Financing LTC

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Providing for Long-Term Care Needs

Relying on Family

In the past, when a person developed a loss in functioning, he or she was usually cared for by a family member. And course, this is still common today -- many people provide care to a spouse, an elderly parent, or another relative. But changes in society and in family structure are making this a less feasible solution for many people. Life expectancies are longer and families are smaller than in the past, so there are simply more elderly people needing care in proportion to the number of younger people available to provide it. There are also more single people and childless couples, so many people have no adult children to rely on. And while in the past many women did not work outside the home and were able to provide care, this is much less common today. Consequently, today when a person needs long-term care, there may be no family member to provide it. Or there may be one person who must take on the entire burden herself, or a married couple must try to raise their children, care for an elderly relative, and hold down full-time jobs all at the same time.

Self-Funding

Clearly then, many people need to receive long-term care services from paid personnel. Can they simply pay for these services out of their own income and assets? Because of the cost and the anticipated impact of inflation, this is difficult if not impossible for all but the wealthy.

Amber is 45 years old. She is concerned about her long-term care needs and has been told that if she entered a nursing home in her area today and remained there for two-and-a-half years (the average nursing home stay), it would cost her $150,000. But she does not expect to enter a nursing home anytime soon -- she wants to plan for her needs 30 years from now. Based on the recent past, her financial planner assumes an average annual increase in long-term care costs of 5 percent. At this rate, costs double about every 15 years, so the cost of two-and-a-half years in a nursing home in Amber's area 30 years from now will likely be about $600, 000. And this does not cover the home health care services or assisted living that Amber may need for months or even years before she enters a nursing home.

Of course, Amber has 30 years to save and invest. But still, it will take an enormous effort. And at the same time she must pay for current living expenses and save and invest for her children's college education and her own retirement.

There are other problems associated with paying for long-term care out of one's own financial resources. Even if a person is able to pay for the care she needs, in doing so she may deplete family assets. What then becomes of her surviving spouse? He may see his standard of living lowered or even be forced into poverty. And how will he pay for his own long-term care?

The use of personal assets to pay for long-term care may also mean that inheritances are not left to children and grandchildren. This is particularly troubling when liquidated assets include a family business or farm.

Finally, what if long-term care is needed sooner than expected? To return to the example of Amber, what if she plans to accumulate in 30 years an amount sufficient to cover her needs, but after only 15 years she suffers a debilitating illness and requires care? She will not yet have the necessary funds.

Self-Funding Options

Those who do not make plans to fund possible long-term care costs often end up having to pay for their care out of their own pockets because they have no alternative. Other people consciously plan to use their own income, savings, and assets to pay for care. Aside from savings accounts, stocks and bonds there are a few other funding sources self-funders can tap, including home equity, annuities, and life insurance policies.

Home Equity

The most important financial asset many older people have is home equity, the value of the home they own after any mortgage amount owed or other liability has been subtracted. The amount of home equity can be substantial, especially if the home was purchased many years before and the mortgage has been mostly or entirely paid off. In such cases, home equity can be an important source of funds to cover long-term care costs.

In the past, there were only two main ways of turning home equity into funds that could be used to pay for long-term care: selling the home or taking out a home equity loan. Each of these alternatives has serious drawbacks. Selling means leaving a longtime residence, and a home equity loan requires regular payments at a time when a person needs more income, not another expense. Fortunately, there is another method of drawing on home equity: reverse mortgages.

Reverse mortgages are typically available to those 62 and older. In a reverse mortgage, as in a conventional home equity loan, a bank lends money to a homeowner with the home serving as security. However, in a reverse mortgage, the homeowner does not have to make regular payments to the lender. Instead, the loan must be paid off only when the homeowner dies, sells the home, or moves out of the home.

Thus a reverse mortgage can be advantageous for an elderly person -- she can obtain funds from her home equity without having to worry about being able to make loan payments, as she would with a conventional home equity loan, and without having to leave her home.

The lender's payment to the homeowner can be made in a lump sum, in monthly payments,

through a line of credit to be drawn on as needed, or a combination of these. The amount a lender advances a homeowner depends on several factors, including the value of the home, the homeowner's age, the interest rate charged, the type of reverse mortgage, the payout method chosen by the homeowner.

