probate and Guardianship:** Assisting when needed to settle a trust upon the death of the trust maker, or to go to probate court to settle an estate or appoint a guardian and conservator.

The aim of each member of Reaves Law Firm is to help our clients accomplish their estate planning and other legal goals. We want to take the mystery out of the planning process. Any legal documents or planning strategies we prepare will be explained in straightforward language that our clients and their family can understand.

**REAVES LAW FIRM, P.C.**

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ADMITTED TO PRACTICE LAW IN MISSOURI AND KANSAS
# Long-Term Care Planning
## In Kansas and Missouri

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I. DEFINITION OF LONG-TERM CARE

Despite what many people think, long-term care includes much more than nursing homes. Long-term care is a phrase that is used to describe a variety of services in the area of health care, personal care, and social needs that are provided to people who are “cognitively” or “functionally” impaired.

A. Cognitive Impairment: "Cognitive impairment" means lacking mental capacity to the extent that a person needs assistance or supervision with his or her daily activities. Examples would be dementia or Alzheimer's Disease.

B. Functional Impairment: Usually a person is classified as "functionally impaired" if he or she cannot perform a minimum of two of the normal “activities of daily living” ("ADL's") without assistance. The basic ADL's are: (1) eating (the ability to feed oneself without assistance); (2) dressing (the ability to get dressed without assistance); (3) bathing; (4) continence; (5) toileting; and (6) transferring (for example, moving from bed to wheelchair without assistance).

II. OPTIONS FOR RECEIVING LONG-TERM CARE

Once a person can no longer provide for his or her own care without assistance, and is beyond the ability of getting by with occasional home visits, Meals On Wheels, or other similar services, there are basically four options to consider for obtaining long-term care.

A. LIVING WITH FAMILY:

1. A family member (often a child or sibling) may move into the home of the person needing long-term care. This allows the person to remain in their own home, which most people vastly prefer. However, the home may not be suitable for such purposes. It may be necessary to climb steps to enter and exit the home, or stairs to get from living to sleeping areas of the home. The bathrooms may not be handicapped accessible. Although it can be done, it may be prohibitively expensive to modify the home to allow the person to continue to live there.

2. Another option is for the person needing long-term care to move into the home of the family member providing such care. As with the person's home, this may require massive remodeling of the house to allow the person needing long-term care access and maneuverability inside the home.

3. In today's society it is becoming less common for any family members to have the ability to provide comprehensive care for another person. The family members may be living alone or be single parents, and need to work to support themselves. Even if married, often both spouses need to work to support the family or pursue a career, and one cannot (will not?) quit work to provide the care. In addition, full time care for a chronically ill person, especially if mentally infirm or physically disabled, is hard work, and few people will be able to maintain the workload required.
B. HOME HEALTH CARE: If family members are not available to provide long-term care, then a second option is to hire an individual or company to care for the person in the person’s home. Although this is often affordable if minimal assistance is needed, this can be extremely expensive if the level of care required is high. Also, all of the previously mentioned problems and costs associated with adapting the person’s home to allow him or her to continue to reside there will have to be considered.

C. ASSISTED LIVING AT RETIREMENT CENTER: This is often utilized as an interim step between home health care and moving into a nursing home. Assisted living is usually not as expensive as full-time home health care since the staff providing the assistance is already on site at the facility. In addition, assisted living is usually less expensive than full nursing home care.

D. NURSING HOME: If none of the options described above are viable, then moving to a nursing home is often the only option.

III. OPTIONS FOR PAYING FOR LONG-TERM CARE

There are basically seven sources people look to for payment of long-term care expenses. Many of these are not very helpful.

A. MEDICARE:

1. When Medicare May Pay For Home Health Care: If the services required are medically "reasonable and necessary", Medicare may provide coverage for home health services when:

   a. Such services are required because the person is confined to his home, and

   b. The person needs:
      1) Skilled Nursing Care on an intermittent basis,
      2) Physical therapy, or
      3) Speech therapy; and

   c. A plan for such services has been established and is periodically reviewed by the person’s physician; and

   d. The person is under the care of a physician.

2. Home Health Care Services Medicare May Pay For: If the above criteria are established, then Medicare may pay for the following services:
a. Part-time or intermittent nursing care;

b. Physical, speech and occupational therapy;

c. Medical social services as directed by a physician; and

d. A home health aide on a part-time or intermittent basis. This does not include homemaker services.

3. **Medicare Pays Little for Nursing Homes:** A study by AARP found that 79% of those surveyed believed Medicare would pay for nursing home expenses for long-term care. This is totally incorrect. Medicare only pays for skilled care in a nursing home, which is the highest level of care provided. And even then, Medicare only helps pay for a maximum of 100 days. Medicare does not pay anything for non-skilled care, and most people in nursing homes are not at the skilled care level.

4. **What Medicare Actually Pays For Nursing Home Care:** If an individual is admitted to a hospital (not just under observation status) for at least three (3) days, and enters the nursing home within thirty (30) days after discharge from the hospital for a condition that was treated in the hospital, then Medicare will pay all "skilled" (sub-acute) nursing care costs for the first 20 days, and all but $167.50 per day for the next 80 days (in 2018). The individual must be receiving "skilled nursing care," as defined by Medicare, for all of those days. After 100 days, or earlier if skilled nursing care stops, Medicare pays nothing.

B. **VETERAN’S BENEFITS:** If the person needing long-term care is a veteran (or surviving spouse of a veteran) of the United States armed services who (i) served in active military service for at least 90 consecutive days, at least one day of which must have been during a war-time period, (ii) does not have enough income to pay for needed care, and (iii) has limited assets, then the Veterans Administration may provide some assistance. This may take the form of monthly income or care in a veteran’s nursing home. If it is possible a person may qualify, then the VA should be contacted to find out if assistance is available. For anyone else, the VA does not provide long-term care assistance.

C. **HEALTH INSURANCE:** Usually private or group health insurance will not pay anything towards long-term care.

    **Medicare Supplement Insurance:** Plans C through J, described on the following chart, will pay the $167.50 per day that Medicare will not pay towards skilled nursing care for days 21 through 100. Plans K and L pay the percentage shown in the chart. There are no payments after 100 days of skilled care, or for any days of care that are not at the skilled level.
Comparison of Medicare Supplement Policies: The following chart compares the provisions of the various types of Medicare Supplement Insurance policies allowed at the time these materials were prepared.

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Through May 31, 2010 the 12 standardized plans A - L could be purchased. As of June 1, 2010 plans E - J could no longer be sold and new plans M and N were added.

