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FINANCIAL AND LEGAL SOLUTIONS FOR LONG-TERM CARE PLANNING: ADVANCED MEDICAID AND FINANCIAL PLANNING TECHNIQUES

By John J. Campbell, CELA

INTRODUCTION

Elder Law attorneys have been helping people plan for Medicaid to pay for long-term care costs for decades now. In fact, Medicaid planning is often considered a "core" part of the practice of Elder Law. However, Medicaid is not the only way to pay for long-term care costs. There are non-legal options, such as long-term care insurance, "hybrid" life/annuity products with long-term care features and life settlements, to name a few, that are essentially financial planning options rather than legal planning options.

As the "baby boomer" generation promises to expand the demographic of persons age 65 and over, the load on public benefit options such as Medicaid is bound to grow heavy. It is a fair question to ask whether Medicaid will even still be there in another 10-20 years. As a result, Elder Law attorneys will now have to be more knowledgeable regarding non-Medicaid options for long-term care planning.

The purpose of this article is to point out some of the financial planning options for long-term care that may have been forgotten or neglected in the process of long-term care planning, as well as to discuss some of the more promising options for Medicaid planning. Hopefully, this will help us, as Elder Law practitioners, to be better able to advise our clients who seek help with planning for long-term care expenses by providing more options to our clients than just Medicaid as a means to pay for long-term care.

FINANCIAL SOLUTIONS

There are basically three ways to pay for long-term care costs: private pay from one's own assets and income; insurance; and Medicaid. Most of us can only endure the private pay option for a relatively short period of time or must be able to utilize one of the other options along with private pay. The "insurance" option is one which seems to get little attention from Elder Law practitioners other than the casual mention of long-term care insurance. Perhaps this is because, as Elder Law attorneys, we are naturally focused on the legal solutions that may be

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available to our clients, leaving discussion of the financial options to insurance producers, financial planners and investment advisors.

The truth is that there are several insurance options that may be available to a particular client to cover future long-term care costs. Not all of these options will be available or appropriate for everyone. However, for those who may be able to take advantage of one or more of these financial options, the result may be a much more thorough and comprehensive long-term care plan, possibly without having to endure the emotional trauma of impoverishment.

While there are many financial planning techniques that could be used to provide for future long-term care costs, this article will focus on long-term care insurance, the so-called "hybrid" life insurance and annuity products with long-term care features and life settlements. Ironically, most of these financial solutions were created by law, specifically the Pension Protection Act of 2006. (PL109-280). As such, this section will begin with a brief overview of that Act's provisions which amended Sections 72 and 1035 of the Internal Revenue Code.

The Pension Protection Act of 2006 is actually a fairly broad piece of legislation, approximately 330 pages in length, dealing with a myriad of issues. However, we are concerned here with Section 844 of the Act which amended Sections 72 and 1035 of the Internal Revenue Code to allow life insurance and annuity contracts with long-term care riders to be eligible for Section 1035 exchanges. This change in the Code, in essence, allows a 1035 exchange of a life insurance policy for a life insurance policy with a long-term care rider and of an annuity for an annuity with a long-term care rider. The Act also permits the exchange of a life insurance or annuity contract for a qualified long-term care insurance policy.

The result of Section 844, which became effective January 1, 2010, was to open up some new financial options for long-term care planning. In particular, it allowed for traditional life insurance and non-qualified annuity contracts to be exchanged for policies with long-term care coverage while deferring income taxes on the growth portion of the cash value of the original policy. This opened the door for "hybrid" life and annuity policies with long-term care riders; and created the ability to exchange life insurance and non-qualified annuity policies for qualified long-term care insurance policies (which would include long-term care insurance partnership policies.)

LONG-TERM CARE INSURANCE

Long-term care insurance has been around in one form or another since the late 1970's. Initially, it was meant to cover nursing home costs. However, it has since evolved so that, depending upon the policy, it may cover long-term care costs in a nursing home, assisted living facility or even at home.

Long-term care insurance coverage will differ somewhat from policy to policy and from company to company. As with coverage options, the premium amounts and policy features, such as elimination periods and policy triggers (i.e., the conditions which must occur before the policy will begin paying out) also differ.

Unfortunately, the long-term care insurance industry suffered some serious problems after the 1990's when policy claims began to exceed expectations. The insurance companies had vastly underestimated the rise in the cost of long-term care and the volume of people who would actually need long-term care. As a result, some companies defaulted on their policies. Other companies raised premiums by as much as 80%-90%. The number of companies offering long-term care insurance dwindled to a few.

Today, long-term care insurance is still available from a few issuers and can still be a very good purchase. Also, changes in Medicaid laws during the last 10 years have made long-term care insurance more attractive by exempting long-term care insurance payments from being counted as income; and by creating the Long-Term Care Insurance Partnership Program. Still, there are some negatives: premium costs are high, sometimes $4,000-$5,000 per year or more depending on the level of coverage; and although insurance companies cannot raise an individual's long-term care premiums, they can raise the rates on *classes* of individuals (and they have on several occasions), forcing policy-holders to either accept substantial increases in premiums or decreases in coverage.

As a result, many people are leery of long-term care insurance. However, considering the costs involved in the private pay option, long-term care insurance is something that should at least be considered as part of a long-term care plan.

For those who anticipate the possibility of having to qualify for Medicaid in the future, the Long-Term Care Partnership Program offers an interesting twist. Qualifying policies (which would include virtually all long-term care insurance policies sold in Colorado today) offer two very attractive incentives:

1. Medicaid regulations permit a dollar-for-dollar credit for Partnership policy benefits to resources. In other words, for every dollar the policy pays for long-term care benefits, the beneficiary can keep an extra dollar of resources when qualifying for Medicaid. Since many policies will pay out in excess of $200,000 over the life of the policy, this can add up to a substantial amount of preserved resources; and

2. Those additional exempt resources are also exempt from Medicaid estate recovery after the death of the beneficiary.

Older policies that do not qualify for the Partnership Program still offer an attractive Medicaid planning tool. Since payments to the beneficiary from the policy are not counted as income, long-term care insurance can be used to cover a period of ineligibility from a transfer without fair consideration in lieu of a Medicaid friendly annuity. This can allow for preservation of a greater percentage of excess resources when a Medicaid plan calls for gifting (discussed later in this article).

Even so, not everyone can afford the premiums for this type of insurance (or just as importantly, not everyone *believes* they can afford the premiums). It is not often easy to explain how it may be worth $500 or more per month for coverage when the average cost for a month of nursing home care has exceeded the $8,000 per month mark in parts of Colorado. This is

because long-term care insurance is only worth the price if you actually need to use it. If not, your premiums are lost.

Occasionally, an individual might find that they are "over-insured" with life insurance. That is, they may have life insurance policies whose total death benefits are more than are needed for the individual's survivors. These policies can be exchanged for long-term care insurance policies pursuant to the Pension Protection Act of 2006.

Finally, long-term care insurance is not "guaranteed issue." In other words, an individual must qualify medically before a policy will be issued. Someone who is already suffering from chronic health problems may very well not be able to purchase long-term care insurance.

LIFE INSURANCE

Mostly in response to consumers' concerns over the cost of long-term care insurance and the fact that premiums paid for long-term care insurance are lost if the insurance benefits are not used, insurance companies invented a hybrid long-term care product. The most popular of these uses a life insurance policy (usually a whole life or universal life policy that builds cash value) with a long-term care rider.

The rider provides for coverage of long-term care costs from the policy during the insured's lifetime. However, since it is first and foremost a life insurance policy, if the long-term care benefits are not used, the full death benefit is payable upon the death of the insured. At the same time, when long-term care benefits are paid from a hybrid policy, it will result in a decrease of the death benefit. Thus, this is a life insurance policy that is really most suitable for someone more concerned with long-term care costs than with leaving a fixed sum for his or her survivors.

Because these policies offer both death benefits and long-term care benefits, the long-term care benefits are usually less than would be obtained for the same premium from a traditional long-term care policy. However, these policies do ensure that long-term benefits not used will not be completely lost due to the death benefit; and these policies are typically fixed premium policies, meaning that premiums cannot be raised so long as the policy remains in force (not even an increase of premiums across a class of insureds as is the case with long-term care insurance).

