

LONG-TERM CARE PLANNING
in Kansas and Missouri

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Human Resources**

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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 and Fellow of the National Academy of Elder Law Attorneys (NAELA)
- Fellow of ACTEC (American College of Trust and Estate Counsel)
- Charter member of the Council of Advanced Practitioners 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, an invitation-only national organization of lawyers dedicated to disability and public benefits law
- Past Chair of the Board of The Kansas City Estate Planning Symposium
- Member of the Appeals Commission of the Certified Financial Planner (CFP®) Board of Standards. Former Member of the Disciplinary and Ethics Commission and the Sanctions and Fitness Commission
- 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 Supreme Court of the United States

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.



COMPLETE ESTATE & PROBATE LAW

About Complete Estate & Probate Law, LLC

In 2020, Polly Bartle Blomquist founded Complete Estate & Probate Law, LLC (Complete) to comprehensively serve clients with excellence in all areas of estate planning. The firm began focusing on 3 distinct areas: general estate planning, probate (decedent's estates, guardianship), and estate and trust litigation. Since 2020, Complete has added 3 accomplished attorneys, Anne Hendrickson who specializes in probate and estate and trust litigation. Maureen Lester who added Elder Law, Medicaid and Special Needs Planning, and most recently in 2025, Craig C. Reaves and the team from Reaves Law Firm, P.C. joined Complete and added highly specialized planning for senior adults and individuals with disabilities.

The team at Complete provides excellent legal services and peace of mind by first listening to you and working to know and understand you and/or your family's unique situation. They lead with educating by explaining the law in a relatable way and providing you with the best options to accomplish your goals.

We concentrate our efforts in the complex areas of:

Estate Planning: Designing and preparing trusts, Wills, durable power of attorney, and other documents to help our clients accomplish their estate planning goals while minimizing probate court involvement and providing the option of asset protection.

Probate and Trust Administration: Helping clients through the Probate and Trust Administration process providing a detailed instructions to accomplish the post death administration in the most efficient way possible to avoid, errors, delays, fighting liability, and confusion.

Litigation: Helping clients through disagreements and conflicts relating to estate planning documents, how assets are spent or managed on behalf of a vulnerable person, and/or the care and treatment of a person.

Elder Law/Medicaid Planning: Helping senior adults or disabled persons to protect their 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 the beneficiary 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.

The Complete Team strives to help you achieve peace of mind for yourself and your loved ones by assisting you with the creation of plans that protect, provide, and minimize cost and stress for loved ones in the future.

Contact us by calling 816-601-1234 or emailing Planning@CompleteLawKC.com

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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 out of the six normal “**Activities of Daily Living**” (“ADL’s”) without assistance. These are common everyday personal care activities that are basic to being able to care for oneself without someone else assisting them. The six 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).

In addition to ADLs, there is a second set of activities that are referred to as **Instrumental Activities of Daily Living (IADLs)**. These require more complex thinking or organization skills and relate to the ability to live independently. They are often used to assess whether a person is showing signs of the early states of a cognitive disease, and to assess whether the person has the ability to live independently. Although not as established as ADLs, the common IADLs can be generally broken down into six areas. The question is whether the person can perform these functions without assistance. These are: (1) House cleaning and home maintenance - cleaning kitchens after eating, keeping the living space reasonably clean and tidy, and keeping up with home maintenance; (2) Managing transportation - whether driving or other means of transportation; (3) Shopping and meal preparation - purchasing food, clothing and other necessary items, and doing what is required to prepare meals; (4) Managing finances - including paying bills and managing financial assets; (5) Managing communication - including the ability to use the telephone and managing mail; and (6) Managing medications - obtaining medications and taking them as directed.

II. OPTIONS FOR RECEIVING LONG-TERM CARE

Once a person can no longer provide for his or her own care, there are two ways to view the options available for receiving long-term care assistance. One focuses on the source of care, and the other focuses on the places the person can receive long-term care services.

A. Sources of Long-Term Care Services and Supports:

1. Informal Care Givers: Informal care givers are people who typically provide care without charging for their services. Usually, these are family members, such as a spouse, child, or sibling. Friends also fall into this category. Approximately 78% of Americans living in the community (as opposed to an institutional setting) who receive long-term care support receive it from informal care givers. Informal care givers are predominately (66%) female, an average of 48 years old, and spend an average of 20.4 hours per week providing care (which increases to 39.3 hours per week if the care giver lives with the person receiving care). This allows the person to remain in their own home, which most people vastly prefer.

