**Sterling Education Seminar**

**Long-term Care**

## IV. FINANCING LONG-TERM CARE (LTC).

**A. <u>Introduction to Financing the Cost of Long-Term Care</u>.** The road to financing a person's long term care can be a confusing, complex, and expensive. Often the aged person has become noncooperative and is experiencing dementia. Stress and panic follows when the family doesn't know who or how the care is going to be paid. Planning ahead for long-term care is important in order to understand what service options are available, what costs are involved, and payment options – public and private that exist.

**1. <u>History of LTC in America</u>.**

**A. <u>The Auction</u>.** Three elderly, frail, confused women stood before the Auctioneer in the town square in Stanford, New Hampshire, the year 1832. These three women were found by the "Overseer of the Poor" to be unable to support themselves, even though he had provided them some food, clothing and a little cash directly. The women probably had some dementia and perhaps some physical limitations, such that they were not able to care for themselves without causing an embarrassment to the small community. The Overseer of the Poor (probably akin to a social services director) decided to auction them off one at a time to the <u>lowest</u> bidder. The winning bid person signed a contract that he would care for the woman for one year, providing her with sufficient medicine, food and shelter to survive. Anna Harvey went for 75¢/week; Ruth Collins for 74¢/week, and Molly Clough for 80¢/week.

This might be early America's first step into developing a plan of government/private partnership. No doubt the concept was efficient and the women were taken out of the community's sight. The quality of care is unknown.

Prior to this auction concept, alms were given directly to those who needed help – those with no family. Families were expected to care for their elderly – if there was a family member nearby.

**B. <u>Ancient Times</u>.** The concept of auctioning the poor would have been alien to the ancient Greeks and Romans. The family not only was expected to care for the elderly, but in Athens you could be jailed if you failed to care for your parents. Sparta held the elderly in special high regard.

**C. <u>Almshouses 1825-1950</u>.** In the early nineteenth century, the elderly were beginning to be placed in institutions known as alms houses, poor farms or poor houses. The elderly were roomed with inebriates, the mentally ill and the homeless. It was thought that putting them in an institution would be more economical than paying them directly ("outside relief"), and their character defects could be addressed in one controlled setting.

As younger paupers were moved into more specialized institutions such as asylums, orphanages and work homes, the elderly began to dominate the alms houses.

The alms houses failed miserably to provide a satisfactory safety net for long term care for the elderly. The institution was a symbol for failure and utter despair. One feared and loathed the possibility that he would some day end up in a "poor house."

By the time of the New Deal, FDR and most government officials wanted to do away with this poor house concept. They argued that giving the elderly a small pension would be less expensive and more humane.

Hoping to do away with the alms houses the Social Security Act prohibited anyone who resided in a public institution, such as alms house, to receive a Social Security pension check. In asserting the constitutionality of the SSA (1935), Supreme Court Justice Benjamin Cardozo proclaimed "the hope behind this statute is to save men and women from the rigors of the pour house as well as the haunting fear that such a lot awaits them when the journey's end is near" (Haber & Gratton).

However, many failed to appreciate that even if the poor elderly received a check from Social Security they still could not care for themselves adequately. In eradicating the poor house, pension legislation had unforeseen consequences. Many were forced to enter private, unregulated sanitariums. Some of the poor houses formerly run by the government become private institutions with the same building doctors and staff. Only the payment now was from the Social Security checks of the patients instead of the county government.

By the 1950s, Congress amended the SSA to allow for pension payments, even to patients in public institutions.

**D. 1965 – Medicare and Medicaid.** In 1965 the passage of the Medicare and Medicaid legislation provided additional growth to the private nursing home industry. Between 1960 and 1975 the industry grew 150%. By

1980 over 80% of all nursing home residents lived in private facilities and the government run houses all but disappeared.

**E. <u>1970s to Today</u>.** Government regulations and laws were passed to enhance the care requirements of nursing homes. In addition, in 1973 statewide nursing home ombudsman programs were established.

While the aged no longer face the loathsome poor house for care, the modern day private nursing home structure reflects its history. In shutting down alms houses, the modern day nursing home was born.

Planning is important because the cost of long-term care services exceeds what the average person can pay from their available income and resources. Planning means you will have a better chance of leaving your estate to heirs, and less likely to use your financial resources paying for care. Planning ahead can reduce stress – financial and emotional on the family and also gives you a greater chance for independence if you should need care in the future.

Long-term care can be instituted in the <u>home</u>, <u>assisted living facilities</u>, <u>intermediate</u> and <u>skilled care facilities</u>, and the <u>community</u> itself, such as <u>adult day care homes</u>. The money available to pay services to meet the long-term care expenses, either from government, quasi-government or private sources, depends on the type of care that is needed and which particular setting it is given in. The type (or severity) of care is often determined as to which agency of person pays for the care and in which setting it is delivered.

<u>Medical care</u> in the context of "long term care" is provided by licensed physicians, and includes providing skilled care or intermediate care. The only real

difference between skilled and intermediate is how often the care is delivered. Skilled care is usually available 24 hours a day; whereas, intermediate care is limited to only several days per week. If skilled care is involved, it almost always is given in a nursing home environment, referred to as a "skilled nursing home facility." Intermediate care includes not only a nursing home, but also more intensive care being administered in a home setting. Licensed health care professionals including nurses, registered and practical nurses, and all types of therapists and general caregivers are able to provide most intermediate care. Intermediate care includes giving injections, giving prescribed medicines, taking blood pressure, physical and speech therapy as well as infusion for kidney dialysis.

Custodial care involves assisting in routine daily activities, frequently as a result of cognitive deficiencies. This type of care usually can be undertaken without professional licensing. Unlicensed professionals such as nurses' aides normally provide this type of care.

With respect to physical functionality, everyday tasks are called "activities of daily living" (ADL); and include walking, eating, grooming, personal hygiene, using the restroom, dressing, bathing, mobility inside, transferring in and out of bed and maintaining continence. ADLs are used as reference points for much of the testing and criteria used to determine what level of care is warranted, and in the insurance context, when certain triggering events have been satisfied.

There are standardized tests that measure deficiencies in cognitive abilities. These tests test activities involving preparing meals, managing medication, housework, communication and managing money.

There is a growing need for long-term care, and the single most important factor is age. One-half of all individuals over the age of 85 need some help with everyday activities. Those over 85 years of age are four (4) times more likely to need long-term care as those who are 65 years of age or younger.

We humans are living longer. Today, if an individual attains the age of 65, he can expect to live another twenty (20) years. The Boomer Generation is adding to the numbers that will enter the elderly or senior age categories. Approximately 13% of the United States population (which is now 295 million) is 65 and over. By the year 2030, there will be an estimated 70 million seniors over age 65 who will then constitute almost 25% of the population.

Not only are there more people who will need long-term care, but the type of care is changing from one that addresses catastrophic problems, such as bad hearts and strokes, to one of dementia including Alzheimer's disease.

**Reform Considerations:**

1. **Determine Society's Role.**

    - How much of the long term needs should be met based on an individual's own resources and income and whether if, and to what extent, society should supplement those resources.
        - Should a safety net exist, and to whom?
        - What choices in LTC should the safety net cover?
        - Affordability.

2. **Personal Responsibility.**

    - Disability status is a risk – how much should it be spread?

- Adequate education of the role government and individual plays.
    - What does Medicaid cover?
    - Are private long-term care policies known?

**3. <u>Roles of State vs. Federal Government</u>.**

- Should it matter what state (different care and dollars spent in each state)?
- State budgets must be balanced – weathering business downturns.

**4. <u>Financially Feasible Reforms</u>.** The current economic model for LTC is unsustainable. Before committing to additional financing by the public, there needs to be a long term sustainable model to fund future costs.

**B. <u>The Cost of Long-term Care</u>.** I have personally seen in my practice an extraordinary increase in institutional as well as home health care costs. Twenty years ago it was not unusual in Mecklenburg County of North Carolina to see monthly assisted living costs range between $2,300 and $2,800; skilled care was slightly higher between $3,500 to $3,800 per month. Today, the average assisted living costs are $3,301 per month or $31,950 per year and nursing home average costs are $71,175 per year. Many of the Boomer Generation by the time they are in their 80s, and utilizing long-term care facilities, can expect to spend in excess of $200,000 per year on care. As "Baby Boomers" enter retirement age, entitlement spending (especially for Medicare, Medicaid and Social Security) is expected to absorb more and more of the federal budget over the next twenty years. Demand for long-term care will further strain federal, state and local

government, primarily because of the sheer numbers. The number of persons needing some form of long-term care will more than double between now and 2040. By that same year, the likely number of elderly over 85 most likely to need long term care will increase 250%. Policymakers will need to reconsider the roles of federal, state and local government as well as the role private health care and insurance may play.