Because of the exchange provisions of the Pension Protection Act of 2006, people with existing life insurance policies might be able to exchange their existing policies for a hybrid policy. For instance, a client may be interested in planning for long-term care well in advance of the actual need for long-term care services. Such a client may be considering planning for Medicaid eventually, which would mean that he or she would have to cash in or transfer ownership of any life insurance policies with cash value (assuming a face value over $1,500). It may be a viable option to exchange a cash value policy for a hybrid policy, use up the long-term care benefits if they are needed and then apply for Medicaid. This will also defer or avoid any taxes that might be incurred on the cash value in excess of premiums should the policy be cashed in.

Like long-term care insurance, life insurance (with or without a long-term care rider) will require medical underwriting. If an applicant's medical history shows conditions that represent a greater risk to the insurance company, a policy might be rated (meaning it will only be issued with an increased premium) or the policy might be denied altogether.

ANNUITIES

Annuities with long-term care riders can be useful in at least two scenarios. First, if there is an existing annuity that may not meet the requirements for a Medicaid friendly annuity under the Deficit Reduction Act of 2005, that annuity might be exchanged for an annuity with a long-term care rider. This would allow for deferral of any taxes on the cash value in excess of premiums. However, this can only be done if the annuity has not been "annuitized," meaning it must be some sort of a deferred annuity. This is because once an annuity has been annuitized, it cannot be cashed in or exchanged. Also, this cannot be done with a "qualified" annuity, such as an IRA annuity.

Also, annuities with long-term care riders can be a very attractive solution for the client who has too much money in IRAs or other qualified retirement accounts. An IRA can be used to purchase an IRA annuity through a "trustee-to-trustee" transfer to avoid immediate taxation on the entire balance of the IRA; then regular "early withdrawals" can be made to cover the premiums for the long-term care insurance provided by the rider. Only the early withdrawals are taxed as they are made (usually these early withdrawals are going to be nearly equivalent to any required minimum distributions anyway).

These qualified annuities are best used over a long planning period. This is because they are deferred annuities. The annuities are never annuitized (as this would eliminate the death benefit) but will use early withdrawals over a period of 10-20 years to move funds into a life insurance policy with a long-term care rider. This way, if the long-term care benefits are not used for 10-20 years, the annuity will have time to be completely depleted and the proceeds (after taxes of course) converted into non-taxable funds. Then, the long-term care benefits can be paid free of taxes and the death benefit will also be tax-free (because the taxes on the IRA have been spread out over 10-20 years and paid as the IRA was depleted.)

The fact that these annuities are subject to medical underwriting, like life insurance and long-term care insurance, the chances of qualifying decrease as the applicant ages or develops chronic health issues. This is another reason why these annuities are best used to plan over a longer period of time.

Since the use of a qualified annuity with a long-term care rider takes so long to bear fruit, it is not usually a strategy that works well with Medicaid. Rather, this is a strategy that one might use if one has a large amount of qualified funds and may be able to avoid having to apply for Medicaid until the annuity and the long-term care benefit have been completely exhausted.

LIFE SETTLEMENTS

Life settlements are a variation of the much-maligned viatical settlement. However,

unlike a viatical settlement, a life settlement will usually result in a greater tax-free return. In a life settlement, an individual essentially sells a life insurance policy to a third party, like a viatical settlement. However, the proceeds of the sale are placed into a Long-Term Care Benefit Fund, which is administered by a third party administrator. Payments from the fund are made directly to long-term care providers. Since the policy is sold, the individual no longer has to pay premiums.

A life settlement will require that the individual selling his or her life insurance policy must be diagnosed with a terminal condition such that the individual is not expected to live more than two years and that the individual is in need of long-term care services right away. As a result, the payments from the life settlement will usually be tax free. However, if the individual is not expected to die within two years, any proceeds in excess of premiums paid will be subject to tax as ordinary income.

Because of this, life settlements are not long range planning tools. Rather, they come into play in crisis planning. Many individuals who engage in Medicaid crisis planning will find themselves with old insurance policies that may stand in the way of Medicaid eligibility. Often, these policies are best cashed out or transferred to the individual's family members to preserve the cash value. However, some have very little cash value (but more than $2,000). These low cash value policies can be ideal for a life settlement, since the amount paid for a policy in a life settlement is based solely upon the face value of the policy and not the cash value of the policy.

Also, many crisis planners may still have old term life policies that they will simply have to drop due to the inability to continue paying premiums. These old term policies can also be used to fund a life settlement.

While a life settlement is generally considered appropriate by Medicaid for spend-down, the resulting Long-Term Care Benefit Fund would be considered an available resource. As a result, the fund would need to be exhausted before qualifying for Medicaid. However, consider that many assisted living facilities (and even nursing homes, in spite of federal law to the contrary) are requiring anywhere from 1-3 years of private pay before accepting Medicaid. A life settlement can be useful in producing "private pay money" from an insurance policy that might otherwise be abandoned or cashed in for very little in cash value. Once the Long-Term Care Benefit Fund is exhausted, the individual can apply for Medicaid, assuming the individual's total resources and income are within eligibility limits.

LEGAL SOLUTIONS - MEDICAID

Medicaid, along with its derivative "waiver programs," is a means tested medical assistance program cooperatively funded by the federal and state governments. To be eligible for Medicaid long term care, HCBS or PACE benefits in Colorado, an applicant must pass three tests: the medical test, income test, and asset test. The medical test states the applicant must require a nursing home level of care. The income test states that a Medicaid applicant in the year 2012 cannot have more than $2,094 in gross monthly income from all sources. The asset test states a Medicaid applicant can have only $2,000 or less in "countable" assets. Medicaid takes a "snapshot" of the applicant's assets and income on the date of application when determining

financial eligibility.

INCOME TREATMENT

Medicaid law is quite specific concerning the use of a person's income after establishment of the person's Medicaid eligibility. A Medicaid recipient retains the first $50 each month as a "personal needs" allowance. This personal needs allowance can be used to pay for personal items and needs, such as beauty shop expenses, non-prescription medications, and clothes. If the Medicaid beneficiary is married and the spouse continues to live at home, a portion of the beneficiary's income may also be payable to the community spouse. The general rule is that the remainder is applied to the cost of nursing home care and is generally paid directly to the nursing home.

Reverse mortgage payments are not counted as income, but may be considered resources if they are held over to the month after they are received. Payments to the nursing home from long term care insurance policies are also not counted as income.

MEDICAL TEST – FUNCTIONAL ASSESSMENT

To be eligible for Medicaid long-term care, HCBS or PACE benefits, the beneficiary must require a nursing home level of care. This is determined, based upon the beneficiary's ability to perform the following "activities of daily living" (ADL's):

Mobility;
Bathing;
Dressing;
Eating;
Toileting;
Transferring; and
Need for supervision.

Generally, if the person requires significant assistance with any two ADL's, or if the person has very significant need for supervision, he or she will be considered in need of a nursing home level of care. Whether the person requires assistance with the requisite ADL's is determined by a functional needs assessment, which is evaluated by the Utilization Review Contractor.

Volume 8 of the Medicaid Staff Manual, §8.401.15 provides as follows:

> "The Utilization Review Contractor shall certify as to the functional need for the nursing facility level of care. A Utilization Review Contractor reviews the information submitted on the ULTC 100.2 and assigns a score to each of the functional areas described . . . above. The scores in each of the functional areas are based on a set of criteria and weights approved by the State which measures the degree of impairment in each of the functional areas. When the score in a minimum of two ADL's or the score for one category of supervision is at least a (2), the Utilization Review Contractor may certify

that the person being reviewed is eligible for nursing facility level of care."

RESOURCE REQUIREMENTS

The general rule regarding resource eligibility is that a Medicaid recipient cannot have "countable" resources of more than $2,000. This figure may seem unrealistically low, but please keep in mind that the following are not countable resources:

1. **Primary Residence.** The Medicaid recipient's equity in his or her home is considered an exempt resource if the home was the Medicaid recipient's principal residence; and (a) the value of the recipient's equity interest in the home does not exceed $543,000, unless the recipient's spouse or minor, blind or disabled child continues to live there; and (b)the recipient (or spouse) actually lived in the home immediately prior to being institutionalized and a spouse or dependent relative continues to live there; or (c) the recipient (or spouse) left the home before being institutionalized, but the recipient intends to return home. This exemption also applies to mobile homes used as the principal residence.