Be careful if you want to compensate informal care givers, whether by gift or payment on an hourly basis. If this is done, it is best if there is a contract signed between the care giver and the person receiving the care, or someone acting on their behalf. If it is possible Medicaid may be needed to help pay for long-term care services, then failure to have a written Care Agreement will most likely result in Medicaid taking the position all payments to the care giver were uncompensated gifts, which will result in the person needing long-term care being disqualified from Medicaid assistance for a period of time. Also, the IRS typically takes the position that the care giver is an employee of the person receiving care. This means the care giver should receive a W-2 at the end of the year and should have taxes withheld and matched by the employer (the person receiving the care).

2. Formal Care Givers: If family members and friends are not available to provide long-term care support, then a second option is to hire an individual or company to care for the person. Between 70% and 80% of paid long-term care in the U.S. is provided by formal, direct care workers, such as home health aids, CNAs, and personal care aids. Approximately 54% of this type of care is provided in the person's home or other community setting, and 46% is provided in an institutional setting. However, paying for direct care in a home setting 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.

B. Places to Receive Long-Term Care Services and Supports:

1. In the Home: Most people prefer to stay in their home as long as possible. Typically their home will be a single family house, a duplex, a condominium, or an apartment. A person unable to live alone can continue to live in his or her own home if they receive sufficient long-term care services and supports that allows them to remain in their home. This assistance can come from informal or formal care givers.

However, even if this care is available, the home may not be suitable for these 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 accessible. Although it can be done, it may be prohibitively expensive to modify the home to allow the person to continue to live there.

If the person's home is not appropriate, the person may be able to move into the home of the family member or friend 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.

2. In the Community: In addition to the above, it is often possible for a person to receive long-term care services and supports by going to places where they are available. Examples are Senior Centers or adult day services facilities. However, this requires that the person be able to live in their home, with or without assistance, and travel to these community facilities.

3. In Residential Settings: If it is no longer feasible or affordable to live at home, a person needing long-term care services and supports can move to a facility where these services are available.

a. Independent Living in a Senior-Oriented Condominium or Apartment: As an interim step, it is possible to move into an apartment or purchase a condominium in a building that caters to people over a certain age, such as age 55 or 65. Even though the facility does not offer on-site assisted living or nursing services (if needed, these must be provided by outside sources), there are planned social events and dining services offered for the people residing in the facility.

b. Assisted Living at Retirement Center: This is often utilized as a step between full-time 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 because the level and amount of care needed is less.

c. Continuing Care Retirement Community: Another option is to plan ahead and move to a continuing care retirement community while still able to live independently, or at the first need for assisted living assistance. By doing so the person will be able to stay at the same facility, or somewhere on the campus of the organization that runs the facility, if the need for more long-term care services grows. These communities offer independent living, assisted living, and nursing home level of care. Often the person moving to a continuing care retirement community will pay a lump sum deposit of a few

hundred thousand dollars and, in return, will pay a smaller monthly amount and will have a higher priority for additional services and a bed in the nursing facility than a person who did not make a large deposit upon entering the community.

d. Nursing Home: If none of the options described above are viable, then often moving to a nursing home is usually 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. These 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 these 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: Part A of Medicare covers up to 100 days in a skilled nursing facility during a benefit period. A “skilled nursing facility” is a facility that primarily provides “skilled nursing and skilled rehabilitation care” and related services to residents who require medical or nursing care, or rehabilitation services if injured, disabled, or sick. “Skilled nursing care” is not mere “custodial” care. Skilled nursing care is care that, as a practical matter, could only have been provided on an inpatient basis and must be provided on a daily basis by registered nurses, licensed therapists, or physicians, instead of non-professional staff. Examples are needing intravenous injections or physical therapy, treating open wounds, or being on a ventilator.¹

In order for a person enrolled under Part A of Medicare to be eligible for Medicare coverage of skilled nursing care in a skilled nursing facility, the person must be hospitalized for medically necessary inpatient hospital care for at least three consecutive calendar days (not counting the day of discharge). Emergency room or “observation status” days do not count towards satisfying this requirement. In addition, the person must enter a skilled nursing facility within 30 calendar days after hospital discharge in order to receive care for a condition for which the person received the inpatient hospital services.