A recent report by GAO (Government Accounting Office) identified general considerations that need to be addressed, sooner than later:

- determining societal responsibilities;
- considering the potential role of social insurance in financing;
- encouraging personal preparedness;
- recognizing the benefits, burdens and costs of informal care giving; assessing the balance of state and federal responsibilities to ensure adequate and equitable satisfaction of needs;
- adopting effective and efficient implementation and administration of reforms; and
- developing financially sustainable public commitments.

**C. The Hopelessly Ill Patient.** Financial planning for long-term care often involves the need for periodic acute care in hospitals, including end of life medical decisions. Most elderly will have Medicare A and B which leaves 20% non-covered and these usually are covered by supplemental health insurance. Be sure to advise retaining the supplemental health plans for LTC patients, because end of life care can be extremely expensive. It is not unusual to have a bill of several hundred thousand dollars for care for the terminally ill. The 20% non-Medicare gap can often exceed $100,000.

Besides having proper living wills, HIPAA and Health Care Agent Appointments, financial planning for long-term care should involve a frank discussion of how much treatment and to what degree certain life support measures should be continued depending on various mental and physical health situations.

Hospitals and physicians are under legal pressure to provide acute care to the dying, and will generally follow the directives of the family in regard to prolonging life. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that receive federal assistance or participate in Medicaid are prevented from denying emergency treatment based solely on an individual's inability to pay. EMTALA created private enforcement actions. Patients who must receive medical treatment include those whose health is in "serious jeopardy." Similar federal law requires all hospitals to treat patients who do have the ability to pay. Finally, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. §794) prohibits federally funded programs from excluding any "otherwise handicapped individual… solely by reason of his handicap." The broad definition of handicap is "physical or mental impairment that substantially limits one or more of a person's major life activity." Certainly, elderly patients in end of life care would fit any of this criteria.

But just because the hospital will treat may not be the most reasonable course of action from a financial (as well as moral) point of view.

Unless end of life care is being paid fully by Medicare/Medicaid and supplemental insurers, such care can be extremely expensive, especially if private insurance refuses to pay for some or all of the services.

Hospice has proven to be a popular form of care for the terminally ill.

Hospice benefits are available under Part A of Medicare for those who are certified as terminally ill with a life expectancy of six (6) months or less. Benefits include drugs, bereavement counseling, inpatient respite care when members of the family need a break from care duties. To qualify for hospice benefits, one must choose such benefits in lieu of other Medicare benefits, except for physician services not related to the terminal illness.

**D. Sources to Pay for Long-Term Care.** Sources for payment of long-term care include (i) government programs such as Social Security, Medicare, Medicaid and VA benefits, and long term care (see CLASS) and (ii) personal resources – one's personal and family wealth, which can be supplemented with long-term care insurance, and charity.

About 70% of long-term care expenses are paid by government programs, primarily Medicare and Medicaid. Individuals finance about 20% out of pocket, 9% through private insurance, 18% Medicare, 48% Medicaid, and 6% other. Medicaid, the joint federal and state funded program for low income individuals, is the largest funding source. Medicaid covers the poor as well as individuals who have become impoverished by "spending down" assets.

Individuals out of pocket payments, the second largest source, accounts for 20% of total expenditures. Most of those expenditures are for nursing home care. Private insurance accounts for only 9% of long-term care expenditures.

Looking at the broader budgetary concerns policymakers will face in the coming years, there needs to be a fresh awareness (alarm) of the expected increased demands on our long-term care system.

As the over 65 group increases in number, federal and state spending on the elderly will absorb more and more of government budgets.

Advances in medicine and technology not only allow people to live longer, but costs increase as well. In addition, there will be a drop in workers to support the elderly entitlements. Medicare and Medicaid are basically "pay as you go" programs. That is, they are funded through current resources such as wage withholdings of the workers. In 2000 there were 4.8 workers to support every 65 year old individual. It is projected that by 2030 this ratio will drop to 2.9.

As the Baby Boomer generation retires and the Medicare eligible population expands, the difference between outlays and revenues will be even more pronounced. Medicaid is the fastest growing item in state spending. In addition to the increase in number of elderly, is the strain of fluctuations in business cycles, as evidence by the recession of 2008-2009. North Carolina's annual costs for its contribution to Medicaid is now 30% of its budget!

**E. Strategies to Self-Finance Care.**

**1. For Whom are they Prudent?** In one sense it could be said that it would be *prudent* if everyone allowed for themselves and their loved ones total private pay for all their medical and long-term care needs. However, this is not realistic for all but a small percentage of the U. S. population. If an elderly couple in their 80s with $50,000 or more of Social Security and investment income and liquid assets of $2,000,000 or more, it is most likely that they will have enough to provide for their long-term care needs, if it is invested wisely with reasonable returns.

But, even those with considerable assets may want to begin planning for long-term care so that their options in terms of wealth retention strategies are available. For example, converting life insurance to cash to help pay for a long-term care policy might make sense for some, and for others it might simply be preferable to gift certain assets to children.

Being able to pay privately, even if for only a year or two, can gain the elderly a certain amount of independence and flexibility as to the location of a facility. It will also afford the family time to transfer titles, convert assets to different investments and, in general, give time to implement a plan of "spend down" to qualify for government support (Medicaid).

If one has little income and assets of $50,000 or less, then reliance on some type of government aid is all but certain. But even in that situation, the elderly person would want to understand Medicaid or VA benefits – what is covered and what is not. Medicare only pays for the first 100 days of long-term facility care, and then only partially. Medicare is not a means tested benefit, like Medicaid, but while Medicare is certainly critical in terms of providing medical care to those over age 65 on a societal level, it is not a reliable source of funding for longer stays in a nursing facility. Only Medicaid covers long-term care, and then only for the "poor" – those with assets valued at less than $2,000.

Age and death are important factors in deciding who should look to self-financing. For most past 70, premiums (as well as physical qualification) for long-term care insurance becomes problematic. Over 70 years, in less than good health and with average assets (less than $250,000) – one might at least partially

need to rely on government support. The life insurance standard benchmark to its sale agents is a minimum of $40,000 in assets before they be a candidate for a LTC policy.

What are some strategies to "self-finance" – wholly or partially, one's long-term care? Besides the obvious of getting a reliable and steady return on one's investments, one can purchase long-term care insurance (see discussion *infra*) and in addition, there are some less well known but important alternative tools to use when considering long-term care financing. Our discussion will begin with these.

**2. Investment Techniques and Alternatives for Financing Long-Term Care.**

**a. Life Insurance.**

**1. Accelerate Death Benefits.** One way to help pay for long-term care could be through the use of accelerating the death benefits of a life insurance policy. The policy could provide cash advances against all, or perhaps some, of the death benefit to pay for long-term care expenses while the insured is still living. This is sometimes referred to as "living needs benefits." Acceleration of the death benefit generally is triggered by one or more terminal illnesses to which the insured is not expected to recover. Some policies allow for the triggering event to include chronic illnesses as well. The benefits are then activated, including payments directly to the nursing home facility, or in some cases, for in home care or community based care.

The advantage of the accelerated death benefit over a traditional long-term care policy is that the accelerated death benefit can be added to an in force life insurance policy as a rider for very little additional premium cost. It is also advantageous for those who, because of health or age, cannot otherwise qualify for a traditional long-term care policy,.

The type of living needs benefits that are paid out, how much and how often, vary greatly; but one can expect anywhere between 1.5% to 2% per month of the face value of the policy to be paid out for nursing home care and 1% for home health care. Thus, if the face value of the policy is $300,000, the nursing home benefit would be $6,000 a month and the home health care benefit would be $3,000.

Accelerated death benefits are either indemnity or reimbursed riders. If the accelerated death benefit is based on reimbursement for costs, it means the repayment is for the actual charges incurred by the insured, up to the available benefit, typically, 2% of the face value. Some policies, generally older ones, are indemnity plans, which pay out 2% of face directly to the insured, and are unrelated to the actual charges.