2. **Vehicles**. The Medicaid recipient is entitled to one car if the car is used for obtaining medical treatment, is specially equipped for a handicapped person, or is used for employment. It will be necessary to obtain a letter from a physician or employer to establish this.
3. **Personal Property.** Personal property, including clothing, furniture, household appliances, wedding and engagement rings, other items of property used by the person, and items required by a physical condition, are exempt. Personal property held for investment, such as valuable artwork or antiques, will not be exempt.

4. **Life Insurance.** If the total face value of all life insurance policies the Medicaid recipient owns does not exceed $1,500, then the policies are exempt regardless of their cash surrender value. If the face value of all policies exceeds $1,500, then the total amount of the cash surrender value is countable toward the $2,000 resource limit. Term life insurance policies are excluded from this calculation.

5. **Burial Insurance.** Irrevocable burial insurance is exempt regardless of its dollar value. Revocable burial insurance is exempt to a maximum of $1,500, but this exemption is reduced on a dollar for dollar basis to the extent that the person has life insurance that was exempt under the rule described above. Also, the value of burial spaces and grave markers for the applicant and immediate family are exempt.

6. **Retirement Accounts.** Retirement accounts of the person receiving Medicaid are countable, but may be reduced for taxes and other penalties that will be charged upon withdrawing the funds. Only in certain limited circumstance will there be an exemption for the community spouse's self funded retirement accounts. This exemption rule for self funded retirement accounts does not apply to your situation.

7. **Annuities.** Transfers to purchase Medicaid friendly annuities.

8. **Promissory Notes.** An actuarially sound promissory note that provides for substantially equal payments over the period of the note, and which does not permit cancellation of the note upon the death of the payee, is not a countable resource if the note was created on or after April 1, 2006 and before March 1, 2006.

Entry fees paid to a Continuing Care Retirement Community (CCRC) are now considered countable resources, to the extent that these fees are refundable upon death or the termination of the CCRC contract; these fees are available to pay for the resident's care when his or her other resources are no longer sufficient; or these fees do not confer an ownership interest in the CCRC.

SPOUSAL IMPOVERISHMENT PROTECTIONS

In the case of a married couple, when one spouse is applying for Medicaid long term care or HCBS benefits and the other spouse is not receiving HCBS or PACE services or residing in a long term care facility, federal law provides special resource and income protection for the spouse not applying for benefits. Under these Spousal Impoverishment Protection rules, the spouse who will receive Medicaid long term care or HCBS benefits is called the "institutionalized spouse;" and the spouse not receiving benefits is called the "community spouse."

In particular, the Colorado Medicaid regulations provide as follows:

10 C.C.R. 2505-10, 8.100.7.K.
Spousal Protection - Treatment of Income and Resources for Institutionalized Spouses

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.

2. For purposes of spousal protection, an institutionalized spouse is an individual who:

a. Begins a stay in a medical institution or Long Term Care institution nursing facility on or after September 30, 1989, or

b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or

c. Receives Home and Community Based Services on or after July 1, 1999; and

d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.

3. A person is considered likely to remain in a medical institution, Long Term Care institution, enrolled in the PACE program, or receiving HCBS when, at the beginning of the institutionalization there is a reasonable expectation, based on medical evidence, that he/she will remain institutionalized for at least 30 consecutive days.

4. A community spouse is defined as a spouse who is the spouse of an institutionalized spouse.

The Community Spouse Resource Allowance (CSRA)

In cases of married couples, the community spouse can retain a certain amount of countable resources without affecting the institutionalized spouse's Medicaid eligibility. The amount retained is called the Community Spouse Resource Allowance (CSRA). The CSRA equals the total of the couple's resources and is in addition to both the $2,000 the institutionalized spouse is entitled to retain and the exempt resources discussed above. For 2015, the CSRA cannot be more than $119,200. Therefore, the institutionalized spouse is eligible for Medicaid when the couple's total countable resources are equal to or less than the CSRA plus the $2,000 the institutionalized spouse is entitled to retain.

Transfers Between Spouses. In addition to determining which assets are not counted, it is important to know that transfers between spouses are not penalized. Consequently, removal of the institutionalized spouse's name from all of the assets is recommended for the following reasons: First, once Medicaid eligibility is established, the couple is given until the next redetermination period to remove the institutionalized spouse's name from CSRA property. Second, once Medicaid eligibility is established, joint treatment of both spouses' resources ends in the first full month after such establishment. Third, the community spouse is advised to change his or her will to leave any inheritance to the institutionalized spouse in a form that will minimize the adverse effect to the institutionalized spouse's Medicaid eligibility. This form is called a testamentary special needs trust. If the community spouse does not change his or her will, the institutionalized spouse will inherit all of the community spouse's estate. If the size of the inheritance is greater than $2,000, Medicaid would cease for the institutionalized spouse because he or she would have resources in excess of the Medicaid resource cap. A testamentary special needs trust allows the institutionalized spouse to protect a portion of the community spouse's estate and allows for a shorter period of ineligibility.

***Minimum Monthly Maintenance Needs Allowance (MMMNA)*:**

The MMMNA is the amount the community spouse needs to pay for his or her basic needs within the community. Medicaid sets limits on this amount:

Basic Allowance (as of July 1, 2015)	$1,992

House Payment/Rent plus Maintenance Fee
plus Insurance plus Taxes plus Utilities
(actual or $597.38, whichever is larger up to
a maximum of $989)
Equals the MMMNA
(But the MMMNA cannot exceed $2,981 in 2015)

Monthly Income Allowance (MIA)

The MIA is the amount of institutionalized spouse's income that is contributed to the community spouse if his or her income does not equal the MMMNA (MMMNA – the community spouse's income = MIA).

If the MIA amount is not sufficient to increase the community spouse's income to the MMMNA amount, the community spouse may request an increase in his or her CSRA. The institutionalized spouse's income must be applied first to determine if there can be an increase in the CSRA. This "income first" rule, which has long been applied in Colorado, is now mandated in all states under the DRA.

The amount of the increase in the CSRA is measured by the cost of a commercial, irrevocable, immediate annuity that will make monthly payments equal to the amount by which the community spouse's monthly income, after inclusion of the MIA, falls short of the MMMNA. However, the community spouse is not required to use the increase in the CSRA amount to actually purchase such an annuity.

Assessment

In determining the resources of an institutionalized spouse at the time of the Medicaid application, all of the nonexempt resources held by either an institutionalized spouse, community spouse, or both, are considered to be available to the institutionalized spouse. The assessment will unequivocally determine the amount of resources that must be transferred to the community spouse to satisfy the CSRA and the minimum value of resources held by the institutionalized individual that must be spent down for eligibility, thereby protecting against excessive spend-down of resources. The CSRA is calculated based on the value of the couple's total resources as they existed at the time of application.

The CSRA is determined as a "snapshot" in time. The regulations prohibit Medicaid from re-evaluating the community spouse's resources after the CSRA is determined. Therefore, if the Community Spouse accumulates resources after your CSRA is determined, this will not adversely affect the Institutionalized Spouse's ability to continue to qualify for Medicaid.

HCBS & PACE

The purpose of Home and Community Based Services (HCBS) is to assist those people who require nursing home level of care, yet fall below the point of requiring all of that care to be provided in a nursing home. HCBS provides a low cost alternative to nursing home care, and

enables people to obtain the care that they need without having to leave the privacy and comfort of their home.

The Program for All-inclusive Care for the Elderly (PACE) is also directed toward providing home care assistance to those requiring a nursing home level of care. The PACE program is only available in the Denver Metro area and Pueblo. PACE differs from HCBS in that PACE coordinates both Medicaid and Medicare benefits to provide a more comprehensive package of both skilled and unskilled home care.

Services which are provided include: personal care assistance with everyday living, homemaker services, adult day care, non-medical transportation, respite care for family/care givers, home modifications, alternative care facilities.

Not everyone is eligible to receive HCBS or PACE. The elderly, physically handicapped, or blind adults may be eligible for HCBS. PACE is only available to the elderly. To qualify for these programs, the applicant must meet two tests - financial and functional.

The financial eligibility criteria for HCBS and PACE are identical to those income and asset eligibility criteria applicable to Medicaid long term care benefits. To meet the medical criteria, the beneficiary must require a nursing home level of care, but still be able to receive that care in the home.