“Core Benefits” for all but plans K and L are: Part A - after the deductible is paid, the plan pays all other coinsurance payments, plus adds 365 lifetime days after the 150 day standard benefits is used. Part B - after the deductible is paid, the plan pays all coinsurance payments.

D. **LONG-TERM CARE INSURANCE:** Long-term care insurance is a source of income that can be used towards the costs of long-term care. However, like any insurance, it must be purchased while a person is still in reasonably good health and not needing long-term care. It is a complex product that has many options to choose from, and the cost varies considerably based on the options chosen. Since it can be quite expensive if every attractive option is in the policy, most people are forced to compromise when designing their policy. It is very helpful if an unbiased agent is used to help sort through the options and companies to choose a long-term care insurance policy that is appropriate. The primary options that are available are summarized below.
1. **Types of Policies:** Although the number is shrinking, there are still many companies that offer long-term care insurance. Some have recently entered the market, while others have been offering this insurance for many years. An individual can buy long-term care insurance through a group or association they are a member of, or on an individual basis. Also, some employers offer long-term care insurance as an employee benefit.

   a. **Group Policies:** Group long-term care insurance policies are obtained through an association or employer. Although these may be less expensive than an individual policy, group policies are generally not "guaranteed renewable." In other words, the insurance company can change the premium, the benefits, or even cancel the master policy.

   b. **Individual Policies:** Individual long-term care insurance policies can be purchased by an individual or by an employer for a group of employees. If an employer purchases a policy, the premiums are typically deductible as an employee benefit.

   Individual long-term care insurance policies are either "stand alone" or connected to a life insurance policy, annuity, or other investment vehicle. A stand-alone policy is the most common type of long-term care insurance. Normally this type of policy only pays if a person has a long-term care claim; similar to automobile insurance only paying if you have an automobile accident. At the death of the insured, the stand-alone policy usually does not pay anything to the beneficiaries. However, it is possible to add a "non-forfeiture" or "premium refund" benefit to a policy. Either of these will pay some money back to the insured (or a named beneficiary) if all of the long-term care benefits are not used.

   A long-term care rider attached to a life insurance (or annuity) policy also pays if there is a long-term care need. These policies will pay a percentage of the face value of the life insurance policy each month toward long-term care expenses. For example, a life insurance policy with a $100,000 death benefit that has a long-term care rider that pays 2% of the face amount towards long-term care will pay $2,000 per month (2% of $100,000) towards the cost of long-term care for a maximum of 50 months.

   Unlike the normal stand-alone policy, if all of the benefit is not used for long-term care needs, this type of policy will pay to a named beneficiary the unused portion of the death benefit upon the death of the insured. This type of long-term care insurance policy is usually more expensive than a stand-alone policy.
c. **Long-Term Care Partnership Policies:** Prior to February 8, 2006, only people living in California, Connecticut, Indiana, and New York could purchase long-term care insurance policies that qualified for a long-term care partnership program. The Deficit Reduction Act of 2005 authorized all states, not just these four, to institute similar programs. Both Kansas and Missouri, along with many other states, have established procedures for companies to offer long-term care partnership policies.

Essentially, these policies must be “tax qualified” policies with a compound inflation provision. See below for a description of a qualified long-term care policy for tax purposes. Policies issued before the effective date of DRA 2005 (February 8, 2006) may not qualify as partnership policies even if they have all of the provisions required.

These policies are a partnership between the state Medicaid program and the long-term care insurance industry, as regulated by the state insurance department. It allows the person who purchases a long-term care insurance policy that qualifies for the program to protect an amount of the person’s assets from Medicaid that is equal to the amount of benefits that are paid out by the policy towards the person’s long-term care.

For example, assume a person purchases a long-term care partnership policy that will pay up to $100,000 towards the person’s long-term care. If the person requires long-term care and the policy pays the full $100,000 towards the person’s long-term care, then the person will be allowed to keep $100,000 in assets (in addition to any other exempt assets) and qualify for Medicaid assistance for payment of the person’s long-term care expenses. And after the person dies, the $100,000 cannot be taken back by the state’s estate recovery program. Therefore, the entire amount that the long-term care insurance policy paid towards the person’s long-term care is protected for the person and the person’s heirs from the state’s Medicaid program.

Although the requirements differ slightly depending on what state a purchaser resides in, essentially a long-term care partnership policy is nothing more than a tax qualified long-term care insurance policy (see below for what “tax qualified” means) that has an inflation rider. It also must be deemed by the State insurance commissioner to be a policy that qualifies for the State’s Long-Term Care Partnership program. There will be something in writing that accompanies the policy that certifies this.

2. **Provisions to Look for in Long-Term Care Policies:** Whether a long-term care partnership policy or not, it is important to carefully review the terms of the proposed long-term care insurance policy to make sure it provides an appropriate...
level of care for a competitive price. The following list contains some of the common provisions to look for in long-term care insurance contracts.

a. **Daily Benefit Amount:** Most policies pay a fixed dollar amount for each day the insured is eligible; e.g., $100 per day. You chose the daily benefit you want to purchase. The combination of the insured’s other income (from Social Security, retirement accounts, and investments) and this daily benefit amount should be large enough to pay for the insured’s expected long-term care and all of the insured's other expenses.

b. **Integrated Benefits:** Some policies will be "integrated," "enhanced," or "pooled" (or similar language). Generally, this means that the potential maximum benefit paid by the policy can be used for different services, and until the full amount is paid out, the policy will continue to pay benefits, even if the time limit of the policy has expired.

For Example, a policy offering a $100-per-day benefit for 3 years will pay a maximum of $109,500 ($100 X 365 days X 3 years). If the policy benefits are integrated, the policy will continue to pay benefits until the entire $109,500 is used. So, if for 3 years the insured received care at home (and the policy paid $50 per day), only half the policy benefits would have been paid out. Even though the 3-year term of the policy had expired, this policy will continue to pay for in home or nursing home care until the remaining benefit of $54,750 is paid out. If the policy was not integrated, coverage would normally stop at the expiration of 3 years following the date the first benefit was paid out.

c. **Inflation Protection:** Inflation provisions allow the daily benefit to increase. Although helpful, it may not increase as fast as actual nursing home costs. This will usually be offered as an automatic yearly increase, or one allowing the insured the option to increase the benefits periodically, such as every three years.