For most types of reverse mortgages, the homeowner can use the money received for any purpose, including long-term care. However, reverse mortgages do have some limitations and disadvantages as a long-term care funding source. If the borrower leaves her home permanently, the mortgage must be paid off, and if she remains in an assisted living residence or nursing home for 12 months or more, she is considered to have permanently left the home; consequently, while a reverse mortgage can fund home care and short stays in a facility, it is not a solution for extended nursing home care. Also, a person taking out a reverse mortgage will substantially reduce her home equity, leaving her with less to rely on as a financial reserve and to pass on to her heirs. Finally, given the high cost of long-term care, the funds obtained from a reverse mortgage may not be adequate to cover costs.

Annuities

An annuity is a type of investment. The investor (called the annuitant) pays money to an insurance company and in return the insurer makes regular payments to the annuitant over a period of time. Depending on the type of annuity, this period may be for as long as the annuitant lives or for a limited, predetermined time. The amount of the payments made to the annuitant may be fixed and unchanging, or it may vary according to the performance of the investments the annuitant's money is placed in.

The payments from an annuity can be used to pay some of the cost of long-term care services. Alternatively, an annuity can be used in combination with long-term care insurance -- the annuity income pays for the premiums of an LTCI policy, and the policy covers the costs of care.

Unless a very large amount is invested in an annuity, the payments will cover only a portion of long-term care expenses. It should also be noted that annuities have costs and charges that can make them in some ways less attractive investment vehicles than mutual funds or individual stocks and bonds.

Life Insurance

A life insurance policy provides protection against the financial consequences of the death of an individual. If a covered person (an insured) dies while the policy is in force, the insurer makes a payment (known as a death benefit) to the beneficiary(s) designated by the insured. People purchase life insurance for various reasons: to ensure the financial security of a spouse, children, and other family members; to preserve an estate for heirs by providing money to pay estate taxes and settle outstanding debts; or to create an inheritance for a loved one or a charity.

Life insurance was not developed to meet long-term care needs. But a person can obtain money from her life insurance policy in various ways and use that money to pay long-term care expenses. However, as we will see, this approach has serious disadvantages and should generally be used only as a last resort by those who have no other options.

Accelerated Death Benefits

Accelerated death benefits (also known as living benefits) are payments of a portion or all of the death benefit before the death of the insured. For an insurer to pay accelerated death benefits, an event specified in the policy (a benefit trigger) must occur. In early versions of these benefits, the insurer paid only if the insured suffered from a terminal illness, and that is still a common triggering event. However, many policies have more flexible benefit triggers: diagnosis of one of several specified critical illnesses; permanent confinement to a nursing home; the need for extended long-term care (in a facility, at home, or in the community) because of an inability to perform a specified number of ADLs; and/or a cognitive impairment.

The amount available from accelerated death benefits varies according to the policy. That amount may be a fixed dollar figure or a percentage of the death benefit (50-80% is typical) .

Of course, monies advanced under the accelerated death benefit will reduce the benefits eventually paid to beneficiaries – and perhaps defeat the initial purpose of the insurance policy. Another problem is that most life policies are for relatively small amounts and the accelerated benefit may not cover long-term costs for an extended period of time.

Viatical & Life Settlements

In a viatical settlement, a terminally or chronically-ill insured (referred to as the viator) sells his life insurance policy to a viatical company. The viatical company pays the viator a lump sum for somewhat less than the policy's death benefit. In exchange the viatical company becomes the owner and beneficiary of the viator's policy, pays the premiums and eventually receives the death benefit after the viator dies.

This transaction has advantages for both parties. The viator gets money while he is still alive, which he can use for any purpose. The viatical company usually earns a profit because the lump sum it pays the viator (plus premiums) is typically less than the death benefit it receives after the viator dies.

Many states today permit life settlements as well as viatical settlements. The two are similar in that both involve the sale of a life insurance policy to a third party. But for a life settlement there is no requirement that the insured be terminally or chronically ill (although he must be elderly -- generally only applicants over 70 are accepted). The lump sum amount received is much lower than for a viatical settlement because the life expectancy of the insured is usually much longer.