For an infographic providing more details about “observation status” see the attachment produced by the Center for Medicare Advocacy at the end of these materials.

If a person qualifies, then Medicare will pay 100% of the first 20 days of skilled nursing or skilled rehabilitation services. After 20 days the person must pay a co-payment equal to one-eighth of the then current Part A inpatient hospital deductible (this equals \$209.50/day in 2025) and Medicare will pay the rest of the skilled nursing costs for up to 80 more days. After 100 days, Medicare pays nothing for this benefit period.

¹ See 42 C.F.R. § 409.31(a) (“To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.”).

If a person leaves a skilled nursing facility for more than 30 consecutive days but less than 60 days, then a new three day hospitalization stay must occur and the person will then continue to use the days remaining in that benefit period.² If the person leaves the skilled nursing facility for at least 60 consecutive days, then the skilled nursing care benefits are renewed and another skilled nursing care benefit period will begin if skilled nursing care is needed in the future.

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 United States Department of Veterans Affairs (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.

1. Medicare Supplement Insurance: Some of the plans described on the following chart will pay the \$209.50 per day (in 2025) 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.

2. 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.

² 42 C.F.R. § 409.36.

Plan	Core Benefits	Skilled Nursing	Part A Deductible	Part A Hospice	Part B Deductible	Part B Excess Charges	Emergency Foreign Travel	At Home Recovery	Preventive Care
A	Yes			Yes					
B	Yes		Yes	Yes					
C*	Yes	Yes	Yes	Yes	Yes*		Yes		
D	Yes	Yes	Yes	Yes			Yes	Yes	
E	Yes	Yes	Yes	Yes			Yes		Yes
F*	Yes	Yes	Yes	Yes	Yes*	Yes	Yes		
G	Yes	Yes	Yes	Yes		Yes	Yes	Yes	
H	Yes	Yes	Yes				Yes		
I	Yes	Yes	Yes			Yes	Yes	Yes	
J	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes
K	Some	50%	50%	50%					
L	Some	75%	75%	75%					
M	Yes	Yes	50%	Yes			Yes		Yes
N	Yes	Yes	Yes	Yes			Yes		Yes

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

*As of January 1, 2020, Plans C and F are no longer able to be purchased unless a person already owns one of these plans or was first eligible for Medicare prior to January 1, 2020. The cancellation of Plans C and F is a result of the termination of plans that pay the Part B deductible, which was part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).³

“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. The first 3 pints of blood each year.

3. Purchasing a Medicare Supplement Policy: A person who is age 65 or older can purchase a Medicare Supplement Plan (sometimes referred to as a “Medigap policy”) within six months after enrolling in Part B of Medicare without any medical underwriting (*i.e.*, coverage cannot be denied because of pre-existing

³ Pub. L. 114-10.

conditions, health status, or claims experience).⁴ After this period the insurance companies can inquire about the person's past health care and current medical condition. With this information, the insurance companies can increase premiums or deny coverage to an unhealthy person.

Medicare offers a website to help people choose an appropriate plan. These plans are referred to as a "Medigap" policy on this website. This can be found at <https://www.medicare.gov/find-a-plan/questiodigap-home.aspx>.

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 (often referred to as a "hybrid" policy). 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

⁴ 42 U.S.C. § 1395ss(s)(2).

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 ($\$100 \times 365 \text{ days} \times 3 \text{ years}$). 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. Generally, an integrated policy is preferred.

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 if non-family licensed providers are providing care at home. Others will pay if family members are providing the care at home.