The insured can usually choose between increases calculated by a "simple" or "compound" method. "Simple" means the benefit will increase by the same dollar amount each time. "Compound" means the benefit increases by a fixed percentage. For example, a $100 daily benefit that increases by 5% on a simple basis will increase by $5 each time (5% of $100 = $5). Although for the first increase the "compound" method will generate the same $5 increase, the second increase will be $5.25 (5% of $105), and the third will be $5.51 (5% of $110.25), and so on.
d. **Length of Coverage:** The policy will pay benefits for a stated length of time. This can range from one year to the lifetime of the insured. Usually a minimum of five years is recommended.

e. **Deductible or Waiting Period:** Most policies require the insured to pay for a specified number of days (generally ranging between zero and 120 days) before the insurance company will begin to pay benefits. The longer the waiting period, the lower the premium. Typical would be 30 to 90 days.

f. **Level of Nursing Home Care:** The policy should provide the same coverage for all levels of nursing home care. Today nursing home care is divided into "skilled" and "non-skilled) care. However, some older policies may describe the care levels as follows:

1) **Skilled Care (or Skilled Nursing Care):** Daily nursing and rehabilitation care under the supervision of skilled medical personnel (for example: registered nurses) and based on a physician's orders.

2) **Intermediate Care:** The same as skilled care, except it requires only intermittent or occasional nursing and rehabilitative care. This distinction is not used today, so the newer policies do not distinguish this level of care. Instead they combine this level of care with the following.

3) **Custodial Care (or Non-skilled Nursing Care):** Help with one's daily activities including eating, getting up, bathing, dressing, use of toilet, etc. Persons performing the assistance do not need to be medically skilled, but the care is usually based on a physician's certification that the care is needed.

g. **Home Care and Assisted Living:** This benefit will pay for assistance at home or in an assisted living facility. The policy should pay the normal daily benefit amount for care at home or in an assisted living facility. Some policies limit this to 50%. Most people prefer to stay at home rather than move to a nursing home. Some policies will only pay non-family licensed providers. Others will also pay family members who provide care.

h. **Coverage Triggers:** It is very important to understand what triggers the payment of benefits from the policy. Look closely at:

1) **Organic Brain Disease:** The policy must include coverage for "organic brain disorders," such as Alzheimer's, Parkinson's, and similar diseases. Some policies specifically exclude coverage for this.
2) **Prior Hospitalization:** This provision should not be in the policy. It prohibits the payment of benefits unless the insured has been hospitalized (normally for at least 3 days) for the same condition that caused the insured to enter the nursing home, and the insured must enter the nursing home within 30 days after leaving the hospital. Many people enter a nursing home without first being in a hospital. This provision would prevent them from receiving any payments from the policy.

3) **Prior Skilled Nursing Care:** This provision should not be in the policy. It prohibits the payment of benefits unless the insured has received skilled nursing care for the same condition prior to entering the nursing home.

4) **Activities of Daily Living:** Policies will typically list 5 or 6 activities of daily living (ADLs), and require that the insured be unable to perform 2, 3 or 4 of them without assistance before the policy will begin to pay benefits. The policies that require the inability to perform 3 ADLs without assistance are more restrictive than those that only require 2 of them.

The normal Activities of Daily Living are eating, toileting, transferring, bathing, dressing, and maintaining continence. The inability of an insured to be able to perform any of these without someone assisting them is what causes the requirement to be met. For example, if a policy requires that an insured be unable to perform two ADLs without assistance and an insured person needs assistance with feeding himself and getting his clothes on, then the policy will begin paying benefits. Bathing is often one of the first ADLs that a person will need assistance with. Some of the more restrictive policies will not list bathing as an ADL.

A “qualified” long-term care policy requires the inability to perform 2 of these 6 Activities of Daily Living in order to trigger the policy benefits. Qualified long-term care policies are described below.

i. **Period of Confinement:** This provision establishes how long the insured must stay out of the nursing home before being re-admitted for the same condition without being required to go through a new waiting period (or deductible). The period typically is not less than 90 days.

j. **Pre-Existing Conditions:** Most policies limit coverage of pre-existing conditions to discourage (prevent?) persons who are already ill from purchasing the policy. Many policies provide benefits if the pre-existing
condition has not occurred or was overcome prior to applying for the policy. Also, many policies will not pay benefits if the pre-existing condition recurs within a certain amount of time after the effective date of coverage. The better option is for the policy to provide coverage for pre-existing conditions after the policy is in force for 90 days.

k. Waiver of Premium: The policy should waive premium payments after the insured has been receiving benefits from the policy for a specified number of days. This should normally be no more than 90 days.

l. Guaranteed Renewability: This provision should be in the policy. It means the insurance company guarantees that it will offer the insured the opportunity to renew the policy and maintain the coverage.

m. Non-Cancellability: This provision should be in the policy. It prevents the insurance company from canceling the policy for any reason other than nonpayment of premiums. However, with group coverage, the entire group can be canceled.

n. Level Premiums: This does not mean that the premiums will never increase. No insurance company can guarantee that. Companies have the right to increase premiums for all of their outstanding policies with the consent of the State insurance commissioner, but cannot increase the premiums for selected individual policies.

o. Non-Forfeiture/Return of Premium: This provision returns to the insured some of the premiums paid if the policy is dropped by the insured. A "premium refund upon death" provision returns to the insured’s estate any premium paid minus any benefits received from the policy.

p. Restoration of Benefits: This provision restores any benefits paid from the policy if the insured stops needing long-term care and does not receive payments from the policy for a stated period of time.

For example, assume the insured was in a nursing home for rehabilitation and received $18,000 of benefits from the policy. The insured then returned home and did not receive any payments from the policy. After a stated period of time (such as one year), the $18,000 would be added back to the policy so that the full amount of the policy benefit would be payable if needed in the future.

q. Rating The Company: The insurance company issuing the policy must be financially sound and not have a history of complaints concerning claims payments, nor of excessive premium increases. A rating of one of the
top two classes by one or more of the insurance company rating services is recommended. Five major services that rate insurance companies are A.M. Best, Standard & Poors, Moody's, Fitch, and Kroll Bond Rating Agency. All of them should be reviewed. In addition, the insurance company should have at least a five-year history of offering long-term care insurance. And have no complaints filed with the State insurance department.

r. Evaluating the Agent: It is important to choose an agent who is knowledgeable in this specialized area. Be wary of policies offered through the newspaper or by direct mailings.

3. Comparing Long-Term Care Insurance Policies: There is no perfect long-term care insurance policy. The policies offered by the various companies, and the options of each, must be carefully compared. Usually, the better the policy, the higher the cost. However, this is not always true.