The applicant's financial eligibility will be determined by the Department of Social Services in the county in which he or she resides. Medical eligibility requirements will be determined in the same manner as for Medicaid long term care benefits.

TRANSFER RULES

On February 8, 2006, the Deficit Reduction Act of 2006 was signed into law. This legislation contained new and harsh restrictions on the treatment of transfers made on or after February 8, 2006 without fair consideration for the purpose of qualifying for Medicaid. Transfers made before February 8, 2006 will governed by the old rules. The following discussion focuses on the rules regarding transfers of assets on or after February 8, 2006.

Medicaid imposes an ineligibility period for an institutionalized individual who disposes of assets for less than fair consideration at any time during the "look-back" period. The look-back period is the sixty-month period prior to the application for Medicaid for outright transfers and for transfers into or out of a trust. (For transfers that were completed before February 8, 2006, the look-back period for outright transfers is only thirty-six months.) The term "assets" includes all income and resources of the individual.

Upon application, the county will determine if an applicant transferred resources without fair consideration within the sixty-month period prior to filing his or her Medicaid application.

The period of ineligibility is calculated as the amount of the transfer divided by the average cost of nursing home care in the state, which is $7,112 in Colorado, effective January 1,

2014. If this calculation is not a whole number, then the decimal amount is multiplied by 30 days to determine the additional daily penalty period. If the number of days is a fraction, it is rounded up the next whole number of days. For example, if you had a penalty period of 4.21 months, then you would have a penalty period of 4 months and 7 days (30 days x . = 6.3 days).

Under the old Medicaid rules, the penalty period began running on the first day of the month in which the transfer was made. However, under the new law applicable to transfers made on or after February 8, 2006, the penalty period does not begin until that *later* of the first day of the month in which the transfer was made; *or* the first day the applicant is receiving services in a nursing home or under HCBS *and* the applicant is eligible for Medicaid but for the transfer. Eligibility but for the transfer must be based on a submitted Medicaid application. This means that, before the penalty period begins to run, the applicant's resources must already have been spent down to eligibility levels and a Medicaid application must be filed and approved, but for the applicable transfer penalty.

This harsh treatment of transfers makes gifting very dangerous if not done correctly. Since all non-exempt resources of the applicant must be spent down to the $2,000 level before the penalty period starts to run, the applicant could be left in a nursing home with no means of payment during the penalty period. This could result in the applicant being discharged from the nursing home for non-payment!

For example, assume an applicant had $100,000 in resources, over and above her $2,000 exemption amount. If she transferred $98,000 on April 27, 2014, her penalty period would be thirteen (13) months and twenty-four (24) days, since $98,000 divided by $7,112 equals 13.78 months ($98,000 ÷ $7,112 = 13.78). (Once again, the .78 is multiplied by 30 days to determine the additional days of ineligibility (30 days x .78 = 23.4 or 24 days).) However, her penalty period would not yet begin to run, since she is not in a nursing home and she still has $40,000 in excess resources.

If she entered a nursing home the following year, on April 1, 2015, her penalty period would now begin to run if she still has only $2,000 in resources; she files a Medicaid application; and the application is denied *solely* because of the $98,000 transfer she made in 2014. Let us assume that the applicant's nursing home expenses at that time are $7,000 per month; and she has income from Social Security of $1,000 per month. This would still leave $6,000 per month that she must cover from her own resources. However, she would then have to wait out an *additional* 13 months and 24 days (the penalty period) before Medicaid would begin covering her nursing home expenses. This situation would leave her in a terrible predicament, since she now would have exhausted her excess resources, she would have no means to cover the $6,000 per month in nursing home costs not paid for by her monthly income during this 13 month and 24 day penalty period. Unless her family is able to pay for her care, she may be forced to leave the nursing home!

There is no limit on how long the penalty period can be. Any transfer that occurred during the five-year look-back period will be imposed in full. For transfers of more than $426,720, the penalty period would last longer than the five-year look-back period. Therefore, if the total amount transferred exceeds $426,720, the applicants must **not** apply for Medicaid until

five years (60 months) after the transfer.

When the amount transferred is large enough to trigger a penalty period of five years or more, the applicants must make sure she has sufficient means from another source or from exempt resources to privately pay for nursing home care until the look-back period expires. If the applicants do not apply for Medicaid until after the five-year look-back period has expired, no transfer penalty will be imposed. When the amount transferred triggers a penalty period of less than five years, the applicants must make sure she has sufficient means from another source or from exempt resources to privately pay for nursing home care until the penalty period expires.

Making gift transfers for purposes of becoming eligible for Medicaid can be potentially disastrous. To avoid the harsh consequences of gifting, some means must be used which will both: 1) provide for private payment during the penalty period; and 2) not be considered an available resource that will *delay* the start of the penalty period. Medicaid planning has now become very difficult and dangerous, but it is not impossible.

A strategy is needed which will allow the penalty period to start running as soon as the individuals enter the nursing home; and provide a means of private payment for the duration of the penalty period. Finally, such a strategy needs to accomplish this while still preserving a portion of the applicants' resources for her family.

In some cases, a special trust, an annuity, long term care insurance, a reverse mortgage or some other strategy may be available to fill this need. However, all of these strategies will not work in every situation. This is why it is so important that an *individualized* Medicaid plan be formulated on a case-by-case basis to fit the exact circumstances of each particular potential Medicaid applicant; and that each individual's own Medicaid plan be followed exactly as written.

Exempt Transfers

The following specific types of transfers will not incur a penalty period:

(1) Transfers between spouses.

(2) Transfer of the home to either (a) the Medicaid recipient's child who is under 21, blind, or permanently and totally disabled, (b) the recipient's sibling who has an equity interest in the home and who was residing in the home for at least one year immediately before the date the individual entered the nursing home, or (c) the recipient's son or daughter who was residing in the home for at least two years immediately before the date the individual entered the nursing home and who provided care that permitted the individual to reside at home rather than in an institution. Applicants are required to obtain letters from their doctors stating that the care that the son or daughter provided allowed the individual to remain at home instead of in a nursing facility.

(3) Transfer of any assets (other than the home) (a) either directly or to a trust established solely for the benefit of the Medicaid recipient's child who is blind or permanently and totally disabled, or (b) to a trust established solely for the benefit of an

individual under 65 years of age who is disabled.

(4) Transfers of assets into a Medicaid exempt Special Needs Trust or Pooled Trust, so long as the transfers are completed before the beneficiary reaches age 65; and transfers of income into a Medicaid exempt income trust.

(5) Transfers to purchase Medicaid friendly annuities payable to the Medicaid recipient or the community spouse if in compliance with Colorado annuity regulations.

(6) Transfers as loans for notes or mortgages if the repayment term is actuarially sound; payments are in equal amounts for the life of the note or loan (no deferrals or balloon payments); and there is no provision for cancellation on the death of the lender.

(7) Transfers to purchase a life estate in another person's home if the purchase actually lives in the home for 1 year after the purchase.

(8) Transfers where the individual can justifiably show that either (a) the Medicaid recipient intended to dispose of the assets, either at fair market value or for other valuable consideration; (b) the assets were transferred exclusively for a purpose other than to qualify for Medicaid; (c) all assets transferred for less than fair market value have been returned; or (d) application of the transfer penalty would deprive the recipient of medical care or other essential needs such that the recipient's life or health would be endangered.

MEDICAID'S TREATMENT OF TRUSTS

On August 10, 1993, President Clinton signed into law the Omnibus Budget Reconciliation Act of 1993 (“OBRA 93"). OBRA 93 is a massive piece of legislation affecting many federal programs and is codified in the United States Code at 42 U.S.C. §1396p. The following discussion is solely concerned with the provisions in 42 U.S.C. §1396p(d) affecting the treatment of trusts in connection with Medicaid eligibility.

For purposes of determining an individual's eligibility for Medicaid benefits, §1396p(d) applies to all or portions of a trust "established by such individual," subject to important exceptions that will be discussed below. There are two requirements for a trust to be considered "established by such individual" under §1396p(d)(2). First, the individual's assets must form all or part of the corpus of the trust. Second, the trust must be a non-testamentary trust established by either the individual, his or her spouse, a third person with legal authority to act for the individual or the spouse (including a court or administrative body), or a third person acting at the direction or request of the individual or the spouse.