Newer policies tend to be reimbursement policies because of the income tax provisions of Health Insurance Portability and Accountability Act (HIPAA) of 1996. Benefit payments in excess of approximately $280 per day (or the monthly equivalent) that exceeds the actual cost of care will be taxed as ordinary income.

One disadvantage of this type of financing is that based on 2% of the face value of the policy, there may be insufficient payout to cover the cost of the long-term care. Most people do not have life insurance policies with large enough face amounts to rely on the living benefits rider to cover enough of their expected long-term care.

Another disadvantage of the acceleration long-term care rider is that it usually pays less for home health care than the traditional long-term care policy. For a long time there also was a question of the income tax consequences of receiving accelerated death benefits. Thanks to HIPPA we now know that accelerated death benefits will be treated as if the proceeds are payable (free of income tax) provided the policies conform to the requirements of HIPPA. Today many employers have accelerated death benefits provisions in their group life insurance plans.

**2. Traditional Settlements.** Another type of self financing for long term care tool is a traditional settlement involving a third person (viatical settlement company) paying a terminally ill insured person a percentage of the death benefit during life. These policies are ones that already are in existence and the insured subsequently becomes ill. The insured must be "terminally ill" as certified by a physician. The terminally ill person receives a percentage of the death benefit, and the company becomes the owner and beneficiary of the policy, even taking over the premium payments. In theory, the terminally ill person then gets funds prior to his death to pay for his long-term care and the third-party

(viatical settlement company) receives the full death benefit, and hopefully a good return on its investment. Viaticals are regulated by most states as to the minimum that the terminally ill must receive.

"Terminally ill" means the viatical settlement company expects someone to live 2-3 years or less.

The amount paid (upside) to the insured for his insurance policy is determined by several factors:

**(i) <u>The Financial Strength of the Third-Party Purchaser</u>:** Most viaticals are simply brokers for investors. The true risk is born by investors and their risk tolerance can vary.

**(ii) <u>Diversification of Cases</u>:** The larger viatical settlement companies tend to admit their cases with different conditions such as cancer, Alzheimer and AIDs. This is because the technology and knowledge of terminal illnesses has increased and the third-party can find themselves paying for lifetime assistance. They want to spread the risk among different illnesses, this limiting what they will pay when their portfolio becomes unbalanced.

**(iii) <u>Insurance Company Ratings</u>:** A viatical settlement company is going to pay less for a lower rated life insurance company. I would suggest that after the 2008 financial stress of insurance companies and banks, there is going to be even

further scrutiny as to the reliability of ratings for insurance companies.

**(iv) Type of Investor:** High risk investors will probably expect a higher return on their dollars, which will reduce the amount payable for death benefits.

**(v) Waiver:** If the premium for the policy is waived (because the insured is disabled), the viatical settlement company will avoid having to continue making the premium payment thus will be able to pay the insured more.

**3. Life Settlements.** Another technique to generate cash is the use of a "life settlement." Life settlements involve selling a life insurance policy even when the insured, is in good health. The insured simply no longer needs the life insurance for what it was originally purchased for, and the owner no longer wants to continue the premium payments, or the insurance is not worth the investment for the next generation. Individuals aged 70 and older with any type of life insurance, be it group, individual, whole life or term can sell policies to a life settlement company. A life settlement company pays what it perceives to be the present value of the policy. Cash received from the settlement can be used for any purpose, which could mean gifting to family members, paying for long-term care expenses to someone who might not be insurable, purchasing long term care insurance for a spouse and other types of investments.

The secondary insurance market is currently under attack by state regulators and private lawsuits. What was once a lucrative investment strategy for selling a policy to an investor on a quick turnaround, has all but collapsed after 2008. The elderly had been able to take out large life insurance policies on their lives and then sell them to private investors for cash sometimes after only a couple of years of ownership. Billions of dollars changed hands. Under the deals, the investors pay the premiums until the insured dies, at which point they collect the death benefits.

Ironically, stranger owned life insurance (STOLI) was initially promoted by the insurance industry in that it opened whole new revenue sources for both the company and commissions for its agents. However, the insureds lived longer and, of course, there were no defaults in paying the premiums, both variables were severely underestimated by the insurance companies. The insurance companies sued the investors and insurers claiming the companies were the victims (defrauded) in that they were unaware the policies were being taken out for resale. Now the investors have struck back, asserting the agents and managers encouraged STOLI policies in order to boost sales and their compensation, and that the industry complained only when they were faced with big losses.

Suits have also been brought by the relatives of the deceased alleging that death benefits belong to the families. Investors face big losses if policies are cancelled.

Now, almost all newer life policies ask in the application whether the owner intends to sell the policy in the near future. With stepped up underwriting requirements, it will be difficult to find buyers in the secondary market for quick turnaround cash. Large scale investors have completely left the market, leaving individual investors as the only possible purchasers. Caution should be the word before an older person contemplates as a form of Long Term Care funding taking out a life insurance policy for resale. They may end up in litigation. Selling older policies which have been in existence for years is still a viable arrangement, however. (See Exhibit 1.)

**4. Single Premium Life Combined with Long-Term Care Policies.** Another type of life insurance policy involves payment of a single premium, which then can be used for both life insurance and long term care. Options might be to pay a small amount annually to a certain age, like 62, after the upfront lump sum. Other "single premium" policies require ongoing payments for life.

This policy might contain a provision that allows one to deposit any amount toward a death benefit just like any other life insurance policy. However, the policy will pay double the amount you deposited should you need long-term care. The longer you keep the policy without filing the claim the longer the accumulation and the more you will have for your long-term care. Typically one time premiums range between $50,000 and $100,000. If the insured is concerned he may have to use the policy in the

first three years (and thereby not having sufficient accumulation to pay more than four years) there are options with some insurance contracts that allow for the insured to receive additional benefits over more years provided he pays more premium. This is known as an “extension of benefits.”

**b. Annuities.**

**1. Long-Term Care Annuities.** Long-term care deferred annuities can help those who cannot qualify for long-term care insurance. Unless they have one of the major health conditions which greatly shorten one's life, such as Lou Gehrig's Disease, and assuming they are not on bed rest, one should be able to obtain a deferred annuity. The annuity is divided into two funds. One fund is used to pay for long-term care costs and are invested in timed instruments, such as money markets and treasuries. The other fund is generally invested more aggressively, for example in stocks. Accessing the long-term care fund of the annuity does not involve any penalties, per the contract. Otherwise, early withdrawal from an annuity would draw penalties if one were to take out more than 10% at a time. These are contractual penalties and not governmental. Typically, benefits would begin paying once the doctor certifies qualification for LTC. There is a qualifying condition such as being cognitively impaired or failing two (2) or more ADLs. The annuity benefit generally is a reimbursement benefit not an indemnity benefit, so the actual expenses are targeted.

**2. Medicaid Qualifying Annuities.** (See Medicaid discussion infra.)

**3. Immediate Annuities.** Considering one's health, the premium for an immediate annuity may be affordable to the elderly who can not otherwise purchase long-term care insurance. If an 80 year

old female desired a monthly benefit of $4,000 she may be expected to pay a premium of around $250,000 to $300,000 in a single premium immediate annuity. However, if she had cancer, this special type of immediate annuity might require only $100,000 to obtain the same $4,000 monthly benefit. Whereas the long term care benefits might be limited, these annuities can be useful to at least partially fund long term care.

**c. Mortgages.**

**1. Reverse Mortgages.** Reverse mortgages are home equity conversion loans to which no repayment of the loan is required until the borrower dies, sells the home, or is permanently admitted into a nursing facility. The risk is upon the provider of the funds, even if the borrower outlives the equity in the home, there is no immediate trigger of repayment. This is a special program to homeowners passed in 1988 to help homeowners over the age of 62 convert equity in their home to cash without incurring a large monthly mortgage payment**.** There are no income qualifications and the credit qualifications are fairly limited because there are no monthly payments required. The provider of the funds will be primarily interested in making sure there is adequate equity in the home, both initially and ongoing.