4. Benefits Excluded from Income if Policy is “Qualified”: As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), beginning with policies issued in 1997, benefits received from a long-term care insurance policy will be excluded from income as an amount "received for personal injury and sickness" (Internal Revenue Code Sec. 7702B), as long as the policy meets the strict requirements to be a "qualified" policy. In addition, benefits must be for services provided to a "chronically ill individual." A limited grandfather clause applies to policies issued prior to 1997.

The maximum exclusion from income is $360 per day ($131,400 per year) for the year 2018, without regard to actual expenses. This is adjusted for inflation for years after 1997.

5. Qualified Long-Term Care Insurance Contract: A “qualified long-term care insurance contract” generally means any long-term care insurance policy if:

a. The only insurance protection provided is coverage of "qualified long-term care services,"

"Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which:

1) Are required by a chronically ill individual (i.e., an individual who has been certified by a licensed health care practitioner as being unable to perform without substantial assistance from another individual at least 2 activities of daily living (eating, toileting, transferring, bathing, dressing, and
continence) for a period of at least 90 days [functional impairment], or who requires substantial supervision to protect such individual from threats to health or safety due to cognitive impairment), and

2) Are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

b. The policy does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (i.e., Medicare), or would be so reimbursable but for the application of a deductible or co-insurance amount,

c. The policy is guaranteed renewable,

d. The policy does not provide for a cash surrender value or money that can be paid, assigned, or pledged as collateral for a loan or borrowed (other than as provided in "e," below),

e. All refunds of premiums, and all policyholder dividends or similar amounts, under the policy are to be applied as a reduction in future premiums or to increase future benefits, and

f. The policy meets the "consumer protection" requirements of I.R.C. §7702B(g).

6. Tax Deductibility of Long-Term Care Insurance Premiums: Beginning in 1997, premiums paid for qualified long-term care insurance, and expenses for qualified long-term care services not paid by insurance, are deductible for taxpayers who itemize. (Internal Revenue Code Section 213(d)(10)). It is also subject to the same threshold of 10% of adjusted gross income that applies to other medical expenses. However, for the years 2013 - 2016 this amount was reduced to 7.5% if the taxpayer or spouse has attained the age of 65 before the close of the taxable year. (26 U.S.C. §213(f)). This Section is amended by Section 11027 of the H.R.1, known as the Tax Cuts and Jobs Act (TCJA) for years 2017 through 2018 to the reduced 7.5% amount for any taxpayer.

The below chart illustrates the maximum amount of long-term care insurance premiums which can be deducted, based on the age of the insured. These annual limitation amounts are adjusted for inflation after 1997.
<table>
<thead>
<tr>
<th>Age Before Close of Tax Year</th>
<th>Limitation in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or less</td>
<td>$ 420</td>
</tr>
<tr>
<td>41 to 50</td>
<td>$ 780</td>
</tr>
<tr>
<td>51 to 60</td>
<td>$1,560</td>
</tr>
<tr>
<td>61 to 70</td>
<td>$4,160</td>
</tr>
<tr>
<td>Over 70</td>
<td>$5,200</td>
</tr>
</tbody>
</table>

E. **CURRENT INCOME**: The next source of money to pay for long-term care is the monthly income of the person needing long-term care, or their spouse. This can be from Social Security, retirement income (such as from a pension, 401(k), IRA, or other retirement income), savings and investments, or earnings from working.

F. **SAVINGS AND INVESTMENTS**: If income and insurance benefits are not sufficient to cover the cost of long-term care, along with all other expenses of the person needing long-term care and his or her family, then the assets of the person need to be liquidated to generate the money to pay these expenses. This includes all accounts at banks, savings and loans, and credit unions; all investments (such as stocks, bonds, mutual funds, Certificates of Deposit, money market accounts, annuities, treasury bills or notes, investment real estate, partnerships, etc.); life insurance cash values; a closely-held business, etc. In other words, basically everything owned by the person. As these are liquidated and spent, the income from such investments also will decrease.

G. **MEDICAID**: This is the last resort for financial assistance with long-term care. It is the only general source of assistance from the government for long-term care. In Missouri Medicaid is referred to as “MO HealthNet” and in Kansas as “KanCare”.

1. **Eligibility**: Simply stated, there are three requirements to qualify for nursing home long-term care assistance from Medicaid:

   a. The person physically qualifies (i.e., blind, permanently and totally disabled, or age 65 or older and needing long-term care);

   b. The person's monthly income is less than the person's nursing home cost; and

   c. The person’s “available resources” (sometimes referred to as “countable” or “non-exempt”) are no more than:

      $2,000 if a Missouri resident; Increases to $3,000 on August 1, 2018, or

      $2,000 if a Kansas resident.

Usually, it is excess available resources that make a person in a nursing home ineligible for Medicaid assistance.
2. Available Resources Are Basically Everything Owned, Less Certain Exclusions:

Some of the more common exempt (non-countable) resources: (These vary by state and may change from time to time)

a. Home: In 2018 up to $572,000 of the net equity in a primary residence is exempt. This increases each year if there are sufficient CPI increases. This does not apply if a spouse or child under age 21 or who has a disability is lawfully residing in the home. The home loses its exempt status after the Medicaid applicant is absent for 12 months (24 months in Missouri), unless he or she signs a statement of intent to return.

b. Household goods, personal effects, and keepsakes.

c. Automobile: One automobile per household, if necessary for employment, medical treatment, or modified for handicapped person.

d. Life Insurance: If face value (original death benefit) is $1,500 or less. If greater than $1,500, then cash surrender value is countable resource.

e. Burial space

f. Funeral plan: $1,500 maximum in revocable plan. More is allowed if irrevocable plan.

g. Pension Plans: In Kansas, the cash value of the Medicaid applicant’s pension plan is exempt only if:

   (1) the applicant would have to terminate employment in order to receive payment. Plans which can be converted to periodic payments are exempt if they are converted to periodic payments by the month following the month they are eligible for conversion, or

   (2) the applicant is not retired or claiming permanent disability. This does not apply if the applicant is retired or claiming disability and not drawing the benefits to which the applicant is entitled

All other retirement accounts of the Medicaid applicant are considered available and countable for Medicaid eligibility purposes.

In addition, for Kansas Medicaid work related pension funds, including IRA's and Keogh plans, of the applicant's spouse or parents are
exempt if such spouse or parent is not applying for Medicaid assistance.

3. Medicaid Planning: It should not be a person’s goal in life to someday qualify for Medicaid. The best strategy for being able to pay for long-term care in the future is to plan to either have sufficient income to pay for the potentially needed care or purchase long-term care insurance, which will provide the additional income when needed. Attempting to pay for long-term care by liquidating assets is a very expensive way to meet those expenses.