If such a trust is revocable, then, for determining Medicaid eligibility, its assets in the trust are simply included in the individual's available resources. Payments from the trust to or for the individual's benefit are simply included in his or her income. If the trust is irrevocable, then, for Medicaid eligibility purposes, *any portion of the trust assets from which a payment could be made to the individual, under any circumstances, is included as an available resource*. Any payment to the individual from the trust is included in his or her income. Any portion of the

trust corpus that could not be paid is considered to be a transfer without fair consideration, resulting in a period of ineligibility.

Irrevocable trusts do have their place, especially in long range (5 -year) Medicaid planning. The trust can be funded with an irrevocable gift of virtually unlimited value, thus triggering the 60-month look back period applicable to transfers without fair consideration. So long as the grantor waits out the look back period before applying for Medicaid, there will be no additional period of ineligibility as the result of the transfer which funded the trust.

However, great care must be taken not to violate the "any circumstances" test. Some common pitfalls are trusts that allow the grantor to substitute property of equal value; allow the trustee to make loans; or allow for early termination of the trust. Also, even for trusts that are carefully drafted to avoid such pitfalls, Medicaid will look at how the trust has been administered to determine if any distributions were made to or for the benefit of the grantor, even if such distributions are prohibited by the trust document. If Medicaid determines that the "any circumstances" test is violated, either through mis-administration or through the language of the trust document itself, the assets in the trust will be considered available resources even where it was funded outside of the 60-month look back period applicable to transfers without fair consideration.

The rather uncharitable provisions of §1396p(d)(3) are ameliorated somewhat by exceptions contained in §1396p(d)(4) (the "(d)(4) exceptions"). Under the (d)(4) exceptions, the treatment otherwise accorded to trusts does not apply to:

> (A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of the Social Security Act) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual by the state.
>
> (This exception codified into law what is commonly known as a “Special Needs Trust,” “Supplemental Needs Trust” or “Disability Trust.”);
>
> (B) A trust established in a State for the benefit of an individual if the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust), and the individual’s income exceeds the income cap ($2,163 per month in 2014), but does not exceed the average cost of nursing home care in the region in which the individual will be receiving nursing home care, if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual by the state.
>
> (This exception codified into law what is commonly known as a “Miller Trust” or “Utah Gap Trust”); and

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of the Social Security Act) that meets the following conditions: (I) The trust is established and managed by a non-profit association; (ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts; (iii) Accounts in the trust are established solely for the benefit of individuals by the individual, by the individual's parent, grandparent, or legal guardian, or by a court; and (iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary by the state.

(This exception codified into law what is commonly known as a "Pooled Trust.")

In Colorado, similar provisions in the Colorado Probate Code allow income trusts, disability trusts and pooled trust accounts to be created in order to establish or maintain a person's resource eligibility for medical assistance. (C.R.S. §§15-14-412.7, 15-14-412.8 & 15-14-412.9.) The Colorado statutes contain the same basic requirements as the federal statute. Further, the Colorado Medicaid Regulations mirror the treatment under federal law of all self-settled trusts.

Income Trusts: **Medicaid Requirements Under**
42 U.S.C. § 1396p(d)(4)(B) and C.R.S. §§ 15-14-412.7

An Income Trust is used solely to qualify an individual for Medicaid long term care or Home and Community Based Services (HCBS) benefits when the individual's monthly income exceeds the income cap of $2,163, but is less than the average monthly cost of nursing home care in his or her region of the state. Medicaid will provide a form which will need to be completed and signed to create the Income Trust.

All of the individual's current monthly income will need to go into the Income Trust each month. From the trust, the trustee can pay the individual's monthly income allowance (usually $50 in Colorado); the Monthly Income Allowance to the individual's community spouse (if applicable); and pre-approved Post Eligibility Treatment of Income (PETI) deductions (if any). The balance of the individual's current monthly income will be paid from the Income Trust to the nursing home as his or her monthly patient contribution amount. The balance of the individual's costs to the nursing home will be paid by Medicaid.

If an Income Trust is used to qualify the individual for HCBS benefits the "patient contribution amount" is limited to the amount of the income cap of $2,094. Any funds remaining after payment of that amount and any other permitted payments must be allowed to accumulate in the trust.

Funds which accumulate in an Income Trust may not be spent on the individual's supplemental needs or support. (Therefore, an Income Trust is not useful as a means to reduce

assets to qualify for Medicaid.) These accumulated funds must remain in the trust until the individual dies or the trust is terminated, whichever occurs sooner. Any funds remaining in the trust after the individual's death must be made available to repay the state for any Medicaid benefits provided to the individual.

Normally, when a person qualifies for Medicaid in the nursing home or for HCBS, that person also will be entitled to full Medicaid coverage for hospitalizations, doctor visits and other expenses not necessarily associated with long term care. However, if a person's income exceeds the income cap for long term care benefits, so that the person must use an Income Trust to qualify, Medicaid will *only* cover that person's long term care expenses. If, for example, that person needs to go into the hospital, those additional expenses would *not* be covered by Medicaid.

If an individual will require an Income Trust to qualify for Medicaid long term care benefits or HCBS, he or she will need to maintain coverage under Medicare Part A and Part B to cover other medical expenses that will not be covered by Medicaid. Further, if the individual has a Medicare supplemental, or "Medigap" policy, he or she should continue to pay the premiums to keep that policy in effect, even after going on Medicaid. Otherwise, a hospital visit or even routine doctor's visits outside the nursing home could present an unexpected and significant expense that Medicaid will not cover.

Disability Trusts and Pooled Trusts: Medicaid Requirements Under 42 U.S.C. § 1396p(d)(4) and C.R.S. §§ 15-14-412.8 & 15-14-412.9

Section 1396(d)(4)(A) of 42 U.S.C. and *Colorado Revised Statutes (C.R.S.)* § 15-14-412.8 permit a disabled individual to preserve assets in trust to pay for basic medical care while maintaining eligibility for public benefits. To qualify as an exempt resource under section 1396p(d)(4)(A) of the federal statute and C.R.S. § 15-14-412.8, the trust must meet the following requirements: (1) the beneficiary is under 65 years of age; (2) the beneficiary is “disabled”; (3) the trust is established by the beneficiary's parent, grandparent, or guardian, or a court; and (4) the trust provides that after the beneficiary's death, the state is reimbursed for all of the medical assistance paid to, or for, the beneficiary.

Upon the death of the beneficiary or the earlier termination of the disability trust, the trustee is required to reimburse the state for medical assistance provided to the beneficiary from the date the trust was funded. Medical assistance provided prior to the funding of the trust may be subject to a Medicaid lien which must be paid before the trust is funded. However, once any Medicaid lien is paid and the trust is funded, the state has a claim for reimbursement only to the extent of the medical assistance dollars paid from assets remaining in the trust.

A decision by the Colorado Supreme Court provides that a trustee of a disability trust may pay state and federal taxes from the trust before repaying the state for Medicaid benefits it has provided to the beneficiary. *Stell v. Boulder County Dept. of Social Services, et al.*, 92 P.3d 910 (Colo. 2004). However, the state must be repaid before any other distributions from the trust after the beneficiary's death.

Congress provides under 42 U.S.C. §1396(p)(d)(4) for the creation of two types of supplemental needs trusts, one trust is for disabled persons under 65 years of age and one trust is for disabled persons who may be either under age 65 or 65 years of age and older. The trust for those under 65 is known as the disability trust or the (d)(4)(a) trust, and is the direct result of the history of special or supplemental needs trusts. The trust for claimants who may be 65 and over is a hybrid, and is known as the pooled charitable trust or (d)(4)(c) trust, codified under federal law at 42 U.S.C. §1396(d)(4)(c), and under Colorado law at C.R.S. § 15-14-412.9.