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 a 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. 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, and Fitch. 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 § 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 \$420 per day (\$153,300 per year) for the year 2025, 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 Unreimbursed Expenses for Qualified Long-Term Care Services and for Qualified Long-Term Care Insurance Premiums:

a. **General Rule of Deductibility:** In general, there is allowed an income tax deduction for the expenses paid during the taxable year, which are not compensated for by insurance or otherwise, for the “medical care” of

the taxpayer, his or her spouse, or a dependent, to the extent that such expenses exceed 7.5% of the taxpayer's adjusted gross income.⁵

b. "Medical Care" Defined: For tax years beginning after December 31, 1996, for purposes of I.R.C. § 213, the term "medical care" includes amounts paid

1) For qualified long-term care services (as defined in I.R.C. § 7702B(c)),⁶ and

2) For any qualified long-term care insurance contract (as defined in I.R.C. § 7702B(b)). In the case of a "qualified" long-term care insurance contract, however, only "eligible long-term care premiums" will be taken into account.⁷ "Eligible long-term care premiums" mean the amount paid during a taxable year for any qualified long-term care contract to the extent the amount does not exceed the applicable limitation set forth in the following table.⁸

This table illustrates the maximum amount of long-term care insurance premiums which can be deducted for income tax purposes, based on the age of the insured. These annual limitation amounts are adjusted for inflation after the year 1997.

Age Before Close of Tax Year	Limitation in 2025
40 or less	\$ 480
41 to 50	\$ 900
51 to 60	\$ 1,808
61 to 70	\$ 4,710
Over 70	\$ 6,020

⁵ 26 U.S.C. § 213(a). The Taxpayer Certainty and Disaster Tax Relief Act of 2020, Title I, Subtitle A, Sec. 101 (134 Stat. 3039), amended I.R.C. § 213(a) to allow a taxpayer to claim an itemized deduction for unreimbursed medical expenses to the extent they exceed 7.5% of the taxpayer's Adjusted Gross Income. This is found in Division EE of the Consolidated Appropriations Act, 2021, Pub. L. 116-260, 134 Stat. 1182.

⁶ I.R.C. § 213(d)(1)(C).

⁷ I.R.C. § 213(d)(1)(D).

⁸ I.R.C. § 213(d)(10).

7. Effective Date: These provisions defining qualified long-term care insurance policies and qualified long-term care services generally apply to policies issued after December 31, 1996.

However, any policy issued before January 1, 1997, which met the long-term care insurance requirements of the state in which the policy was issued, will be treated as a “qualified long-term care insurance contract” and services provided under, or reimbursed by, the policy will be treated as “qualified long-term care services.” If a policy providing for long-term care insurance coverage is exchanged solely for a “qualified long-term care insurance contract,” taxable gain or loss may be recognized. It is important that you obtain competent tax advice before exchanging insurance policies.

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: Medicaid 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 (in 2025):
\$5,909.25 if a Missouri resident; this increases slightly each July 1, 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 2025 up to \$730,000 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. Motor Vehicle: One motor vehicle 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 the current Medicaid available resource limit (\$2,000 in Kansas, \$5,909.25 in Missouri in 2025; will change July 1) 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 a single premium immediate annuity that cannot be sold, assigned to anyone else, or converted into cash: 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". 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.

As of April 2024, **Missouri uses \$7,536 per month**, which equals \$247.75 per day. This usually changes every April. In **Kansas**, the current amount is **\$264.41/day**, which is equivalent to \$7,932.30 for 30 days and \$8,196.71 for 31 days. 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 and she applies for Medicaid in March 2025, she will not be eligible for Medicaid for 151 days:

$$\frac{\text{Fair Market Value of the Gift}}{\text{Average Daily Nursing Home Cost}} = \frac{\$40,000}{\$264.41} = 151$$

Note that this gift did not generate a gift tax since it is not more than \$19,000 per donee (the amount that can be given away without making a taxable gift in 2025). 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) Spouse;
 - b) Child less than 21 years of age, or blind, or permanently disabled as defined under SSI;
 - c) 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
 - d) 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 persons'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.

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 is 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 (currently \$2,000 in Kansas and \$5,909.25 in Missouri) the spouse in the nursing home will qualify for Medicaid.

c. Community Spouse Resource Allowance (in 2025): The community spouse can keep one-half of the marital "countable resources," with a minimum of **\$31,584** and a maximum of **\$157,920** (in 2025). 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 March 2025:

<u>Exempt Resources:</u>	
Home	\$200,000
Auto	20,000
Personal Property	<u>5,000</u>
	\$225,000

<u>Countable Resources:</u>	
Bank Accounts	\$ <u>80,000</u>
	\$ 80,000

Mary can keep all of the exempt resources and one-half of the countable resources up to a maximum of \$157,920. The countable resources of $\$80,000 \div 2 = \$40,000$. Since this is more than the minimum (\$31,584) and less than the maximum, Mary can keep only \$40,000. Before Bill can qualify for Medicaid assistance, the other \$40,000 must be spent down to \$2,000 if Bill is in a Kansas nursing home; or \$5,909.25 if Bill is in a Missouri nursing home.