However, there are many people who cannot qualify for or afford long-term care insurance. Or they (or their spouse) are struck by accident or disease before they have purchased it. Unless they have sufficient income to pay for their long-term care they will have to liquidate their assets and “spend them down” to $2,000 before they are eligible to qualify for Medicaid assistance.

When they reach that level, they will be totally dependent on the Medicaid program for virtually everything they need. Once a person is living in a nursing home and receiving Medicaid assistance, all of their income goes to the nursing home or health insurance except for a “personal needs allowance” of $62 per month (if in a Kansas facility) and $50 per month (if in a Missouri facility). This means that if Medicaid does not pay for something the person needs or wants, then they only have their monthly personal needs allowance to cover the cost. If this is not enough, then they must either do without or hope someone else will spend their own money to purchase the items or services for them.

It is for people caught in this trap that Medicaid planning strategies are something that should be considered.

Although Medicaid is called “KanCare” in Kansas and “MO HealthNet” in Missouri, for ease of reference, it will be referred to as “Medicaid” throughout these materials.

4. Objectives of Medicaid Planning: There are three objectives of Medicaid Planning. They are:

a. To enhance the quality of life of the person needing long-term care by allowing the person to utilize Medicaid to provide for basic needs while structuring the person’s assets in such a way that they can supplement the Medicaid and pay for items Medicaid will not cover.

b. To making excess resources “disappear” in a way that benefits the Medicaid applicant and the spouse, if any; and

c. To maximize the assets and income of the spouse remaining at home (the community spouse), if one spouse is in a nursing home.
5. **Medicaid Planning Strategies:** All planning strategies for qualifying for Medicaid can be broken into three categories:

   a. Reduce available resources;
   
   b. Convert available resources into exempt resources or income; and
   
   c. Maximize the resources and income for the spouse remaining at home, if one spouse is in a nursing home.

6. **Strategies for Reducing Available Resources:** There are many strategies that can be utilized to reduce available resources. Typically this involves spending the resources in such a way that benefits the Medicaid applicant or spouse. Examples are traveling and paying existing or anticipated debts, such as real estate taxes, pharmacy bills, insurance premiums, etc.

7. **Strategies for Converting Available Resources Into Exempt Resources or Income:** Some of the strategies to consider using to convert available resources into exempt resources are:

   a. **Purchase exempt resources:** Home, automobile, household goods, etc.
   
   b. **Repair exempt resources:** Home repairs, such as a new roof, new furnace, new windows, etc.
   
   c. **Prepay irrevocable funeral plan.**
   
   d. **Buy an annuity:** BE CAREFUL! This is not a normal annuity. It must contain some unusual provisions to qualify.

8. **Disqualifying Transfers:**

   a. **Overview:** Congress does not want an individual to be able to give away his income and assets in order to intentionally impoverish himself to become eligible for Medicaid. In an attempt to prohibit this, a penalty is imposed for certain gifts made prior to the date Medicaid is applied for. Congress drastically changed these rules effective February 8, 2006.

   b. **General Rule:** For any gifts made on or after February 8, 2006, a person is not eligible for Medicaid for long-term care assistance if he or she (or their spouse) has given away assets within a 60 month (5 year) period
prior to the date the person files an application for Medicaid assistance and would otherwise have been eligible to receive such assistance.

c. **Look-Back Period:** An applicant for Medicaid must disclose all financial transactions for the 60 months preceding the date he or she applies for Medicaid. This is known as the "look-back period". For any transfers made before February 8, 2006 the look-back period was generally 36 months. However, even under prior law there was a 60 month look-back period for a transfer from a revocable trust that was deemed to be established by the Medicaid applicant, or to an irrevocable trust from which the applicant does not retain sufficient rights. If there are any "disqualifying transfers" that took place within the look-back period, a "transfer penalty" of ineligibility for long-term care Medicaid benefits is imposed.

d. **Disqualification Period:** The person who gave away the property is disqualified from long-term care assistance for a period of time calculated by dividing the amount given away by the average monthly cost for nursing homes for the state the person lives in. Every state uses a different amount.

Currently Missouri uses $4,889 per month, which equals $160.73 per day. This is supposed to change every January, but has not changed for a few years. In Kansas, the current amount is $4,000 per month for transfers that occurred before February 8, 2006. For transfers made on or after February 8, 2006, the transfer penalty divisor is currently $197.88/day, which is equivalent to $6,018.85/month on average. This is rounded to the next lowest whole number and the result is the number of days the transfer penalty runs.

**For Example:** If Dorothy, a Kansas resident, gives away her last $40,000 of cash to her friends, Auntie Em, Hunk, Hickory, and Zeke the day before she enters a nursing home, she will not be eligible for Medicaid for 202 days:

\[
\text{Fair Market Value of the Gift} = \frac{\$40,000}{\$197.88/day} = 202 \text{ days}
\]

Note that this gift did not generate a gift tax since it is not more than $15,000 per donee (the amount that can be given away without making a taxable gift in 2018). From a tax planning perspective, this gift might make good planning sense, but from a Medicaid eligibility point of view it causes problems.

e. **Penalty Start Date:** In the Deficit Reduction Act of 2005 (DRA 2005) Congress drastically changed the way these penalties are imposed. The prior
law started the disqualification period in the month the gift was made. This meant that a person who made a gift that caused a 10 month penalty would be eligible to apply for Medicaid anytime after the 10 months following the date the gift was made had passed, even though this was still within the look-back period.

However, for all gifts made on or after February 8, 2006, the transfer penalty will not begin to run until the person who made the gift actually files an application to apply for Medicaid and would otherwise be eligible to receive Medicaid assistance but for the transfer penalty. In other words, the penalty will start at a time when the person does not have any money with which to pay for his or her long-term care. How they will pay, or what the nursing homes will do with people who can not pay for their care but are not eligible for Medicaid because of a transfer they made within the past five years, is any body’s guess.

f. **Allowed Transfers:** Certain transfers are exempt from these rules and will not cause a person to be disqualified from Medicaid. Some of the more common ones are:

1) Transfers more than 60 months prior to the date of the Medicaid application; i.e., outside the look-back period;

2) Transfers permitted by the division of assets/spousal impoverishment rules (see below);

3) Transfers between spouses;

4) Transfer of the person’s home to the person’s:

   a) Child less than 21 years of age, or blind, or permanently disabled as defined under SSI;

   b) Sibling who has an equity interest in the home, and who has been residing in the home at least 1 year before the date the person becomes institutionalized; or

   c) Child residing in the home at least 2 years immediately before the date the person becomes institutionalized, and who is providing care that allowed the parent to stay in the home.