Colorado is one many states in the nation that have established procedures for implementing a pooled charitable trust. The reason why all states have not established pooled charitable trusts is that to qualify for exempt treatment under the statute, the trust must be established and managed by a non-profit organization. Colorado has two pooled charitable trusts. The older of the two is managed by the Colorado Fund for People With Disabilities, Inc.; the newer is managed by the Special Needs Trust Network, Inc. Colorado has also adopted the federal requirements for pooled charitable trusts with some requirements of its own. Section 15-14-412.9 of the Colorado statute provides that:

> (a) The trust is established and managed by a nonprofit association that is approved by the United States internal revenue service [*sic*];
>
> (b) A separate account is maintained for each beneficiary of the trust; except that the accounts are pooled for purposes of investment and management of funds;
>
> (c) The sole lifetime beneficiaries of the trust are the individual for whom the trust is established and the state medical assistance program. After the death of the person for whom the trust is created or after the trust is terminated during the beneficiary's lifetime, whichever occurs sooner, no person is entitled to payment from the remainder of the trust until the state medical assistance agency has been fully reimbursed for the assistance rendered to the person for whom the trust was created;
>
> (d) The account is established by the parent, grandparent, or legal guardian of such individual, by such individual, or by a court;
>
> (e) The trust provides that, upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever occurs sooner, to the extent that amounts remaining in the beneficiary's trust account are not retained by the trust, the state medical assistance program receives any amount remaining in that individual's trust account up to the total medical assistance paid on behalf of the individual;
>
> (3) A pooled trust is not valid for the purpose of establishing or maintaining a person's eligibility for any category of public assistance other than medical assistance;
>
> (4) No pooled trust shall be valid unless the department of health care policy and financing [*sic*], or its designee, has reviewed the trust and determined that the trust conforms to the requirements of this section and any rules adopted by the medical services board pursuant to section 26-4-506.6, C.R.S.

The advantage of the pooled charitable trust is that while the beneficiary is alive, his share in the trust can be used for supplemental existence expenses, such as the cost of a case

manager or for special needs, while he is on Medicaid. For an individual 65 years of age or older, the pooled charitable trust may be the only way to shelter his assets. However, due to the wording of the federal statute regarding exemptions from imposition of penalties for gift transfers, some states, Colorado included, currently treat the funding of a pooled trust by a person over age 65 as a transfer without fair consideration and will impose a penalty period of ineligibility for Medicaid benefits unless the individual can demonstrate that he or she is receiving fair value in return for the funding of his or her pooled trust account through an actuarially sound care plan to which the pooled trust is committed. Therefore, the funding of a pooled trust account for an individual over age 65 may require careful planning to ensure that there will be sufficient resources available to the individual to privately pay for his or her care during any period of ineligibility.

Trusts Not Subject To The Strict Laws On Self-Settled Trusts:

Third Party Trusts

The federal statute and Colorado's Medicaid regulations provide exceptions to the harsh treatment of self-settled trusts. One exception is for trusts that are not self-settled trusts at all, but rather are created and funded solely with property not belonging to the beneficiary or the beneficiary's spouse. Such trusts are permitted and will not be considered an available resource to the beneficiary for purposes of determining the beneficiary's eligibility for Medicaid. However, the trust must be created and funded fully by a third party. If the trust ever accepts funds that are property of the beneficiary or the beneficiary's spouse, those funds will either be considered an available resource or will constitute a transfer without fair consideration and will trigger a Medicaid ineligibility period under the regulations.

Third Party Trusts must also meet the following conditions to be considered exempt as a resource:

1. The beneficiary must have no authority to compel distributions from the trust or to exercise any powers of ownership over assets in the trust;

2. The Trustee must have complete discretion regarding any distributions from the Trust, otherwise any assets subject to non-discretionary distribution requirements will be deemed available to the beneficiary; and the assets in the trust should not be used for the beneficiary's support, since payments from the trust for support will be treated as income to the beneficiary;

3. The trust may only have one lifetime beneficiary; and

4. The trust must be irrevocable.

A third party trust can be created by one or more individuals with property they may have previously received from the trust's beneficiary as gift, but not at the request or direction of the beneficiary. Also, the property must have completely changed in ownership from the beneficiary to the donee/grantor before being transferred into the trust. As a practical matter, the Colorado Medicaid agency has required that the trust be created *after* the completion of the gift and must meet all of the other requirements for third party trusts. Usually, this type of "third party donee

trust" should not be created or funded for at least 30-45 days after completion of any gifting from the beneficiary.

Sole Benefit Trusts

A special type of Third Party Trust, called a "Sole Benefit Trust", provides additional flexibility in Medicaid planning. It is a trust that you can create and fund with your or your spouse's assets for the sole benefit of a disabled person under age 65 or your blind or disabled child of any age. The funding of such a trust will not be considered a transfer without fair consideration and will not incur a penalty period; and the assets in the trust will not be considered available to the trust beneficiary for purposes of his or her Medicaid eligibility.

A Sole Benefit Trust must meet all of the conditions applicable to Third Party Supplemental Needs Trusts. However, a Sole Benefit Trust must also meet additional requirements. First, the trust may only have a single beneficiary and no other person can benefit from the trust at any time. Medicaid will not currently allow a Sole Benefit Trust to name specific remote contingent beneficiaries following the death of the lifetime beneficiary, other than to name the lifetime beneficiary or the lifetime beneficiary's estate. Medicaid also will not currently allow a Sole Benefit Trust to contain a provision reserving the grantor a testamentary special power of appointment. Finally, the trust must provide that the assets in the trust will be spent or distributed in a manner that is "actuarially sound." In other words, the assets must be distributed each year in an amount that is calculated to deplete the trust within the beneficiary's remaining life expectancy. Typically, a minimum annual distribution amount must be identified in the trust before the Colorado Medicaid agency will approve the trust.

A Sole Benefit Trust does not have to meet the "actuarially sound" requirement if it contains a "state pay-back" provision, as with a trust established under OBRA '93.

Testamentary Special Needs Trusts

The other trust exception to the rules on self-settled trusts applies to trusts created by a will. These trusts are commonly known as "Testamentary Special Needs Trusts." Such trusts are commonly created in the will of a spouse, family member or friend of the Medicaid beneficiary.

After several conflicting administrative rulings, Colorado passed regulations concerning the treatment of Testamentary Special Needs Trusts for Medicaid eligibility. The regulations now provide that if an applicant for Medicaid refuses or fails to make a reasonable effort to secure a potential resource or income, amount of potential resources or income foregone will be considered a transfer without fair consideration and medical assistance will be denied during the resulting penalty period. This regulation is specifically aimed at beneficiaries who attempt to exclude their community spouses as beneficiaries by leaving all of their property in a Testamentary Special Needs Trust.

In Colorado, one cannot legally disinherit one's spouse. The Colorado Probate Code guarantees that a surviving spouse is entitled to an elective share, a family allowance and an exempt property allowance from the deceased spouse's estate. In most, but not all cases, these entitlements amount to approximately one-half of the deceased spouse's estate.

If a Medicaid beneficiary refuses or fails to obtain his or her statutory elective share, family allowance, or exempt property allowance from the spouse's estate, the regulations provide that this refusal or failure to obtain those assets is treated as being a transfer without fair consideration. *Staff Manual,* Volume 8, §8.110.53(D) *et.seq.* A period of ineligibility will be imposed for such a transfer, based on the amount of assets that *could* have been obtained from the deceased spouse's estate.

The effect of this regulation is that the applicant will be required to elect against a deceased spouse's will where the will leaves everything to a Testamentary Special Needs Trust. It is important to note that the rest of the deceased spouse's estate *can* be left into a Testamentary Special Needs Trust and will not be considered a transfer or an available resource to the Medicaid beneficiary. However, the Medicaid beneficiary will be disqualified from eligibility until he or she "spends down" his or her elective share, exempt property and family allowance to an amount less than $2,000.

Creating a Testamentary Special Needs Trust is still a valid and advisable Medicaid planning tool. It will result in the creation of an exempt source of funds to provide for those of the institutionalized spouse's needs that are not covered by Medicaid. However, in the case of a married couple, it is a tool that is now limited to preserving only those funds to which the surviving institutionalized spouse is not entitled as his or her elective share, exempt property or family allowance.

MEDICAID'S TREATMENT OF ANNUITIES

The state regulations on treatment of annuities are found in Section 8.100.7.I & 8.100.7.J, Volume 8 of the Colorado Department of Health Care Policy and Financing Medicaid Staff Manual, 10 C.C.R. 2505-10. In that section, an annuity is now defined as:

". . . a contract between and individual and a commercial company, in which the individual invests funds and in return is guaranteed fixed substantially equal installments for life or a specified number of years."