The funds available to the homeowner are tax free and do not affect Social Security eligibility. Typically the disbursements are made on a monthly basis during the life time of the homeowner. The home can be sold at anytime, at which time the reverse mortgage is then repaid. The

remaining equity goes back to the owner, or in case of death, it goes to the estate of the homeowner. Probably the most widely used reverse mortgage is the Home Equity Conversion Mortgage (HECM). Fannie Mae (Federal National Mortgage Association) has a product know as HomeKeeper. Financial Freedom is a private reverse mortgage product, and there are a few other private lenders in the market. The lending limit is determined by the age of the homeowner and the value of the home. A 75 year old person can generally get around 60% of the value of his home in lump sum payment.

Clearly, since the 2008-2009 recession and retirement of bank lending in general, reverse mortgages today have been limited. Very few lenders want more realty their portfolios with real estate, much less reverse mortgages. Also, valuations are more scrutinized and are 25%-30% less than 2007.

Upon arranging for reverse mortgage, monies are used to payoff all then outstanding mortgages and other debts of the home, origination fees, insurance, and closing costs. A homeowner must maintain payment of homeowner insurance, property tax as well as the home's physical and structural integrity.

If the homeowner dies, the issue with heirs is that they might not receive any value from the home. One option might be for the children of the homeowner to purchase life insurance on the parent to partially offset

the lost value. Proceeds from a reverse mortgage could be used to purchase a small life policy.

One technique employed by a parent with a disabled child, is simply to transfer the proceeds to the disabled child. This is an exempt transfer for Medicaid purposes. However, if the parent has undertaken a reverse mortgage, upon death, the Note is due. There is no disabled child exception for calling the Note.

Another strategy might be to obtain a reverse mortgage and use it as a line of credit to pay for long-term care insurance. In some instances, the bank may allow a single premium payment for the reverse mortgage which then can be used to purchase long-term care insurance plan. Another strategy would be to buy a single premium annuity which in turn can be used to pay for the long-term care insurance premiums. There are no less than then (10) reverse mortgage websites in North Carolina, which can be found at www.reversemortgage.org.

**d. Charitable Remainder Trust.** The elderly could contribute assets (*e.g.* land) to a Charitable Remainder Trust. The trust could sell the assets and give back to him/her an income stream for a term of years. The term would be greater than his/her life expectancy. The income could be used to pay for long-term care, or even used to purchase a long-term care policy. At the end of the term, the assets would go to charity.

**e. Long-Term Care Insurance Strategies.**

**1. For Whom Are They Prudent?** Long-term care insurance is an individual, consumer oriented product. Because it is consumer driven, it is subject to the perceptions of the individual purchaser as to whether or not they will ever need the product, whether they can afford the product, whether they understand the product and the immediacy of any need.

For the most part, long-term care insurance does several things: (1) ensures the individual a certain amount cash flow in which to pay long-term care at a nicer, and maybe more healthy facility than one otherwise could afford; (2) provides the patient with a certain degree of asset protection; that is, rather than spend down assets that would otherwise be going to heirs, insurance would be a replacement asset, if not at least slowing down process of assets and personal wealth attrition. Nevertheless the National Association of Life Insurance Under Writers (NAIA) recommends to their agents that anyone that has assets of $50,000 or less or has an income of $20,000 a year or less at the time he expects to need long-term care, then that person is not a good candidate for long-term care insurance. On the other hand, there are people that even though they fall within these criteria, want to make sure they have sufficient funding to place themselves in a facility that they otherwise could not afford. Therefore, it's not a straight assets and/or income test, but rather one has

to look into the psychology of the person as well as, reasonably forecast how much governmental help would be available 20 years henceforth.

There are various reasons individuals do not purchase long-term care insurance. Some believe that the government already covers long-term care facility costs or if not, in the near future they will. Why should they pay for long-term care insurance now if the government is going to eventually pay anyway? Medicaid is the consummate safety net for long-term care.

Other individuals do not believe they will ever need long-term care insurance – they plan to "die with their boots on" type of mentality, or they intend to purchase it later in life when the need becomes more imminent. But probably the number one factor that prevents universal purchase of long-term care is cost. Most people significantly under-estimate the cost of nursing home care and overestimate the cost of long term care. Assisted living in the Mecklenburg County North Carolina today typically exceeds $4,000-$5,000 per month. Skilled care averages more – as high as $7,000 per month. Although people are becoming more aware of long-term care insurance, there is still the lack of motivation on their part to purchase the product. There may even be psychological reasons why long-term care insurance is not universally purchased. The mere act of purchasing is an acknowledgment of the frailty of a human condition. Yet, almost everyone will be affected by some type of long-term care need either themselves or their family during their lifetime. For

those that can qualify for LTC insurance, the cost is usually less than they would have expected. Here is a summary of issues that need to be addressed by the potential purchaser of LTC insurance.

**2. Why the Public is Hesitant.**

**a. Cost.** Most people think the premiums are high. In my practice many think that the premium will be several thousand dollars per month after age 60, when in fact the premiums would probably be only 10% of what the client estimates.

**b. Failure To Understand Policies.** Most people understand life insurance. They pay a premium during life and a death, benefits are paid to a named beneficiary. The main event when they die, death benefits are paid. It is relatively simple to understand. Long-term care insurance policies take many forms and many variables that are extremely complex in comparison.

**c. Lack of Trust.** The consumers simply may not trust the life insurance companies to pay for with payment of the long-term care should it be needed, or that the companies will be around for many years in the future. Indeed, several of the largest companies have now retreated from the business (*e.g.* Conseco). Thus, in order to give confidence to the potential buyer of long-term care insurance, he must think that the insurance company will continue to back not only the particular

product he is buying, but the company is in it for the long run. The insurance industry has a long way, in my opinion, to go in convincing the population that they are 100% behind this product. If a large company gets out of the business, it affects the credibility of those companies that remain.

While there are other considerations that the consumer must face when deciding whether to purchase a long-term care insurance policy, here is a list of some of the more common factors:

- When should coverage be purchased?
- Tax qualified policy?
- Is the coverage appropriate?
- What is the appropriate amount of coverage?
- The type of coverage?
- Per diem or reimbursement policy?
- Inflation adjustment?
- Non-forfeiture option?
- How should premiums be paid?
- Evaluation of insurers?

**3. <u>Features of Long-Term Care Insurance</u>.** There are many variations of long-term care insurance. Aside from the few mandatory provisions as required by state law, insurance companies have developed an array of various terms and provisions with varying costs to address almost any situation.

The insured long-term policies can cover one or more individuals. The joint policies can include covering the spouse as well as other family members.

A benefit trigger is a criteria which must be met in order to establish eligibility for benefits. All tax qualified long-term care policies use two criteria to determine eligibility.

The insured is unable to perform at least 2 of either 5 or 6 of the activities of daily living (ADLS) for at least 90 days due to chronic or functional incapacity. The 6 ADLS under NIC model regulation and North Carolina law:

- Bathing
- Continence
- Dressing
- Eating
- Toileting
- Mobility
- Getting in and out of bed or wheelchair

The second criteria is the inability to protect one's self from a health and safety stand point due to severe cognitive impairment or dementia. All tax qualified policies require someone certify that the insured meets certain criteria of being chronically ill. Generally a licensed physician is required to certify although some policies allow registered nurses and licensed social workers to make the determinations.

There are various types of care settings for which benefits maybe paid through the long-term care policies. These include nursing home care, assisted living care, Alzheimer care facilities, hospice care, home health care and other. The long-term care policy can provide benefits for one or up to all of these different settings.

Nursing home care generally refers to skilled nursing care, intermediate nursing care and custodial care within a facility setting. Nursing home care benefits are paid if:

- Facility is fully licensed under the state
- Availability of a doctor duly licensed 24 hours
- Nurse licensed RPN nursing provided 24 hours a day
- Maintenance of records of procedures

There are some facilities that normally would meet this criteria, however, they are frequently excluded in long-term care policies and include homes for drug addicts, alcoholics, and the mentally ill, Acts of War, attempted suicide, treatment provided in a government facility (*e.g.* Butner).

An assisted living facility provides care for those who cannot fully care for themselves but does not need a 24 hours nursing care as in a skilled nursing facility. The definition of assisted living need includes:

- Licensed facility
- Serves meals

- Trained but not necessarily licensed people to provide care
- Arrangements are made to get the insured to a hospital or physician if needed
- Twenty-four (24) hours of unsupervised care

Hospice is for the treatment of persons who are terminally ill is a fairly new phenomenon in the medical care industry. To be eligible a licensed physician normally must certify that insured is expected to live six months or less.