Example 2: Bill and Mary have the following assets on the day Bill enters the nursing home in March 2025:

<u>Exempt Resources:</u>	
Home:	\$200,000
Auto:	20,000
Personal Property:	<u>5,000</u>
	\$225,000

<u>Countable Resources:</u>	
Bank Accounts:	\$ 50,000
Investments:	<u>\$350,000</u>
	\$400,000

Mary can keep all exempt resources and one-half of the countable resources up to a maximum of \$157,920. The countable resources of $\$400,000 \div 2 = \$200,000$, which exceeds the maximum. Therefore, Mary can only keep countable resources equal to \$157,920. Before Bill can qualify for Medicaid assistance, the remainder of the countable resources (\$242,080) must be spent down to \$2,000 if Bill is in a Kansas nursing home; or \$5,909.25 if Bill is in a Missouri nursing home.

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 **\$2,555** per month. This may be increased without going to court to no more than **\$3,984** (Kansas uses \$3,948) per month (as of January 2025).

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 intellectually incapacitated.

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

- 1) When you sign it, **OR**
- 2) After a physician or two certifies you are cognitively 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. General Durable Power of Attorney: This document appoints a person to make legal and financial decisions on your behalf. This may also be referred to as a Financial Durable Power of Attorney or a Property 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: 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 incapacitated).

Examples of Authority Granted: Authorizing any medical, surgical, or other health care treatment to be performed on you;

- Admitting you to a 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 artificially supplied hydration and nutrition through 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, such as "My agent can do anything I could do," are usually not accepted. As a result, these documents are usually 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 and kept current so it is clear to others that they are a current expression of your wishes.

B. Advance Medical Directive - Stopping Life Support (or not): Everyone should sign a document that clearly describes whether they prefer to have their life artificially prolonged by medical treatments or machines, or have life support stopped, if they are not capable of communicating their wishes at a time when they are terminal or in a persistent vegetative state. This document is referred to as an "Advance Medical Directive" (sometimes also referred to as an "Advance Directive").

An Advance Medical Directive is a written document that expresses your preferences regarding medical treatment you want if you (i) are going to die in the next few months no matter what health care you receive (*i.e.*, you are "terminal") or (ii) you are in a persistent vegetative state or other irreversible condition where you will never regain consciousness.

Some people prefer to have a Do Not Resuscitate Order (DNR) entered and life support stopped in this situation, while others prefer that every means be taken to keep them alive. This is a very personal decision and there is no right answer. However, no matter how you feel about this, you should have an Advance Medical Directive where your wishes are expressed. Without this, no one confidently knows what you want to have done if this happens to you.

An Advance Medical Directive is only effective if you are NOT able to make or communicate decisions concerning your health care. Even you have an Advance Medical Directive, you can always change your mind and direct your attending physician differently if you are capable of making and communicating your decisions.

There are three types of Advance Medical Directives:

1. Instructional: The first is “**instructional**” and specifically enumerates what medical treatments are to be utilized, or stopped, upon certain findings by your treating physician. These documents instruct your physician and family what is to be done when your attending physician determines you are terminal or in a persistent vegetative state. They speak for you and do not empower anyone else to intercede and make decisions on your behalf

The two types of instructional Advance Medical Directives are often referred to as a “Living Will” and a “Health Care Treatment Directive.”

A **Living Will** 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, and they will not allow the stopping of artificially supplied nutrition or hydration.

A **Health Care Treatment Directive** is based on common law (constitutional and court decided) and, unlike a Living Will, is also effective if you are in a persistent vegetative state or have some other irreversible mental condition where you will never be conscious again. If desired, they can specifically authorize the stopping of artificially supplied nutrition and/or hydration.