Under Colorado Medicaid regulations, once a Medicaid compliant annuity has been annuitized and the annuitant is receiving regular distributions, the annuity is no longer considered as part of the asset pool for purposes of determining Medicaid eligibility. Instead, the monthly distributions are considered income to the annuitant in the month received. However, under the new rules effective April 1, 2012, an annuity that is not irrevocable and non-assignable will be treated as an available resource, even if it has been annuitized.

I. TREATMENT OF ANNUITIES PURCHASED PRIOR TO APRIL 1, 1998

The regulations governing treatment of annuities purchased prior to April 1, 1998 distinguish further between annuities purchased before or after July 1, 1995.

Any annuity purchased prior to July 1, 1995 by the applicant or the applicant's spouse will be considered a countable resource to the Medicaid applicant only if it has not been

annuitized. If the annuity is annuitized and the annuitant is receiving regular returns, the funds received will be considered income to the annuitant in the month received.

The only limitation imposed on annuities purchased before July 1, 1995 is that the annuity must meet the definition of "annuity". That is, it must be: 1) a contract between and individual and a commercial company; 2) the annuity must provide a guaranteed income stream that is in fixed substantially equal installments (e.g., not a balloon or deferred lump sum annuity); and 3) the annuity period must be for life or a specified number of years.

For annuities purchase after July 1, 1995, the regulations provide four additional restrictions. If the annuity does not fit within all of the additional restrictions, the entire purchase price of the annuity is considered a transfer of assets without fair consideration and would trigger a period of ineligibility. In order to avoid the transfer penalty, the annuity must meet the following criteria, in addition to those applicable to annuities purchased prior to July 1, 1995:

1) The annuity must have been purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;

CCCCCCCCCCCC2) The annuity must be annuitized for the applicant or the community spouse;

CCCCCCCCCCCC3) The annuity must have been purchased on the life of the applicant or the community spouse; and

CCCCCCCCCCCC4) The annuity must provide payments for a period not to exceed the projected life of the annuitant (as determined by use of the appropriate life expectancy table -- male or female -- contained in the regulations).

II. TREATMENT OF ANNUITIES PAYABLE TO THE COMMUNITY SPOUSE AND PURCHASED ON OR AFTER APRIL 1, 1998 AND BEFORE FEBRUARY 8, 2006

Annuities purchased on or after April 1, 1998 are governed by the regulations which became effective on that date. The effect of these regulations is to impose limitations on the amount of assets in excess of the CSRA that can be converted into an annuitized income stream to the community spouse. The April 1, 1998 regulations do not affect the treatment of annuities payable to the institutionalized spouse; or to a single person applying for Medicaid.

If annuitized regular payments from an annuity, purchased with assets in excess of the CSRA, cause the community spouse's monthly income to exceed the MMMNA, a transfer penalty will be imposed. Also, if the monthly payments from the annuity are not "substantially equal" over the life of the annuity, as would be the case with a balloon or deferred lump sum annuity, the entire purchase price of the annuity will be considered a transfer for less than fair consideration and a penalty period will be imposed.

Effective April 1, 2012, any "transfers" which could be deemed to have taken place under the regulations are subject to the 36-month look-back period for annuities purchased before February 8, 2006. That is, if the annuity was purchased more than 36 months prior to the filing

of the Medicaid application, any penalty period will be treated as having expired. This means the monthly annuity payment, regardless of whether it causes the community spouse's monthly income to exceed the MMMNA, will be treated as income in the month received and there will be no transfer penalty imposed.

III. TREATMENT OF ANNUITIES PAYABLE TO THE MEDICAID RECIPIENT OR THE COMMUNITY SPOUSE AND PURCHASED ON OR AFTER FEBRUARY 8, 2006

As stated earlier, the old rule penalizing community spouse annuities only applies where the annuitant is the Medicaid recipient's community spouse and only if the annuity was purchase between April 1, 1998 and February 8, 2006. Thus, purchasing an annuity which make monthly payments to either the Medicaid recipient or the community spouse will not result in a transfer penalty, regardless of the size of the annuity payment, so long as the annuity meets the following criteria:

1) The annuity must have been purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; and

2) The annuity must be irrevocable and non-assignable or it will be treated as an available resource, even if it is annuitized; and

3) The annuity must name the state as death beneficiary, at least up the amount of Medicaid benefits paid to the Medicaid recipient during his or her lifetime. The state must be named as first death beneficiary unless the recipient has a spouse or a minor or disabled child, in which case that spouse or child may be named as first death beneficiary, with the state as second beneficiary if the spouse or child dies before the recipient or disposes of his or her remainder interest without fair consideration; and

4) Only if the annuity is payable to the Medicaid recipient:

a) The annuity must be "actuarially sound," meaning it must be designed to pay out completely during the Medicaid recipient's remaining life expectancy (as determined by the appropriate life expectancy table -- male or female – issued by the Office of the Chief Actuary of the Social Security Administration); and

b) The annuity must make substantially equal payments over the entire period of the annuity; OR

c) The annuity is a qualified individual retirement annuity under IRC §408(b) or (q), or the annuity is purchased from a qualified individual retirement plan under IRC §408(a), (c), (p) or (k) or IRC §408A.

At first glance, it would seem futile to purchase such an annuity, since virtually all of the annuity payments after the Medicaid recipient enters the nursing home (or begins receiving long term care services at home) will be used to pay for long term care expenses. However, such an annuity could be a very effective planning tool whenever the Medicaid recipient makes gift transfers on or after February 8, 2006 to qualify for Medicaid.

The annuity would be purchased with all of the Medicaid recipient's excess resources remaining after completion of the recipient's "spend down" and other gift transfers; and would be structured to pay out for a term not to exceed the penalty period from the transfers, or 60 months, whichever is shorter. Further, the monthly payments from the annuity would be designed to pay for the recipient's monthly long term care expenses in excess of the recipient's other income during the penalty period or look-back period. Finally, the annuity should not be annuitized until the recipient enters the nursing home or begins receiving long term care services at home.

Once annuitized, the annuity would no longer be countable as a resource and would not, by itself, delay the start of the penalty period once the Medicaid recipient is in a long term care setting and receiving services, since the recipient would have no more excess resources and would qualify for Medicaid, but for the transfers. The annuity payments could then provide for the Medicaid recipient's nursing home or other long term care expenses during the penalty period or look-back period. Once the annuity is exhausted and the penalty period or look-back period has expired, the recipient could begin receiving Medicaid long term care benefits in the nursing home or at home through HCBS.

Effective April 1, 2012, an irrevocable and non-assignable annuity, payable to the community spouse, can also provide additional income to the community spouse without affecting the institutionalized spouse's Medicaid eligibility. The annuity must name the state as death beneficiary, at least up the amount of Medicaid benefits paid to the institutionalized spouse during his or her lifetime. This means that the annuity will need to have some guaranty period to meet the "death beneficiary" requirement. However, although the annuity could be designed to pay out for the Community Spouse's lifetime, there is rarely a compelling reason for any guaranty period to be more than the 60-month look back period for transfers without fair consideration.

In many cases, some or all the institutionalized spouse's income will not be available to the community spouse after the institutionalized spouse dies. For example, the institutionalized spouse may have chosen a "life only" option on his or her retirement pension in order to receive a greater monthly pension payment. However, in such a case, the pension benefit would no longer be available after the institutionalized spouse's death. Purchasing a Medicaid compliant annuity for the community spouse is now an available solution to this dilemma and offers the community spouse annuity a very attractive vehicle for "spending down" excess resources instead of making gifts.

THE ESTATE RECOVERY RULE

Often, one of the primary goals in Medicaid planning, in addition to achieving Medicaid eligibility, is asset preservation. As a result it is a common planning strategy to make planned gifts of excess countable resources as a means to realize both of these goals. However, it is not unusual for the single most valuable asset of an individual or married couple to be the family home.

Certainly, transferring an interest in the home is not necessary in most cases to achieve Medicaid eligibility, since the home is generally not a countable resource.

However, for an individual owning more than $543,000 in equity in his or her home, the home would be counted as an available resource in determining eligibility unless the recipient's spouse or minor, blind or disabled child continues to live there. Even for an individual whose home would be considered exempt as his or her primary residence, the desire to preserve this valuable asset may provide sufficient reason to consider transferring an interest in the residence to a spouse or other family member, even if the transfer incurs a penalty period. This is due to the State's right to seek reimbursement of Medicaid benefits paid through Estate Recovery.