Note: North Carolina does not allow long-term policies to exclude Alzheimer's or other forms of mental degeneration diseases. Today many Alzheimer patients are included in the need for assisted living facilities, in what is referred to as "dementia wards."

Home health care includes not only a care setting in an insured's residence but also an adult daycare, and respite care. Home health care involves at times family member contributions to the care; anywhere for a few hours a week to full 24 hours around the clock custodial care in the home. Home health care includes home maker companions who are usually employees of licensed health care agencies. They typically help with the cooking, shopping, and cleaning. Long-term care policies vary greatly on what they will cover with respect to home health care.

Finally, long-term care policies frequently cover "Care Coordinators." Care Coordinators are usually independent from the

insurer and provide a road map of care recommended for the insured through the use of a Care Coordinator.

**1. Benefits.** There are many variations among long-term care policies with respect to the types of benefits that are insured. The variations related to the types of care provided: there are facilities only policies, home health care policies and comprehensive policies

**2. Comprehensive Policies.** Most long-term care policies you will **encounter** today are what are referred to as comprehensive policies or integrated policies. These types of policies include benefits for facility care and home health care into a single agreement.

**3. Home Health Care Policies.** Home health care policies are benefits for care other than **in** a facility, it is rare you will see a policy that only insures for home health care benefits, but if you do, the premium will be much less.

**4. Facilities Only Policies.** These are the types of policies that were originally sold **in the** beginning **of the 1980's which benefits were granted only if the in**sured qualified for skilled nursing care. Today facilities only policies include not only skilled nursing care but assisted living and hospice as well.

**5. Benefits – Amounts.** The purchaser of a long-term care policy will have various options to choose with

respect to amount of benefits to be provided. Benefits are often designated in terms of certain dollar amount per day. For example a typical policy might read an amount up to $230 per day. Many policies base benefits on a monthly and not a daily basis. This can be beneficial in that the insured will be able to see benefits at times that otherwise would exceed the daily limit, but overall not the monthly benefit. Today policies that include benefits for home health care pay the same or close to the same benefit as that of nursing facilities.

Policies pay benefits either on a per diem basis or reimbursement basis.

**6. Reimbursement.** Reimbursement policies do just that -- they reimburse the insured for the expenses up to a specified limit either a daily or **monthly basis.**

**7. Per Diem Policies (Indemnity Policies).** These types of policies pay a benefit amount daily or monthly regardless of the actual charges incurred. Usually the per diem policies pay out the claim amount regardless of the surviving spouse or family member or licensed professional. The indemnity policy may be full or partial.

**8. Duration of Benefits.** Generally covers 1, 3, 5, 6 or indefinite number of years.

**9. Elimination Period.** Almost all long-term care policies provide for an elimination period or waiting period. When purchasing the policy, the insured will normally have the option of choosing which elimination period he desires. The insurance company will typically offer several different duration periods. Obviously, the longer the duration period, the less premium charged. Policies have much flexibility here and may or may not allow for applications of prior elimination periods to be carried over to satisfy new elimination periods.

Medicare does pick up the first 100 days of skilled nursing facility. Tax qualified policies will typically exclude benefits that are provided under Medicare including the 100 days of care. Long-term policies typically exclude benefits for services that are otherwise provided by Medicare and any tax qualified policies was generally have this exclusion. Most policies however allow an insured's Medicare covered days to be applied toward the elimination period. (See Exhibit for comparison of LTC tax Qualified and Nonqualified.)

**10. Maximum Duration of Benefits.** The insured is also given a choice as to the maximum period of which benefits are to be paid. The period begins from the time the benefit payments start once the elimination period is satisfied. Usually there are several options, for instance one might choose a five year,

eight year or lifetime benefit. Other policies might limit the duration to the maximum benefit paid rather than a matter of years. For instance a sum of $500,000 once it is paid, in effect determines the duration. In addition there are policies written that allow for different durations for different types of care settings. With a 5 year period of time to transfer assets before Medicaid eligible, one might want to tie the duration to Medicaid requirements (60 months).

**11. Inflation Protection.** Premiums might reflect the option for inflation protection. This protection carries a stiff price however. If the purchaser is over 65, it probably would be more cost effective to simply purchase a greater amount of benefit without inflation protection, especially if compounded. Most policies offer a 5% benefit increase compounded annually over the life of the policy. The benefits will increase 5% per year over the previous year's benefit amounts. Other insurance policies might be written to increase 5% regardless of inflation each year with the original benefit amount being the base. Simple inflation coverage will be much less than compounded.

**12. Exclusions.** Most long-term care policies contain some exclusions, provided they are permitted by state law. An example would be given mental health history, chronic alcoholism and drug addiction as well as Acts of Ware and

attempted suicide or care in a government facility. North Carolina specifically does not allow an exclusion for Alzheimer or Parkinson's. Many policies do not cover treatment received outside of the United States other than Canada. Most policies do exclude for pre-existing conditions. North Carolina under Chapter 58 of the statues, however does not allow exclusions for pre-existing conditions outside of six months from application date.

**13. Non-Forfeiture Options.** Many policies now offer a return of premium if the policy owner doesn't use the policy or dies after receiving a limited amount of benefits. The most common type of non-forfeiture option, and one that is required and is always available for tax qualified policies, is the option to have coverage continued as a paid out policy, but reduce the benefit period. Some policies actually refund all of the premiums if the insured dies before a certain age (65) thereafter a percentage of refundable premiums gradually decreases over time.

**14. Premiums.** Most long-term care policies are determined by the age of the time of issue. If the policy is guaranteed renewable the premium will not change unless the insurance company raises it on a class basis. Some of the older policies had guaranteed renewable and with a guaranteed premium. Today few if any insurers would include such a provision to not raise premiums. A level premium guaranteed renewable is a very

valuable policy indeed, as insurance companies today, after having negative experience with such premiums while guaranteeing renewability, will not guarantee that the premiums will not rise or be increased by class.

Recently insurers have begun offering accelerated premiums. These are especially popular with executive incentive plans where the employer pays all of the premiums for the executive's long-term care insurance on a tax deductible basis. A single premium payment prior to retirement can generate a full income tax deductibility for a C corporation. Other options may include a very high first year premium with reduced premiums thereafter typically until the insured obtains the age of 65. There are other premium options such as a higher premium until age 65 and thereafter a reduction. These accelerated premiums payments however are typically combined with some type of reimbursement should the insured die within ten (10) years.

**15. Waiver of Premium.** Most insurance contracts allow for the discontinuance of premiums once the insured has triggered the reception of benefits. The waiver of premiums option however takes on many variations itself. Some policies will waive premium once there has been an elimination period, other's not until the insured receives benefits over a number of days or months. Other waiver of premiums may be based on the type of

setting. For instance the waiver of premiums may apply only when the insured is living in a nursing home facility, others may waive the premium once he requires any type of trigger. A joint policy premium can occur when the first spouse attains a trigger and others may only waive the premium only after the first spouse dies.

**16. Reinstatement.** One problem with long-term care policies is that the insured might become cognitively impaired and not pay the premium. North Carolina state law requires a grace period of 30 days (in which the policy cannot lapse for lack of payment of the premium) and notice. Many policies and state law allow for reinstatement if the policy lapses because of cognitive impairment. There will be a time limitation, for instance of 6 months. Of course, the insured will have to prove that the reinstatement was based on his failure to pay the premiums based on his cognitive impairment.

**17. Renewability.** All long-term care policies are guaranteed renewable, even if premiums increase. North Carolina law does not allow policies that can be terminated based upon one's age or deterioration of any mental or physical health.

**18. Community Living Assistance Services and Support (CLASS) Act.** The CLASS Act is a voluntary, federally administered, consumer financed plan. It became law when

President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010.

All working Americans, age 18 and older, and not living in a nursing home (or institution) can enroll. You cannot be excluded for pre-existing conditions, but there is a 5 year vesting.

The Plan will pay a cash benefit ($75.00?) day and there are no lifetime limits. But the Plan does contemplate that many consumers will purchase supplemental private insurance.

Neither benefits nor premiums are income related (except for low income subsidy). The cash can be used for various purposes, at the consumer's choice: caregivers, renovating home, obtaining assistance devices.