5) Transfers of the person's assets other than the home:
a) To the person’s spouse, or another for the sole benefit of the spouse;

b) From the person’s spouse to another for the sole benefit of the spouse;

c) To the person’s child, or to a trust for the sole benefit of the child, who is blind or permanently and totally disabled, or

d) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined under SSI;

6) Sometimes transfers of a resource that would have been exempt at the time of the transfer are allowed.

a) In Kansas, this is allowed except for:

   a) The person’s home and surrounding property (including the transfer of a life estate interest only), and

   b) Income-producing real or personal property with a value greater than $6,000 or included in a trade or business in which the Medicaid applicant or spouse is actually participating in the production of income. Multiple transfers of such property occurring within the same month are treated as a single transfer for purposes of establishing the $6,000 limit as well as the total uncompensated value.

   b) In Missouri, this is allowed for any property that is exempt, other than the Medicaid recipient’s home (IM 1040.020.20)

7) Transfers pre-approved by the agency overseeing the Medicaid program.

8) Transfers where a satisfactory showing is made that the assets were transferred exclusively for purposes other than to qualify for Medicaid. The presumption is that any transfer for less than fair market value within the look-back period creates a transfer penalty. The burden in on the Medicaid applicant to prove by clear and convincing evidence that the transfer in question qualifies for this exception.
For Kansas Medicaid purposes, there are some unique rules. For purposes of this exception, in determining whether clear and convincing evidence exists to substantiate the purpose of the transfer, the state will consider the following factors (among others):

a) The transfer was ordered by a court and neither the Medicaid applicant nor spouse nor anyone acting in their legal authority or direction took any action to petition the court to order the transfer.

b) Unexpected events that have altered the circumstances present at the time of transfer which occurred between the transfer and the application, including:

   (1) a traumatic onset of disability or blindness;

   (2) the diagnosis of a previously undetected disabling condition; or

   (3) an unanticipated loss of other income or resources completely outside of the control of the Medicaid applicant or spouse which would have otherwise precluded medical eligibility;

c) Gifts and other charitable contributions are presumed to be given for the purpose of becoming eligible for medical assistance. The following exceptions apply when considering gifts:

   (1) “When the total amount of all gifts given totals less than $50.00 in a given month.” If more, then all charitable gifts are counted.

   (2) “For applicants only, gifts consistent with an established, well-documented, history of charitable contributions occurring over a number of years prior to the transfer. For example, an individual who has regularly given $100/month to her church for 25 years or an annual contribution to the Salvation Army at Christmas.” (Medical KEESM 5723.3.1.d)
9. Division of Assets/Spousal Impoverishment Rules:

a. **The Situation:** Sometimes one spouse will need nursing home care (the "institutionalized spouse"), while the other one is healthy enough to stay at home (the "community spouse"). State laws require spouses to support each other, so the community spouse will have to spend his or her income and assets to support the other spouse in the nursing home.

b. **A Solution:** If the nursing home stay will exceed 30 days, then the couple will be eligible to divide their assets and income. This sets aside some assets and income for the community spouse, and all the rest must be spent. Once all of the non-protected assets are "spent down" below the maximum Medicaid resource level ($2,000) the spouse in the nursing home will qualify for Medicaid.

c. **Community Spouse Resource Allowance (in 2018):** The community spouse can keep one-half of the marital "countable resources," with a minimum of **$24,720**, and a maximum of **$123,600** (in 2018). Normally, these numbers change each January. However, they were not changed in 2010, 2011, or 2016 because there was not a Social Security cost of living increase. Note that the normal definition of "countable resources" applies, so the home, one automobile, etc., are exempt.

**Example 1:** Bill and Mary have the following assets on the day Bill enters the nursing home in February 2018:

<table>
<thead>
<tr>
<th>Exempt Resources:</th>
<th>Countable Resources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home:</td>
<td>Bank Accounts:</td>
</tr>
<tr>
<td>$200,000</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>Auto:</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>4,000</td>
<td></td>
</tr>
<tr>
<td>Personal Property:</td>
<td></td>
</tr>
<tr>
<td>5,000</td>
<td></td>
</tr>
<tr>
<td>$209,000</td>
<td></td>
</tr>
</tbody>
</table>

Mary can keep all of the exempt resources and one-half of the countable resources up to a maximum of $123,600. The countable resources of $50,000 ÷ 2 = $25,000. Since this is less than the maximum, Mary can keep the entire $25,000. The other $25,000 must be spent down to $2,000 before Bill qualifies for Medicaid.
Example 2: Bill and Mary have the following assets on the day Bill enters the nursing home in February 2018:

**Exempt Resources:**
- Home: $200,000
- Auto: $4,000
- Personal Property: $5,000

\[ \text{Total Exempt Resources} = \text{Home} + \text{Auto} + \text{Personal Property} = 209,000 \]

**Countable Resources:**
- Bank Accounts: $50,000
- Investments: $200,000

\[ \text{Total Countable Resources} = \text{Bank Accounts} + \text{Investments} = 250,000 \]

Mary can keep all exempt resources and one-half of the countable resources up to a maximum of $123,600. The countable resources of $250,000 ÷ 2 = $125,000, which exceeds the maximum. Therefore, Mary can only keep countable resources equal to $123,600. The remainder of the countable resources ($126,400) must be spent down to $2,000 before Bill will qualify for Medicaid.

There are strategies for maximizing the amount that can be kept by the community spouse. Which ones will work in for a given couple depends entirely on the exact situation the couple is in.

If the community spouse receives anything after the institutionalized spouse begins receiving Medicaid assistance, it remains the property of the community spouse and does not affect Medicaid eligibility of the institutionalized spouse.

d. **Community Spouse Income Allowance:** The community spouse can keep all of his or her income. In addition, if the community spouse's income is not equal to the "Minimum Monthly Maintenance Needs Allowance (MMMNA)" a sufficient portion of the income of the spouse in the nursing home can be allocated to the community spouse so his or her total income equals the MMMNA. This allowance varies by state, but the current minimum is $2,030.00 per month. This may be increased without going to court to no more than $3,090.00 per month (as of January 2018).

10. **Estate Recovery of Medicaid Payments:** Since the inception of Medicaid, states have been authorized to recover assets from the estate of deceased individuals who had received Medicaid benefits, or the estate of his or her surviving
spouse. This became mandatory in 1993. The purpose is to repay the Medicaid program for benefits paid. This is referred to as “estate recovery.”