2. Proxy: The second type of Advance Medical Directive appoints someone of your choice as your “**proxy**” or agent to act on your behalf to determine whether your attending physician’s determination of your condition is accurate and what options are available for your medical treatment. Once these are determined, your agent can either (i) enforce your wishes to stop the medical treatment you are receiving and remove the devices that are artificially keeping you alive, or (ii) enforce your wishes to keep providing medical care to keep you alive if the removal of life support is not appropriate for you and not what you would have wanted in that situation. This type of Advance Medical Directive allows you to appoint someone you trust to assess your situation and make the decision you would make if you were capable of doing so. It does not leave your attending physician in charge of deciding when your life support should be continued or stopped.

3. Combined: The third type of Advance Medical Directive is a “**combined directive**” which is a combination of the other two types of Advance Medical Directives. Usually this is a Health Care Durable Power of Attorney that also contains a detailed description of what you prefer the appointed agent do if you are terminal or in a persistent vegetative state or permanent coma. In other words, your Advance Medical Directive becomes part of your Health Care Durable Power of Attorney document. In addition, this will convert to an instructional Advance Medical Directive if all of the people you have appointed to make this decision for you are unable or unwilling to act on your behalf.

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 General 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, General 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 Living 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 your Living Trust.

c. You retain the power to appoint new trustees, add or remove property, and change or revoke your Living Trust.

d. During your lifetime the assets in your Living Trust are used for your benefit (also can include your spouse, children, and others), or as you otherwise direct.

e. At your death, your Living Trust becomes irrevocable (*i.e.*, it cannot be changed or revoked) and trust assets distribute according to the terms of the Trust Agreement. Options are one or any combination of the following:

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** (court formalities, expense, and public disclosure, and delay).
- 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. For example, there must be a probate proceeding in each state where you own real estate in your sole name when you die. This is avoided if the property is owned in the name of your Living Trust, or in your name (or jointly by a person who survives you) and transferred by a Transfer on Death deed to a trust or living person when you or the last joint owner dies.
- 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 nominate a person to serve as guardian for children who are minors or have an intellectual disability.
 - 2) A Will "pours over" into your Living Trust any assets titled in your name alone and required to go through probate.

a) This prevents potential conflicts between people 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 your Living Trust upon your death, or

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

Example: "Jane Doe, or her successors, as Trustee of the Jane Doe Living Trust Dated February 14, 2025."

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, Living 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 should be 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 your Living Trust is properly designed and drafted, it is possible for IRA distributions paid to your Living Trust to be held in an "inherited IRA" and paid out over a 10 year period of time to the people who are beneficiaries of your Living Trust. In certain circumstances, it is possible to make this payout over the life expectancy of your surviving spouse, your minor child (while a minor

or in school), a person who is sufficiently disabled or chronically ill, and a person who is less than 10 years younger than you.

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 and 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 in Kansas (and currently \$5,909.25 in Missouri prior to July 1, 2025, and will be increased by an inflation factor for the 12-months following).

h. A Revocable Living Trust has **no impact on taxes**. Since you retain so much power and control over your Living Trust (the total control of the assets in the Trust, right to remove and replace a trustee, and right to amend or revoke the Trust, etc.) you are treated as the owner for tax purposes of all the property held in your Living Trust.

1) **Income Taxes:** All income, capital gains, and losses are taxed to you during your life, even if you do not draw the money out of your Living Trust.

2) **Tax Identification Number and Returns:**

a) **While you are living**, no separate tax identification number is required for your Living Trust (your Social Security number is used) and no separate tax returns are filed. All income earned on assets owned by your Living Trust is reported on your personal income tax returns.

b) After your death, 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** your Living Trust during your lifetime 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** your Living Trust during your lifetime are treated as gifts from you and all gift tax rules must be observed. This also subjects the gifts to a five year look back period for Medicaid eligibility purposes.

4) Estate Taxes: For many years U.S. citizens have been taxed on the transfer their property to others upon their death. As of January 1, 2025, the current estate tax law allows up to **\$13,990,000** to pass estate tax free for people who die in 2025 and imposes a flat **40% tax on the excess**. Despite this, with proper planning these taxes can often be reduced or avoided. There is usually an automatic “step up” in income tax basis for all capital assets owned or controlled by a person when they die. This increases the basis to the fair market value of the assets on the date of death, which 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 \$27,980,000 for a married couple who both die in 2025.