One concern is that with a guaranteed income stream, nursing homes will raise prices. Today those fees are negotiated with Medicaid.

The success or failure of the CLASS will depend on the public's response to voluntary insurance. Most western countries have chosen mandatory, universal coverage.

Perhaps, the biggest unknown is what the behavioral response will be to the opt out provision. The Congressional Budget Office and the Actuaries at Medicare initially addressed only a 5% participation rate and high average premiums, without a

major expansion of the risk pool to drive down premiums, it is unlikely a large percentage of consumers will buy in.

A successful national long-term care program should accomplish (1) consumer choice, (2) shift away from Welfare based Medicaid to universal coverage and (3) stable funding source. The CLASS Act attempts to address all three concerns.

**19. Critical Illness Insurance.** This is a type of insurance which pays a lump sum once one is diagnosed with one of the terminal illnesses or cognitive impairment such as Alzheimer, Multiple Sclerosis, stroke, cancer, kidney failure, blindness, and some others. Some of these Critical Illness Policies do have a return of premium provision so that if benefits are never paid out the policy holder does receive some of the benefits back. While the policies are generally purchased prior to age 64, after that age the benefits are usually reduced by at least 50%. The lump sum payments vary depending on how much premium is being paid. Usually they are sold as a rider to different type of policy so that they are not extremely expensive. Sometimes they might be included as an employment benefit. If an employer benefit, the lump sum payment is payable income to the recipient. Again, like annuities, this type of insurance might be beneficial if the insured can not obtain long-term care insurance.

One should note that critical illness insurance typically are triggered when one needs help with at least three activities of daily living, long-term care policies only require two.

**4. Income Tax Issues.**

**a. LTC Cost Deductibility.** Long term care costs are deductible if due to chronic illness. However, only unreimbursed expenses that exceed 7.5% of AGI are tax deductible. The chronic illness must be certified by a licensed health care practitioner.

The patient must be unable to perform two (2) ADLs to be deemed chronically ill. Expenses related to room and board are not deductible. Only those that are "qualified long term care" expenses. These "qualified long term care" expenses include diagnostic, preventive, therapeutic and rehabilitation services.

**b. Premiums.** The deduction for a qualified long-term care policy's premium is limited:

| Age | Maximum Tax Deduction |
|---|---|
| 51-60 | $ 1,190 |
| 61-70 | $ 3,180 |
| Over 70 | $ 3,980 |

**c. Benefits.** Benefits are paid by a qualified LTC policy. To the extent that they reimburse expenses, benefits paid by an indemnity type contract are tax free. Benefits paid on a per diem are tax free up to $280 per day.

## F. Government Programs.

### 1. Medicaid.

**a. How Funded?** Medicaid is a jointly funded federal and State Health Insurance Assistance Program (SHIP), state welfare program that is the largest source of medical care payments to individuals who qualify. It is primarily run by the states which have leeway to develop their own rules within the federal guidelines. Medicaid provides care for over 40 million individuals in the United States, most of which are children. It is also the largest source of government aid for long-term care for the elderly and disabled.

To qualify as a Medicaid beneficiary, the beneficiary (known as an account recipient) must satisfy both income and asset requirements; that is, the form of entitlement is "means tested."

**b. Means Tested Benefit – Medicaid.** Individuals over 65 are generally entitled to Medicare, regardless of income or net worth. However, both asset and income limitations apply to Medicaid qualification.

An individual cannot be required to live in the state of North Carolina for a specified period of time in order to qualify for Medicaid. However, they must provide proof of their residence. This would include the usual subjective criteria, such as voting, drivers' license, physical presence and above all stated intent.

All states are required to include certain eligibility groups of individuals, and may include others. The states' eligibility groups are one of three types:

- Categorically Needy.
- Medically Needy.

- Special Groups.

Elderly recipients in long term care usually are attempting to qualify under the medically needy group. Although under the categorically needy group are Supplemental Security Income (SSI) recipients.

Recipient cannot have countable assets that exceed individual or couple limitations ("resource limits"). For the elderly, normally this would be $2,000 for an individual and $3,000 for a couple.

The "medical needy" coverage includes the aged, blind and disabled who may have too much income or resources to receive SSI, but still not enough to pay for medical care.

Individuals can have what is referred to as a deductible, that is they can spend down enough and thereby qualify by incurring medical expenses equal to the amount of the excess income. In North Carolina the deductible is based on income in a six month period, less medical expenses paid.

**1. Income Limits.** In addition to limits on resources there are limits on income. Not all income counts, for instance, income received for Aid and Attendance from VA is non-countable income for Medicaid. Almost all other income does count including wages, salaried commissions, tips, social security, Annuity or IRA distributions.

North Carolina has no income cap, although the Account Recipient or "AR" is only able to keep in reserve income of $30.00. Each facility has assigned a Medicaid reimbursement daily rate of the medical needs of the facility's population. To go to that rate you can look at the DMA

website at www.ncdhahs.gov look under publication and click on fee schedules. When the, AR's gross income is greater than the Medicaid reimbursement rate for the facility you still have to look to the predictable medical expenses in addition to the reimbursement rate to see if the AR is financially eligible. If his/her income exceeds this amount, then he/she does not.

**2. Community Spouse Income Allowance.** If there is a community spouse (CUSP) who is legally married to the AR, or separated less than 12 months prior to the institutionalization, then there is an allowance of income for the spouse provided she is living in the home. This amount is calculated as follows: (a) compute the basic spouse allowance ($1,822.00) and (b) excess shelter cost. Basic allowance for community spouse is currently $1,822.00, which is 150% of the federal poverty limit for two people. Total this amount and subtract the CUSP's income. This is the amount the CUSP would be able to retain from income from the Institutionalized Spouse (ISP). In addition, excess shelter costs are added to the amount that the CUSP is able to retain from that of the ISP. Standard shelter amount is $547.00. Total shelter costs including mortgages, insurance & taxes which exceed $547.00 are "excess total shelter costs." The excess shelter costs are added to the $1,822.00 maximum community spouse allowance. The combined total cannot exceed $2,739.00 (MA-2270).

**3. Asset Limits.**

**a. Home Site.** Not all assets are counted, this includes the home site. The AR can only have only one residence excluded. The residence is excluded if a spouse continues to reside in the home or if there is no spouse living in the home, the Account Recipient signs a statement that he intends to return home. The subjective intent means that it is his intent regardless of the circumstances of why he is not living there. If he cannot state his intent, due to cognitive impairment, then social services are directed to obtain a written statement from his personal representative, such as Power of Attorney or Guardian.

**b. Non-Countable Personal Property.** Includes clothing, jewelry, furniture, appliances, and artwork. In addition one motor vehicle of any value is excluded, provided that motor vehicle is necessary for transportation of the AR or a person living at home with the AR.

**c. Property That Is Excluded Due to Usage.** This includes business property that's used in a trade or business, self employment, farming operations, whether or not they are profitable, even liquid assets of the business provided they are not comingled with personal funds. The AR however, must be actively involved in the business on a day to day business. This requirement can be difficult to meet if the AR is living in a nursing facility.

**d. Income Producing Real or Personal Property.** Only $6,000 of equity in real or personal property is deemed income producing and excluded. At one time there was no limit. This exclusion offers little help to qualify for Medicaid today.

**e. Annuities.** To be an exempt asset after November 1, 2007 annuities must have North Carolina's Medicaid program named as the remainder beneficiary. If the annuity was purchased before November 1, 2007 the cash used to purchase the annuity is an allowable transfer provided the beneficiary is the AR or is the spouse of the AR. The beneficiaries must be expected to live long enough to receive an amount that is equal to or greater than the amount originally invested. Thus, the annuity would be "actuarially sound."

Those annuities purchased after November 1, 2007 are exempt only if the State of North Carolina's Medicaid program is the remainder beneficiary in the first position. However if there is community spouse or a child under the age of twenty-one (21) or a disabled child of any age, the North Carolina Medicaid program may be named in the next position after those individuals. If the North Carolina Medicaid program is not named as remainder beneficiary or in the correct position then there is a transfer of assets equal to the original full price paid. In addition all annuities

purchased after November 1, 2007 must be sold by a bank, insurance company or other person engaged in the business of the sale of commercial annuities. Private annuities are not qualified. Qualified annuities must be irrevocable, and cannot allow the policy holder to assign or transfer ownership or income to a third party, and the purchase price must be expected to be paid back in full during the expectant lifetime of the annuitant. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral or balloon payments.