The money obtained from a viatical or life settlement can be used for any purpose, including paying for long-term care services or LTCI premiums. Proceeds from viatical settlements are typically received tax-free; there may be tax consequences for life settlements.

Like accelerated death benefits, a viatical or life settlement defeats the purpose of life insurance; when the insured dies no death benefit is available for taxes, mortgage payments, or survivors. However, for a person in need of long-term care services and without other means of paying for them, these settlements may be an appropriate funding source.

Policy Loans, Withdrawals, and Surrenders

There are two types of life insurance. Term life insurance is in force for a limited, specified period (the term of the policy), and it pays a death benefit only if the insured dies during that period. Permanent life insurance, on the other hand, is designed to be in force for the entire lifetime of the insured. It generally remains in force until the insured's death unless he lets it lapse by failing to pay premiums.

While both term and permanent life insurance policies have death benefits, a permanent policy (but not a term policy) also accumulates a cash value. The cash value of a policy normally grows during the life of the policy as the insured pays premiums and those premiums yield investment earnings. An insured can access her cash value by means of a policy loan, a policy withdrawal, or policy surrender.

As with accessing the death benefit of a policy, accessing the cash value tends to defeat the purpose of life insurance by reducing or eliminating the benefit available to heirs, and the accumulated cash value is not usually sufficient to pay for long-term care for very long.

Medicare

Many people believe that the Medicare program will pay most of their long-term care expenses after age 65. Others think that Medicare supplement (Medigap) insurance covers most long-term care services not reimbursed by Medicare. Unfortunately, the benefits Medicare and Medigap insurance provide do not adequately meet long-term care needs.

Medicare Programs

Medicare is a federal healthcare benefits program. It helps pay for medical services (such as hospital stays and physician visits) of people age 65 and older, as well as some persons under 65 who are disabled or suffer permanent kidney failure (end-stage renal disease).

A Medicare beneficiary may choose the original Medicare plan or (where available) a Medicare Advantage plan. The original Medicare plan operates on a fee-for-service basis. Medicare reimburses health care providers who serve beneficiaries by paying them a fee for each service rendered. Beneficiaries can go to any physician, hospital, or other provider that accepts Medicare fees as payment. Beneficiaries must pay a deductible, and they also usually pay a portion of the cost of covered services in the form of copayments and coinsurance. The original Medicare plan has two parts:

- Medicare Part A primarily covers inpatient care in hospitals.
- Medicare Part B primarily covers physician services, outpatient hospital care, and some other medical services not covered by Part A.

Medicare Advantage (formerly Medicare-Choice, also called Medicare Part C) is a program under which private-sector health insurance plans provide coverage to Medicare beneficiaries. It consists of managed care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), as well as private fee-for-service plans. Medicare Advantage plans provide a benefit package comparable to Medicare Parts A and B benefits.

Finally, the Medicare Modernization Act created Medicare Part D, a new prescription drug benefit program that began operating in January 2006.

Medicare Eligibility

Those at least 65 years old and eligible for retirement benefits from Social Security, the Railroad Retirement system and some government employee retirement plans can enroll in Medicare Part A without paying a premium. Those 65 and over who do not fall into one of these categories can enroll in Medicare Part A, but they must pay a premium, (As a general rule, those who paid into the Medicare system during their working lives through payroll deductions -- the great majority of senior Americans -- do not pay a premium for Part A.) Medicare Part A coverage is also extended to persons of any age who are disabled or suffer permanent kidney failure (end-stage renal disease) and meet certain criteria.

Anyone 65 or over can also enroll in Medicare Part B, as can disabled persons eligible for Medicare Part A -- but all must pay a monthly premium. Because Part B covers important health care services not covered by Part A, almost all those enrolled in Part A choose Part B as well. Starting in 2007, the

Part B premium is adjusted according to the income of the beneficiary. Single persons with a modified adjusted gross income (MAGI) over $80,000 and couples with a MAGI over $160,000 will pay a higher premium than other beneficiaries. This increase will be phased in over five years.

Individuals enrolled in both Medicare Part A and Part B may opt for a private-sector Medicare Advantage plan instead. All Medicare enrollees may also enroll in Medicare Part D for an additional premium.