Also, the Medicaid agency now has the ability to collect from assets passing by beneficiary designations, life estates, trusts, and joint ownership. In addition, the agency can impose liens on real estate owned by the person receiving Medicaid assistance or their spouse to make sure the agency gets paid upon death.

It is important that any long-term care plan take the state’s estate recovery powers into account.

11. **BE CAREFUL!**: The objective of proper Medicaid planning is to utilize the Medicaid rules in such a way that Medicaid benefits can be received without making the recipient totally destitute. With proper advice and planning, this can be accomplished.

However, be very cautious. The laws governing this subject are very complex, usually confusing, and they change often. It is very easy to miss something or not understand these provisions, and the result can be loss of Medicaid eligibility for a long period of time.

**BE CAREFUL.**

THIS BOOKLET IS A SUPPLEMENT TO THIS PRESENTATION AND ONLY A SUMMARY OF THE LAWS AS THEY EXIST AT THE TIME OF THIS PRESENTATION. DO NOT RELY ON IT.
IV. PLANNING FOR YOUR INCAPACITY

Statistics show that at almost any given time during your life it is more likely that you will become disabled than die. Your ability to make rational decisions may be lost in an instant (through an accident, stroke, etc.) or gradually (through the effects of a disease like Alzheimer's or Parkinson's, or just the natural aging process). If you become intellectually incapacitated and you have not done any planning, the only way your family or friends will be able to legally assist you and make decisions for you is to go to court to have a guardian and conservator appointed for you. This is true even if your spouse is living. In order to avoid this, or if you prefer to not be attached to mechanical life-sustaining machines for a prolonged period of time, then the following should be considered.

A. Durable Power of Attorney: This written instrument is used to appoint someone (the "attorney-in-fact" or "agent"), or a series of people, to legally act on your behalf even if you are mentally incapacitated.

1. When Effective: You can choose to make your Durable Power of Attorney effective at one of the following times:

a. When you sign it, OR

b. After a physician certifies you are mentally incapacitated.

2. Types of Durable Powers of Attorney: There are two types of Durable Powers of Attorney. Although it is possible to combine them into one document, it is usually better to keep them separate.

a. Durable Power of Attorney for Financial and Legal Decisions: This is often referred to as a Property Durable Power of Attorney, or a General Durable Power of Attorney.

Examples of Authority Granted: Signing contracts and tax returns for you; endorsing and depositing your checks; gaining access to your safe deposit box; protecting and handling all of your assets and possessions that are not in a Living Trust; selling your property; spending your money for your benefit; making gifts on your behalf; applying for Medicare, Social Security, Medicaid, and other public assistance, etc.

b. Durable Power of Attorney for Health Care Treatment Decisions: This authorizes someone to make all health care related decisions and signing required forms. Usually this instrument is only effective after a physician has determined you are unable to make or communicate decisions (i.e., you are intellectually incapacitated).
Examples of Authority Granted: Authorizing any medical, surgical, or other health care treatment to be performed on you;

- Admitting you to any hospital, nursing home, or other treatment facility;
- Authorizing surgeries and the administration of drugs and other medical treatment;
- Refusing any or all of the above on your behalf, even to the point of authorizing your agent to remove hydration and nutrition tubes.

3. HIPAA Requirements: As of April 14, 2003, the Privacy Regulation portion of HIPAA (the Health Insurance Portability and Accountability Act) became effective. All Durable Powers of Attorney, whether health care or general/financial, should comply with this law. If not, it is quite likely that the agent appointed by the Durable Power of Attorney will have difficulty accessing information relating to your health care. This includes not only information at a hospital or physician’s office, but also with the company that administers your health insurance plan.

At the least, this requires signing a HIPAA authorization document. However, it is highly recommended that your Health Care Durable Power of Attorney and General (legal and financial) Durable Power of Attorney be drafted so that they comply with HIPAA.

4. Do Not Rely on Standard Forms: Your Durable Power of Attorney should clearly list each action your agent can take on your behalf. General grants of authority, i.e. "My agent can do anything I could do," are usually not accepted. This causes these documents to be detailed and long.

5. When Terminated: Upon revocation by you or upon your death.

6. How Often to Update: These should be reviewed every two or three years.

B. Living Will Declaration and Health Care Treatment Directive:
These written instruments are used to express your desire that if death is imminent or you are in a persistent vegetative state or other irreversible condition, your life is not to be artificially prolonged by medical treatments or machines. They allow the entering of a Do Not Necessitate Order (DNR) and the stopping of life support.

These documents are only effective if you are NOT able to make or communicate decisions concerning your health care. You are in control of these decisions as long as you are able.
Living Will Declarations must comply with local state statutes and are only effective if you are in a terminal condition. They only prohibit the artificial slowing down of your dying process. They are not applicable if you are in a persistent vegetative state.

Health Care Treatment Directives are based on common (constitutional and court decided) law and, unlike a Living Will, are even effective if you are in a persistent vegetative state or have some other irreversible mental condition. They can specifically authorize the stopping of artificially supplied nutrition and/or hydration.

These documents can either be a separate document or contained in your Durable Power of Attorney for Health Care Decisions. If this is a separate document, then it is essentially your physician who will decide when it is to be enforced. If in your Health Care Durable Power of Attorney, then the people you have appointed to make decisions for you are the ultimate decision makers.

C. Revocable Living Trust: This will allow a person or trust company of your choice to quickly step in after your incapacity and manage the property in your Living Trust for your and/or your family's benefit. It is generally easier to use and more readily accepted by financial institutions than a Durable Power of Attorney. However, since the trustee of your Living Trust will only be able to manage the property you transfer into your trust, Durable Powers of Attorney are still needed so someone can make personal decisions for you not related to the management of your property that is in your Trust.

1. **Definition:** A Revocable Living Trust is a trust created by you during your lifetime. You retain the power to change (amend) or terminate (revoke) the trust at any time.

2. **Common Design:** A "Revocable Living Trust" is often designed as follows:

   a. **You establish** the trust (i.e., you are the Settlor).

   b. **You serve as the sole trustee**, or co-trustee along with your spouse, another person, or an institution such as a bank or trust company. As trustee you have the authority to manage the property you put in the trust.

   c. **You retain the power** to appoint new trustees, add or remove property, and change or revoke the trust.

   d. **During your lifetime** the trust assets are used for your benefit (also can include your spouse, children and others), or as you direct.
e. At your death the trust becomes irrevocable (i.e., it cannot be changed or revoked) and trust assets distribute according to the terms of the trust. Options are:

1) Continue as a single trust for all beneficiaries;

2) Divide into multiple separate trusts for each beneficiary; or

3) Distribute the trust assets outright to beneficiaries.