**f. Promissory Notes.** As of February 1, 2008 promissory notes can no longer be cancelled upon death and still remain an exempt asset. The purchase of a nonnegotiable promissory note is a transfer and since it cannot be sold it has no value, and therefore, uncompensated transfer results in a sanction period. In addition after November 1, 2007 negotiable notes have to have a provision such that the principal will be paid back during the life expectancy of the AR, similar to "actuarially sound" annuities. Transfer of a life estate, is an uncompensated transfer of value of the equity of the remainder interest. After November 1, 2007 the purchase of a life estate in another individual's home will be evaluated as a transfer of assets, sanctionable if at the time of the application for Medicaid the purchaser has not resided in the home for a period of at least 12 consecutive months.

**g. Joint Ownership.** Tenants in common interests are no longer exempt when the account recipient or spouse owns a tenants in common interest in real property. The fair market value of the tenants in common interest will be evaluated. Tax value is used to determine the net value when is used determining the amount of sanctionable transfer.

**h. Life Insurance.** Cash value of life insurance generally is a countable resource. However, you exclude as a resource, the cash value of life insurance policy when the face value of all policies equals $10,000 or less.

**i. Burial Exclusion. T**his is an exclusion that is only used when the AR has excess countable resources. It is a way to reduce $1,500 of otherwise countable resources. The $1,500 spent on burial can reduce excess cash value of life insurance, bank accounts, stocks and bonds. Confusion with the burial is that there was a change made in the adult Medicaid manual on November 1, 2008, which confirmed that the irrevocable burial contracts are not limited in amount, it is just not a countable resource.

**j. Community Spouse Resource Protection – Assets.** While all assets of a married couple are considered when determining Medicaid eligibility, the spouse living at home, referred to as the community spouse (CUSP), is entitled to retain

assets a certain amount of assets of the marital unit. The institutionalized spouse (ISP), is referred to as the person applying for or receiving Medicaid who is in a long-term care living arrangement.

Determine the total countable reserve for the month prior to when the continuous period of institutionalization began.

Compute the protection amount as follows for 2008:

If the total countable reserve for the month of the institutionalization began is:

a.) $21,912 or less then all assets are protected for the community spouse;

b.) if the assets total more than $21,912 but not more than $43,824, then the $21,912 is protected;

c.) if the assets total more than $43,824 but not more than $109,560, then you protect half; and

d.) if there is more than $219,120, then you protect $109,560 only.

If the AR has over $2,000.00 then it must be spent down or property paid such as burial expenses or bills during the next 45 days after the assessment period, or they will become Medicaid ineligible.

**4.** **Sanction Period.** The length of the sanction period is based on the uncompensated value of the transfer, with transfers prior to

November 1, 2007 beginning with the month of the transfer. If the total of the uncompensated value of transfers is less than the current average private nursing facility rate of $5,500 there is no sanction. The private nursing facilities rate changes periodically. DMA issues these changes generally on July 1 or January 1 of each year. If the devisor is $5,500, the quotient is rounded down to the lowest whole number. This results in the number of months of sanction. For transfers after November 1, 2007, the penalty period is calculated based on when the AR meets all of the eligibility criteria, and in addition, for nursing facility cases the first day he is in a nursing facility.

**5. Transfer of Resources.** If the applicant/ recipient (AR) financial responsible spouse or their representative gives away or sells assets below fair market value, then the recipient will be sanctioned and become ineligible for a certain period of time for Medicaid. The look back date to determine when an unauthorized transfer was made depends on the date of the transfer. If the transfer occurred prior to November 1, 2007 then the look back date remains unchanged, which generally would mean 36 months unless transferring from Trust (60 months). If the transfer was after November 1, 2007, it would require a 60 month look back period.

Not all transfers are subject to sanctions:

**1. Compensated Transfer.** If real or personal property is transferred in exchange for full consideration that is

received a benefit equal to a greater than the equity of the transfer asset then it is not a sanctionable transfer.

**2.** **<u>The Home Site</u>.** It can only be transferred without receiving equivalent value to a spouse, a child under 21, a blind or disabled (determined by SSA) child of any age or a sibling who is a co-owner of the home and has lived there for at least one (1) year. A final exception is transfer to a child including a step child who resided in the home for at least two (2) years immediately before the AR entered into a nursing facility and provided care to the AR which allowed him to live at home rather than being in the nursing facility throughout the two (2) year period.

**3.** **<u>Other</u>.** There are other allowable transfers for instance to a trust for the "sole benefit" of an allowable person. The allowable person would include the legal spouse, the AR's disabled child of any age, or an unrelated disabled individual under the age of 65 years of age.

**4.** **<u>Personal Service Contracts</u>.** Personal services contracts are recognized as reasonable spend down techniques, but must be a written agreement, and the AR must not be paying more than what is commercially reasonable for the services rendered. In addition the services will not be recognized in terms of personal services while the AR is residing in the

nursing facility. At the time of the contract is signed the services must be recommended in writing by the AR's physician as necessary to prevent the entry of the AR into a nursing home. The personal services that are compensated do not include or cannot include companionship or visits. Social Services will verify that the contract shows the type, frequency and duration of the services being provided to the AR or the AR's spouse and the amount of assets being transferred by the AR or the AR's spouse to the provider of the services.

**2.** **VA BENEFITS.** Department of Veteran Affairs ("VA") from time to time readjust benefits to eligible individuals on the basis of congressional appropriations. These budgetary amounts are changed by Congress. Individuals 65 and over who are eligible for veterans' benefits may seek care in a VA facility. Usually there are no costs to eligible veterans, but they must qualify for the type of care they seek. For these people care in a VA facility, no doubt, would be more economical than trying to pay for the services outside the VA system. The VA is allowed to recover reasonable expenses for medical charges incurred for treatment not related to a service-connected injury. For most priority groups (there are seven) the veterans are not responsible for paying VA charges that are not otherwise covered by their private medical plan. In the last priority group, there are income-based co-payments required. Enrollment in healthcare program through the VA is based on seven different priorities.

1. Veterans with service-connected disabilities who are rated 50%.

2. Veterans with service-connected disabilities who are rated 30% or 40%.

3. Veterans who are former POW's or were awarded purple hearts and have disabilities with 10% or 20%.

4. Veterans who will receive an increase in pension because of their need for aid and attendance.

5. Veterans who are determined to be unable to pay for care.

6. Veterans who are seeking care associated with toxic disorders of the Gulf war.

7. All other veterans who do pay co-payments.

The first five (5) priorities have a resource test. The basic health benefits of the VA include all types of immunizations, screening, primary healthcare, surgery, drugs and pharmaceuticals. Many of the VA facilities provide in-home primary medical care. Other benefits include nursing home care, domiciliary care, and out-patient geriatric.

The VA has two basic kinds of benefits, Compensation and Pension. Both are applied for on the same form (21-526), but only one kind will be awarded. The Veteran or their spouse should determine which is a better benefit.

The VA Pension provides benefits to any veteran over 65 yrs. of age who served in a war zone for 90 days and is disabled and not service related. Elder care attorneys should be familiar with the Aid and Attendance and Homebound

benefits which may benefit the veteran and spouse with cash payments. Those benefits are asset and income means tested, like Medicaid. Assets are generally limited to $80,000.00 (with exceptions) and the residence and automobiles are not counted as assets. There are no transfer penalties like in Medicaid rules. The maximum Aid and Attendance benefit for a married veteran is $1,843 in 2008. For more information please refer to www.veteranspension.com

**3. OTHER GOVERNMENT PROGRAMS.**

**a. Senior Tarheel Discount Card, Other.** A person over 60 may present two (2) forms of I.D. at the local aging service provider and receive a Senior Tarheel Discount Card. See Centralina Council of Governments 525 North Tryon Street, Charlotte, North Carolina (704-372-2416).

**b. Ombudsman.** In response to many nursing home problems, North Carolina passed the Long Term Care Ombudsman Program in 1976 and is part of the Older Americans Act passed by Congress in 1978.

All elder care practitioners should become familiar with their local elder care ombudsman. The ombudsman investigates and mediates disputes between the patient and the long-term care facility. The word "ombudsman is derived from a Swedish word ("umbodhsmadhr") that means an agent between a private citizen and a governmental entity.