The State of Colorado through its Medical Assistance Estate Recovery Program can seek recovery for the amount of medical assistance provided to an individual age 55 or older or provided to an individual in an institution, regardless of age. The State of Colorado is an interested party in that individual's probate estate because of the assistance it provided to him or her. After the individual dies, the state must be notified of the death and be given notice of the individual's estate proceedings. The state will then try to assert a lien against individual's estate to obtain reimbursement for the assistance it provided to him or her. The state will file a claim against the individual's estate to obtain the equity in the home and any other assets owned by the individual.

While the State's estate recovery claim can be satisfied out of any property in the individual's probate estate, the fact is that, other than $2,000 or less in cash, the estate's most valuable and saleable asset will be the individual's home. Clearly, the vast majority of estate recovery is asserted against the homes of deceased Medicaid beneficiaries, as opposed to any other asset in the estate.

The State of Colorado can recover for the individual's Medicaid only to the limit of his or her equity or interest in the home and any other property in the individual's estate. The state cannot recover against any other owners of the property, including a trust. Further, a life estate or joint tenancy interest owned by the individual ceases at the moment of death and is not considered part of the individual's estate, so these interests cannot currently be reached by a lien or estate recovery claim.

This provides a opportunity to preserve the entire value of the family home while only risking imposition of a transfer penalty for a fraction of the home's total value. If a joint tenancy or remainder interest in property is transferred by the Medicaid applicant to a child or other individual, the penalty for the transfer is calculated only upon the value of that property interest. However, when the applicant dies, the surviving joint tenant or the owner of the remainder interest then becomes the sole owner of the *entire* property, free from any Medicaid estate recovery claim or lien.

Of course, the best situations for preserving the home involve circumstances in which transfer of an interest in the home is exempt from the imposition of a transfer penalty. Thus, where the Medicaid applicant has a spouse or a minor, blind or disabled child, the house can be transferred entirely to that spouse or child without penalty. Similarly, the home can be transferred without penalty to the applicant's child who lived in the home for at least two years and provided care during that time for the applicant which allowed to applicant to delay entry into a nursing home, or to the applicant's brother or sister who owned an equity interest in the home lived in the home for at least

one year.

Where a transfer exemption is not available, it is usually better to transfer a partial interest in the home, such as a joint tenancy or remainder interest, to minimize the transfer penalty that will apply. However, joint tenancy has some significant disadvantages over ownership by a life tenant and remainderman.

The fact that a Medicaid recipient may own property in joint tenancy with another person does not necessarily mean the property is “safe” from Medicaid estate recovery liens. When real property is held in joint tenancy and one joint tenant dies, ownership of the entire property automatically falls to the other joint tenant outside of the decedent's estate.

The only protection provided against estate recovery liens to a Medicaid owning property under joint tenancy with another person is when the Medicaid recipient dies first. In that case, the property automatically passes to the other joint tenant and Medicaid cannot place an estate lien on the property. However, if the other joint tenant dies first, the property passes entirely to the Medicaid recipient. Medicaid may still consider the property to be exempt as the individual's principal residence, but the home would then be vulnerable to estate recovery liens. Thus, for example, where a house is owned in joint tenancy between an applicant and his or her spouse, it is advisable to transfer ownership to the community spouse before applying for Medicaid.

Another danger of holding property in joint tenancy is that the property will be subject to claims, judgments or liens by the other joint tenant's creditors. This risk is especially high when a joint tenancy interest is transferred to someone other than a spouse, such as a child, grandchild or sibling. If an interest in joint tenancy has been transferred to someone other than a spouse, it is often advisable to ask that joint tenant to transfer his or her interest back to the Medicaid applicant to allow for more appropriate and less risky planning.

Finally, when interests in joint tenancy are transferred, the interests will be deemed to be equal under Colorado law for Medicaid purposes. Thus, if a Medicaid applicant has transferred a joint tenancy interest to one co-owner, the value of the transfer is calculated at one-half the value of the property. However, if the same applicant makes a transfer to two other co-owners in joint tenancy, the value of the transfer will be calculated at two-thirds the value of the property. As a result, a transfer in joint tenancy to more than one co-owner can result in a significantly greater transfer penalty than a transfer to a single co-owner.

On the other hand, the value of a remainder interest in property will be the same, regardless of the number of persons receiving the remainder interest. That value is calculated according to the age of the person retaining the life estate and can be determined by reference to the Life Estate Remainder Interest Table in Colorado's Medicaid regulations. Depending on the age of the life estate holder, the table will assign a percentage, which is multiplied by the total value of the property to obtain the value of the remainder interest. That value is then divided by the average monthly cost of nursing home care in Colorado ($7,112 in 2014) to arrive at the penalty for transfer of

that remainder interest. Thus, whether the remainder interest is transferred to a single individual, to a trust or to multiple co-owners, the value of the entire remainder interest and of the transfer penalty will be the same.

For the reasons stated above, when transferring real property interests to persons other than a spouse, it is usually a better plan to transfer a remainder interest in real property, while retaining a life estate for the applicant, especially when the transfer will be to more than one individual. Medicaid cannot successfully execute an estate recovery claim or lien against a life estate held by the Medicaid beneficiary. Moreover, a remainder interest will have the same total value, whether it is granted to a single individual or to numerous joint tenants, making it a more attractive method of transferring property interests to more than one person in the context of Medicaid planning.

In some cases, the penalty for a transfer of a remainder interest in property will be longer than that which would be incurred for a transfer of a joint interest in property. However, the advantages of retaining a life estate over owning property in joint tenancy will usually be worth the additional penalty.

Of course, any transfer that incurs a transfer penalty should only be made where the applicant has other assets sufficient to provide for his or her care expenses during the penalty period.

It is also important to note that this strategy, while most effectively pursued prior to applying for Medicaid, can sometimes be successful even after the individual is already receiving Medicaid benefits. The *caviat* in this situation is that if Medicaid has provided any type of notice of its existing claim, for example through the filing of a TEFRA lien against the individual's home, the transfer of an interest in the home may be voidable as a *fraudulent transfer*.

WORKSHEET FOR 2015

GROSS MONTHLY INCOME – MONTHLY EXPENSES = _____
MONTHLY DEFICIT

COUNTABLE ASSETS – 2,000 (AND – 119,200 for married couple) = _____
EXCESS RESOURCES

MONTHLY DEFICIT + 7,249 = _____

7,249 ÷ _____ = _____
(MONTHLY DEFICIT + 7,249) (PERCENTAGE TO TRANSFER)

_____ ÷ _____ = _____
(MONTHLY DEFICIT) (MONTHLY DEFICIT + 7,249) (PERCENTAGE TO KEEP)

_____x _____ =_____ (TRANSFER AMOUNT)
(EXCESS RESOURCES) (% to Transfer)

_____x _____ =_____(HOLD BACK AMOUNT)
(EXCESS RESOURCES) (% to Keep)

DOUBLE CHECK

PERCENTAGE TO TRANSFER + PERCENTAGE TO KEEP = 100%

TRANSFER AMOUNT ÷ 7,249 = PENALTY PERIOD

PENALTY PERIOD x MONTHLY DEFICIT = HOLD BACK AMOUNT

WORKSHEET FOR 2015
Married Couple both Applying

MONTHLY INCOME – MONTHLY EXPENSES = $_____ = MONTHLY DEFICIT

COUNTABLE ASSETS – 3,000 = $_____ = EXCESS RESOURCES

MONTHLY DEFICIT + 14,498 = $_____

14,498 ÷ _____ = _____
(MONTHLY DEFICIT + 14,498) (PERCENTAGE TO TRANSFER)

_____ ÷ _____ = _____
(MONTHLY DEFICIT) (MONTHLY DEFICIT + 14,498) (PERCENTAGE TO KEEP)

_____ x _____ = _____ (TRANSFER AMOUNT)
(EXCESS RESOURCES) (% to Transfer)

_____ x _____ = _____ (HOLD BACK AMOUNT)
(EXCESS RESOURCES) (% to Keep)

DOUBLE CHECK

PERCENTAGE TO TRANSFER + PERCENTAGE TO KEEP = 100%

(TRANSFER AMOUNT ÷ 7,249) ÷ 2 = PENALTY PERIOD

PENALTY PERIOD x MONTHLY DEFICIT ≤ HOLD BACK AMOUNT