Medicare and Long-Term Care

The Medicare program was created to help pay the medical expenses of the elderly, and it primarily covers hospital and physician services. Medicare does provide limited benefits for nursing home care and home healthcare. But as we will see, these benefits do not meet the need for ongoing personal care or supervisory care, which is the focus of long-term care.

Nursing Home Coverage

A Medicare beneficiary can receive benefits for care in a skilled nursing facility provided all of the following conditions are met:

- The individual has had an inpatient hospital stay of at least three consecutive days within the last 30 days.
- The individual needs skilled care. The individual may require personal or supervisory care in support of skilled care, but if he needs only personal or supervisory care, he is not eligible for benefits.
- A physician has determined that there is a medical necessity for skilled care -- this means that skilled care is required for the diagnosis and treatment of a medical condition. In practice, benefits are paid to those who need care to help them recover from an acute illness or injury and regain normal functioning. Benefits are not paid to those who need care indefinitely to help them cope with a chronic impairment.
- The skilled nursing facility is certified by Medicare. (Most are, but not all.)

In those cases in which Medicare continues to pay benefits beyond 20 days, the beneficiary must make a daily copayment ($133.50 in 2009). And all benefits end after 100 days.

In theory, Medicare can pay up to 100 days of nursing home benefits. But in practice this does not often happen, as few people continue to meet the medical necessity requirement for very long. Most people recover from their injury or illness within a few weeks, so that care is no longer medically necessary. Others do not fully recover and become chronically impaired. These people also cease to meet the medical necessity requirement because they no longer need skilled care for the diagnosis and treatment of a medical condition, but instead need personal care to cope with their impairment.

Home Healthcare Benefits

Medicare Part A also pays benefits for home health care, but as with nursing home benefits, only if strict conditions are met:

- The beneficiary must need home care within 14 days after a stay of at least three consecutive days in a hospital or skilled nursing facility.
- A physician must certify the medical necessity of intermittent skilled nursing care or physical, speech, or occupational therapy. (Intermittent care is defined as less than eight hours per day of care, or fewer than seven days a week of care over a period of 21 days or less.) A need for only personal or supervisory care is not sufficient.
- The physician must certify that the beneficiary needs to receive care at home, and the physician must develop a plan of care.
- The beneficiary must be homebound -- that is, she must be unable to leave home, or doing so must require a major effort. When she does leave home, it must be infrequently and for a short time, and it must be for urgent purpose, such as to get medical treatment or to attend religious services.
- Care must be provided by a Medicare-certified home healthcare agency. (Many but not all agencies are Medicare-certified.)

If all these conditions are met, Medicare pays for intermittent skilled nursing care and therapy. In some cases other services and supplies required to support skilled care, such as home health aide services or durable medical equipment, may also be covered. Medicare pays the full approved amount for covered services, except for 20 percent coinsurance for durable medical equipment. However, there is a limit of 100 visits by home care personnel, and as with nursing home benefits, the duration of home care benefits is in practice severely limited by the medical necessity requirement. Like nursing home benefits, Medicare Part A home care benefits are designed to meet the needs of those recovering from an acute illness or injury, not those requiring long-term care to cope with a chronic impairment.

Medicare Part B provides the same home healthcare benefits as Part A and requires that the same conditions be met, with two exceptions:

- To receive Part B benefits, a person need not have had a prior stay in a hospital or a skilled nursing facility.
- Part B benefits are not limited to 100 visits. However, they are limited by medical necessity, and the physician may be required to periodically recertify that care is medically necessary.

In summary, Medicare does provide home healthcare benefits -- but only skilled care that is medically necessary. Consequently, few people qualify for benefits and even fewer qualify for more than a short time.

Medicaid

The Medicaid program pays for healthcare for the poor of all ages. Unlike Medicare, Medicaid provides extensive benefits for long-term care, but only to those who are impoverished. However, some people who are not poor when they first need long-term care are eventually able to rely on Medicaid to cover the costs of their care. They spend their assets and income on care until they have very little left, at which point they meet Medicaid's definition of poverty and qualify for benefits. This practice is called "spending down", and it is a viable means of meeting long-term care needs, but it has significant drawbacks, some obvious and others not so obvious, as we will see.