In North Carolina, the Program is located in the Department of Health and Human Services, Division of Aging and Adult Services. The Regional Long-Term Care Ombudsman Programs are housed in seventeen (17) area Agencies on Aging. In Charlotte, contact Debi Lee (704-398-2714).

**c. Other.** While preparing for long-term care costs, if the aged is staying at home, don't overlook governmental and nonprofit help with meals, utilities and companionship, Health and Wellness Programs, Adult Care, Senior Centers, other related services. See NC CareLink which links to quality services and support facilities. (Also, see SHIP.)

**d. Adult Care Home Special Assistance for Adults.** In addition to Medicaid there is North Carolina State Special Assistance for Adults ("SA") which provides a cash supplement to help low income individuals residing in adult care homes (such as rest homes). Adult care homes, unlike skilled nursing facilities, do not require medical care although designated staff may administer medications. They generally provide personal care for bathing, eating, etc. Since October 1, 2005, there has been a designation for dementia and Alzheimer's within adult care homes. These are special care units and the homes are reimbursed at a different rate. Note this designation does not normally allow for qualification under Medicaid because there is insufficient finding of need for skilled care. Special assistance is limited only to those who have very low incomes. Assets are limited to the same standard for Medicaid, but income is more restrictive. A special assistance payment for an eligible individual can receive is tied to the maximum rate adult care homes can charge. Presently, that rate is $1,515.00. Thus, one would first have to deduct the amount of income of the eligible individual from $1,515.00 and that difference would be the amount of special assistance potentially available.

**e. Government Sponsored Long-Term Insurance.**

**1. The Federal Long-Term Insurance Program.** The Long-Term Care Security Act which became effective in September 2000, authorizes the federal government to negotiate with insurance companies offering long-term care insurance to federal employees and participants in the military. Included in the group and postal employees, all other federal employees and retirees and their spouses, current and retired military personnel and certain of their relatives. In addition, the State of North Carolina has a long-term care insurance program for their employees and retirees. The U.S. Office of Personnel Management ("OPM") has negotiated with Metropolitan Life Insurance Company and John Hancock Life Insurance Company to produce a group federal long-term insurance program (FLTIP). The OPM continues to regulate and oversee the program and regulate the premiums.

The current contract with these two insurers ends on April 30, 2009. OPM is in the process of selecting additional insurers. The federal government as the nation's largest employer is attempting to model for other employers and encourage them to develop their own long-term care insurance programs.

**2. Partnership Programs for Long-Term Care.**

**a. Robert Wood Johnson Foundation.** In 1987 the Robert Wood Johnson Foundation funded a study by Connecticut which concluded that when the insurers and the state work together, they can reduce the costs of Medicaid through the use of private long-term care insurance. The Foundation awarded similar grants to California, Indiana

and New York. In these states, the purchasers of long-term care policies can retain more assets than those from other states who qualify for Medicaid.

The Omnibus Budget Reconciliation Act of 1993, however, prevented the continued growth of partnership programs to other states. This is because OBRA 93 legislation required every state to recover the costs of nursing facility services from Medicaid recipients' estates. The result of this legislation effectively eliminated the asset protection incentive for the consumer to purchase the long-term care insurance through this partnership program. But in 2005 the program was lifted and now many states have such programs, but not North Carolina as of 2011.

**b. PACE.** Programs referred to as All-Inclusive Care for the Elderly (PACE) are optional benefit programs under Medicare and Medicaid. The PACE providers are not-for-profit private organizations that are engaged in providing care for the elderly whose combined comprehensive medical and social services that are generally provided at adult daycare centers or at home for those that otherwise would be forced to be institutionalized. The PACE programs are only available in a few states, but does include North Carolina. To be eligible you must be 55 years of age or older, in need of nursing home level of care, and reside in a residence that meets health and safety standards.

Medicaid pays a monthly fee to those enrolled in PACE.

As of December 1, 2008, there are only two organizations currently operating PACE programs in North Carolina. One is the Elder Haus of Wilmington, North Carolina which serves New Hanover and Brunswick Counties. The other is Piedmont Elder Services of Carrboro, North Carolina which serves Alamance and Caswell counties. St. Joe's of the Southern Pines has identified the Fayetteville area as their service region and they are scheduled to open in early 2010.

**4. Specific Medicaid Planning Strategies.**

**A. Use of Spousal Needs Trust.** This is a testamentary trust established in the Will of one spouse for the sole benefit of the other. It is often appropriate, especially when the surviving spouse currently or in the near future will need Medicaid. In many states a support standard would not allow for Medicaid qualification. Use a broad discretionary standard only consider using a trust protector that will allow for early termination. Remember, leaving all outright to the vulnerable spouse may disqualify her later for Medicaid. She cannot disclaim as it will be considered a sanctionable transfer. Simply bypassing the spouse is also problematic in that the Medicaid Program (DMA) expects the surviving spouse to seek his/her marital share. Again, this trust must be under the Will! (OBRA 1993.)

**B. Use Some Trust for Child or Disabled.** The same considerations except you can use a revocable trust as the creating force. Consider using the home site as the funding source as that is usually the only asset DMA seeks to recover.

**C. Consider Transfers by Single Person.** While the old "half a loaf" planning no longer works, a transfer to a spouse or disabled child does (42 U.S.C. §1396p(c)2).

Transfers to a disabled child are blessed transfers as is transfers to a child which meets the 2 year caretaker exception.

Transfer to a sole benefit trust will not cause a sanction, but query whether the assets in the trust are still "countable."

D**. Consider Transfers to Children.** After the gift, the children can create an LLC to invest the assets. The children can be the members. In this way, if any of the children die, become incompetent or divorce, the underlying assets remain intact. Similarly, transfer assets to a child who becomes grantor of a grantee trust for the benefit of children. The 5 year look back period will be out of play.

**5. MULTIPLE STRATEGIES TO FINANCE LONG-TERM CARE.** In concluding the development of a strategy for the payment of long-term care, it is readily apparent that no one strategy will work for every case, but as a disciplined strategy I would suggest:

One: Understand the primary concerns of the long-term care recipient as well as their family. What is the importance of retention of assets and control? How important is independence? How important is geography in terms of residence, and what is the realistic life expectancy and health, mental and physical of the recipient?

Two: The interview process must be conducted in such a way as to elicit all financial, health and social facts, so that not only the long-term care recipient, but their family fully understand their financial and health picture.

Three: The recipient and the family must have a thorough understanding of the various options to pay for long-term care. How much are they willing, and can they pay privately versus reliance upon government? How long a window is available in order to implement some of the strategies or utilize some of the options?

Four: Once there has been a thorough study of the tax and government programs, private insurance and self-financing alternatives, there needs to be a learning curve for the recipient, the advisor and, if appropriate, family members.

Five: A strategy must be implemented. The strategy should involve a commitment. There often is a plan A and a plan B. Any strategy should involve some flexibility that will allow for changes depending on the health of the recipient, changes in the state and federal law, or in the financial status – can the recipient or family still afford the strategy undertaken? Follow up within the same year is helpful and usually appreciated.

**Case Study.** Frederick (69) is married to Bertha (61). Both are mentally competent although Frederick has early stages of Parkinson's, but he is still getting about and even driving. Bertha is in excellent health and still works. They have two grown children of modest means. Both are concerned about paying for long-term care, want to control assets, and leave something to children.

Their assets:

| Assets | Value | Ownership |
|---|---|---|
| Home | $ 200,000 | Tenants by the Entireties |
| CD | 100,000 | |
| Stocks | 20,000 | |
| IRA | 215,000 | |
| 1999 Chrysler | 1,500 | |
| 2010 Lexus | 29,000 | |
| Whole Life Insurance | 150,000 death benefit | |
| | 40,000 cash value | |

Solution Alternatives:

| | |
|---|---|
| Long-term Care Insurance (*e.g.* CLASS) | Family Support |
| Life Settlement | Investment Returns |
| Medicaid/VA | Gifting |
| Annuities | Reverse Mortgage |
| Private Investments | Trusts |

Their Income:

| | |
|---|---|
| IRA Distributions | $ 500 |
| Social Security (Husband) | 1,2500/month |
| Social Security (Wife) | 600/month |
| Pension (Husband) | 600/month |
| Interest | 200/month |
| TOTAL: | $ 3,100/month |