3. Advantages of Revocable Living Trusts:

a. Avoids probate (delay, expense, and publicity).

b. Avoids the necessity of probate court controlled conservatorship if you become incapacitated, and it is often easier for the successor trustee to manage your assets than a person named in your financial Durable Power of Attorney.

c. Serves as a receptacle for estate assets, retirement plans, and life insurance.

d. Brings together assets in multiple states, and avoids multiple probates.

e. Relieves you of investment management, if someone else is trustee.

f. Allows you to view the trust in operation and to make changes if desired.

g. May be less vulnerable to attack on grounds of your lack of capacity, fraud, or duress than a Will or testamentary trust.

4. Disadvantages of Revocable Living Trusts:

a. It usually costs more to create and fund a Living Trust than a Will.

b. Assets must be retitled and transferred (or made payable) to the Living Trust during your lifetime. This is not difficult, but will require some of your time to accomplish.
5. Other Thoughts and Information Concerning Living Trusts:

a. You still need a Will

1) A Will is the best place to name a guardian for children who are minors or have an intellectual disability.

2) A Will should "pour over" assets titled in your name alone and caught in probate into your Living Trust.

   a) This prevents potential conflicts between persons who would inherit probate property if there were no Will and those named as beneficiaries of your Living Trust.

   b) These "non-trust" assets go through probate to reach your Living Trust.

b. To avoid probate and to be helpful if you become incapacitated, your Living Trust must be funded, i.e., title to property must be:

1) Payable to the trust upon your death, or

2) Transferred to the Trust before your death or incapacity. Technically, property is titled in the name of the Trustee.

Example: "John Doe, or his successors, as Trustee of the John Doe Living Trust Dated February 14, 2016."

c. A Living Trust can own or hold any kind of property, such as real estate, bank accounts, stocks and other investments, personal property, safe deposit box, furniture, copyrights, royalties, life insurance, etc.

d. A Living Trust can be named as beneficiary of life insurance, retirement plans (including IRA's), pay on death (POD) and transfer on death (TOD) accounts and Wills.

1) If you are married, your spouse must consent to retirement plans other than IRAs being paid to anyone other than your spouse.

2) Also, trusts cannot minimize income taxes by electing to roll retirement benefits over into a beneficiary owned IRA; only your surviving spouse can make such an election. Therefore, if you are married, then usually your spouse is named the first beneficiary of
retirement accounts, and your Living Trust is named as contingent beneficiary (in the event your spouse does not survive you).

3) If you are not married, usually your Living Trust is named the primary beneficiary. There are exceptions to this, though, and you need to be sure to obtain advice from a competent estate planning attorney before changing beneficiary designations.

4) If the Living Trust is properly designed and drafted, it is possible for IRA distributions paid to your Living Trust to be paid out (“stretched”) over the lifetime of the people who are beneficiaries of your Living Trust, rather than being required to payout over a shorter period.

e. Living Trusts are controlled by state law. Therefore, the rules and laws governing them will vary from state to state.

It is extremely important that an attorney familiar with the laws of the state you live in, and authorized to practice law in that state, be consulted before a Living Trust is established.

f. Living Trusts should only be prepared by a competent, experienced estate planning attorney.

1) DO NOT attempt to create one on your own, even with the assistance of computer programs and form books.

2) DO NOT purchase a Living Trust from a financial advisor or sales person, even if they say it will be written or reviewed by an attorney. They are practicing law without a license.

Although simple in concept, Living Trusts are very technical and complex documents. It is easy to miss important provisions, and no one will know there is a problem until it is too late to correct: after your incapacity or death.

g. A Revocable Living Trust does not help you qualify for Medicaid. All assets held in the Trust are deemed to be “available resources” and count towards the $2,000 maximum available resources you can have and qualify for Medicaid.

h. A Revocable Living Trust has no impact on taxes. Since you retain so much power and control over the Trust (the beneficial enjoyment, right to remove and replace a trustee, and a right to amend or revoke the trust, etc.) you are treated as the owner for tax purposes.
1) **Income Taxes:** All income and losses are taxed to you during your life, whether or not you draw the money out of your Trust.

2) **Tax Identification Number and Returns:**
   a) While you are living, no separate tax identification number is required (your Social Security number is used) and no separate tax returns are filed. All income earned by your Living Trust is reported on your personal income tax returns.
   b) After your death the your Living Trust becomes irrevocable and must obtain its own tax identification number and file its own tax return (Form 1041).

3) **Gift Taxes:**
   a) All transfers to the trust are treated as transfers to you. If from you, it is not a taxable gift. If from anyone else, all gift tax rules must be observed.
   b) All transfers from the Living Trust are treated as gifts from you and all gift tax rules must be observed.

4) **Estate Taxes:** For many years U.S. citizens have been taxed on the "privilege" of being able to transfer their property to others upon their death. As of January 1, 2018, the new estate tax law allows up to $11,200,000 to pass estate tax free for people who die in 2018 and imposes a flat 40% tax on the excess. Despite this, with proper planning these taxes can often be reduced or avoided. There is an automatic step up in income tax basis for all assets owned or controlled by a person when they die to the fair market value of the assets on the date of death. This has the effect of eliminating all capital gains upon death. Also, a surviving spouse can use any estate tax exemption that was not used by the first spouse to die; effectively increasing the amount that can pass estate tax free to $22,400,000 for a married couple in 2018.

Trust assets are taxed as part of your estate at death.
i. If you are married and your taxable estate exceeds the amount that can pass estate tax free (the Estate Tax Exemption Amount)\(^1\) then you and your spouse should properly design your estate plan to maximize the amount that will transfer estate tax free after the death of both of you.

1) The traditional way to accomplish this is for each spouse to have their own separate Living Trust. This was the most common method chosen for residents of Kansas and Missouri. It may also simplify trust administration when the first spouse dies.

2) Since the 2010 federal estate tax law changes became "permanent" in 2013, it is becoming more common for a married couple to use one Living Trust that both spouses are Settlors of and that divides the trust assets at the death of the first spouse into two separate shares, one for each spouse. If the size of the couple’s taxable estate is less than the combined estate tax exemption for both spouses, then the entire estate is often transferred to the surviving spouse, although a federal estate tax return must be filed in order to preserve the unused estate tax exemption for the surviving spouse.

3) If separate trusts are used they should try to have assets of equal value, (or have at least the Estate Tax Exemption Amount) to take full advantage of estate tax credits.

\(^1\) This started at $5,000,000 in 2010 and is adjusted for inflation thereafter. This was doubled in 2018 to $11,200,000.