The Medicaid Program

Medicaid is a federal-state program. The federal government establishes broad guidelines for its operation, and each state administers its own program and determines, within these guidelines, eligibility criteria; the type, amount, and duration of services its program pays for; and rates of payment for services. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the benefits provided in one state may not be provided in another. In addition, state Medicaid programs may change from year to year in response to changing needs, fiscal constraints, or emerging problems. For information on a particular state's program, visiting the website of the National Association of State Medicaid Directors (www.nasmd.org), which includes links to state Medicaid websites.

Medicaid is jointly funded by the federal government and the state governments. In 2006 the federal government provided 50 to 76 percent of funds, depending on the state, with an average federal contribution of 59 percent; the states paid the rest.

Despite the disadvantages, many people end up relying on Medicaid to pay for their long-term care because they did not make other provisions. Approximately 60% of all nursing home patients receive Medicaid funding – and consequently Medicaid is the single largest payor of long-term care expenses in the U.S.

Medicaid Eligibility

In the simplest terms, to be eligible for Medicaid a person must be poor. But determining who is considered poor for purposes of Medicaid eligibility is anything but simple. There are many categories of eligible individuals, and as mentioned above, requirements differ from state to state, and they may change from year to year. What follows is a summary of the complex rules that apply in this area. Details of Florida's Medicaid program can be found in Appendix A and Appendix B

Some people are deemed "categorically needy" by Medicaid, that is, they are defined as poor and eligible for Medicaid benefits because they fall into certain categories. Most of these categories consist of children of low-income families and low-income pregnant women, so they are not normally relevant to long-term care. But a few categories include adults without dependent children, such as recipients of Supplemental Security Income (SSI). These are people with very low incomes (in 2009, no more than $674 per month for individuals, $1,011 for couples) who receive government assistance to help them maintain a minimal standard of living.

Most (but not all) state Medicaid programs also extend eligibility to some people who do not belong to one of the categorically needy groups but are considered “medically needy”. These are people whose income and assets were above the poverty level but have been depleted by medical or long-term care expenses. For a person to qualify as medically needy, the value of her financial assets must be below a certain level, and her income (or her remaining income after medical or long-term care expenditures) must also be below a certain level. These levels are known as eligibility limits. If a person's assets and income are above her state's eligibility limits, to qualify for Medicaid she must spend down -- that is, she must liquidate her assets and spend the proceeds on care until the value of the remaining assets falls below the asset eligibility limit, and she must spend almost all her income on healthcare or long-term care, so that the remaining amount falls below the income limit. Once she reaches the eligibility limits, she can begin receiving benefits for Medicaid-covered services.

Medicaid eligibility rules are applied somewhat differently to individuals who participate in a state long-term care partnership program. If their long-term care insurance benefits run out and they are forced to apply to Medicaid, they are allowed to keep some assets that others would be required to spend down. The specifics of partnership programs and how they affect Medicaid spend-down requirements are covered in detail later in this course. In this chapter we will focus on the standard rules that apply to most applicants.

The Deficit Reduction Act (DRA) of 2005, effective February 8, 2006, made significant changes in the rules governing Medicaid eligibility. These changes are highlighted in the discussion that follows.

Assets

The asset eligibility limit varies by state, but it is generally about $2,000 for an individual and $3,000 for a married couple. (For cases in which only one member of a couple is applying for Medicaid long-term care benefits, see "Spousal Impoverishment" below.)

Medicaid divides financial assets into two categories: countable assets are those that are considered in determining whether a person exceeds the eligibility limit, and noncountable assets (also called exempt assets) are those that are not. Countable assets include:

- cash, savings and checking accounts, and certificates of deposit;
- stocks and bonds;
- IRAs, Keogh accounts, and other retirement funds;
- trusts;
- the cash surrender value of life insurance policies with a combined face value greater than $1,500;
- items that may be converted into cash, including vacation homes, second vehicles, collectibles, and any other items not specifically listed as noncountable assets by Medicaid; and
- in some cases, the applicant's home (see below).