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),⁹ 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. This type of planning requires the expertise of a qualified estate planning attorney.

j. If you are married, you have a choice of using a separate Living Trust for each spouse or one joint trust where both spouses are the Settlers. There are advantages and disadvantages to each design that you should discuss with your estate planning attorney.

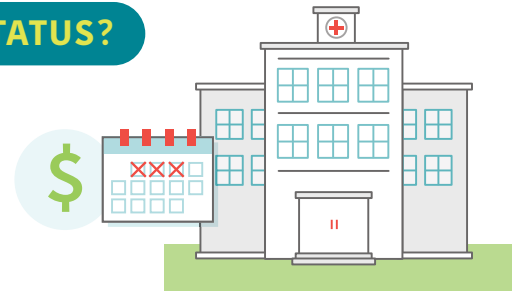
⁹ This started at \$5,000,000 in 2010 and adjusted for inflation thereafter. In 2018 this doubled, and the inflation adjusted amount in 2025 is \$13,990,000. The doubling is scheduled to stop at the end of 2025.

The Center for Medicare Advocacy is partnering with the John A. Hartford Foundation to help people caught in the web of “outpatient” Observation Status. **HAVE YOU DEALT WITH OBSERVATION STATUS?** Share your story at MedicareAdvocacy.org/ObservationStory

WHAT IS “OUTPATIENT” OBSERVATION STATUS?

A hospital billing classification that can make **Medicare patients pay for the cost of their:**

- Hospital stay
- Hospital prescriptions
- Nursing home care
 - Patients must be classified as **inpatients for 3 days** in the hospital in order for Medicare to pay for subsequent nursing home care.



AskAboutObservation



OBSERVATION STATUS...

- May be called “outpatient,” but it has **NOTHING TO DO** with where a patient receives care or the kind of care received.
- IS A BILLING CODE.** Hospitals use it to protect from overzealous auditors and Medicare readmission penalties.
- May just seem like semantics, but **for Medicare beneficiaries, IT CAN RUIN LIVES.**
- Saddles patients with increased out-of-pocket expenses. Patients who don't have Medicare Part B are responsible for the **FULL COST** of the hospitalization.

WHY DOES OBSERVATION STATUS MATTER?

Observation Status can be devastating. It can result in thousands of dollars in hospital bills, and thousands more in nursing home bills after a hospital stay.

In 2012 an average hospital stay in the U.S. cost **\$10,400**, and the median monthly cost for a nursing home in the U.S. was almost **\$8,000**.

AskAboutObservation



- The use of “outpatient” Observation Status isn't just wrong, **it can be DANGEROUS.**
- Many patients **CAN'T AFFORD their care** if Medicare won't pay.
- If post-hospital care in a nursing home won't be covered by Medicare, **many people GO WITHOUT that care altogether**, rather than face the enormous bills.
- The problem is growing: the number of patients cared for under Observation Status **DOUBLED** from 2006 to 2014.

HOW TO FIGHT OBSERVATION STATUS

Observation Status is very hard to fight.

But here's what individuals can do:

ASK

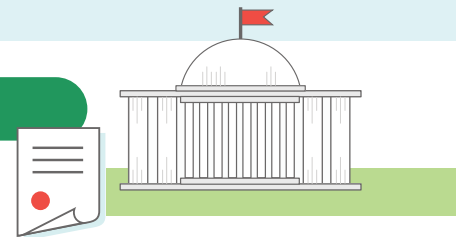
- Take action at the BEGINNING** of a hospital stay to try to stop Observation before it starts.
- Ask the hospital doctor to “**admit the individual as an INPATIENT**” based on needed care, tests and treatments.
- Ask the patient's regular physician to **CONTACT THE HOSPITAL DOCTOR** to support this request.

SPREAD THE WORD

- CONTACT** The Medicare Agency (CMS), your Senators and Congressional Representatives.
- WRITE** to your local paper, **SHARE** this graphic on social media and **SUBMIT** your Observation story at MedicareAdvocacy.org/ObservationStory

ACT

- FILE AN APPEAL** with Medicare, if the patient's nursing home coverage is denied.
- FILE A COMPLAINT** with the patient's state health department, if he/she did not get notice about “outpatient” Observation Status.



AskAboutObservation