If the total value of a person's countable assets exceeds the eligibility limit, she is not eligible for Medicaid. To become eligible, she must spend all countable assets above the eligibility limit on care; illiquid assets, such as houses and vehicles, must be sold and the money spent on care.

Noncountable assets are not counted in calculating whether the eligibility limit is exceeded, and they do not have to be sold to pay for care. They include:

• household goods and personal effects, such as furniture and clothing;
• one automobile, regardless of its value, if its primary use is the day-to-day transportation of a household member;
• the cash surrender value of life insurance policies with a combined face value of less than $1,500;
• one wedding and one engagement ring;
• burial plots for the applicant and her immediate family, as well as burial funds for the applicant and her spouse; and
• the applicant's home, in most cases.

Medicaid's treatment of a person's home (her primary residence) is complex and has been modified by the DRA. The rules can be summarized as follows:

• If the applicant is living in the home and is not applying for payment of long-term care services, the home is noncountable, regardless of value.
• If the applicant is applying for long-term care benefits, the home is countable if the equity value is more than $500,000 (or $750,000, at the option of the state) unless a spouse, dependent child, or disabled child lives in it.
• If the applicant has left her home permanently to live in a nursing home, the home is countable, regardless of value, unless a spouse, dependent child, or disabled child lives in it.

In addition, in cases where a home is deemed noncountable and the applicant is not forced to sell it, a lien may be placed on it so that if it is sold, Medicaid must be reimbursed for long-term care benefits out of the proceeds.

Income

Many states also have income eligibility limits. Like assets limits, income limits vary from state to state, but in all states they are very low -- usually even lower than the income limits cited above for the Supplemental Security Income (SSI) program. Some states grant Medicaid eligibility to certain persons with incomes up to the federal poverty level (in 2009, $10,830 annually for an individual and $14,570 for a couple).

In calculating whether a person's income exceeds the eligibility limit, Medicaid counts all but the first $20 per month of unearned income, including Social Security benefits, other government and private pensions, veterans' benefits, workers' compensation, annuity payments, and investment income. Food stamps and certain other forms of public assistance and charity are not counted. (A portion of any earned income, such as wages or earnings from self-employment, is not counted, but this is of course not normally relevant to applicants in need of long-term care.)

Whether a state has income eligibility limits or not, if a person qualifies for Medicaid and enters a nursing home, almost all her income must be spent on care. She may retain only a small personal needs allowance (usually between $30 and $90 per month depending on the state) to cover items such as toiletries and reading material. In addition, any income used to pay health insurance premiums may be retained.

Spousal Impoverishment

The Medicaid eligibility rules explained above give rise to a question: If one of the spouses of a married couple needs long-term care and applies for Medicaid, must all the income and assets of the couple above the eligibility limits be spent on her care, leaving the spouse who does not need care with nothing to live on?

Medicaid rules have evolved to prevent spousal impoverishment -- that is, to ensure that the spouse who remains at home (called the community spouse) retains a reasonable amount of financial resources. States may also apply these rules when a person does not enter a facility but needs home healthcare or community-based care, but for the sake of simplicity, we will refer here only to the "nursing home spouse." These rules are complex, and we will summarize them.

Spousal Income

If a community spouse has income of his own, he retains that income and does not have to spend it on his spouse's nursing home care. If the community spouse has little or no income of his own, some of the income of the nursing home spouse is set aside for his use and is not required to be spent on care. Specifically, the spousal impoverishment rules provide for a minimum monthly maintenance needs allowance (MMMNA) for the community spouse (In 2009, the MMMNA is $1,821.50 except in Alaska and Hawaii). The MMMNA works in this way:

- If the community spouse has no income of his own, he receives the entire MMMNA amount from the income of the nursing home spouse.
- If the community spouse does have some income of his own, he receives an amount from the income of the nursing home spouse necessary to bring his income up to the MMMNA level.
- If his own income is greater than the MMMNA, he receives nothing from the income of the nursing home spouse.

Jane and Ted are a married couple. Ted enters a nursing home and is expected to remain there indefinitely. They apply for Medicaid. Jane receives $700 a month from a trust left her by a relative but has no other income of her own. Assuming the applicable MMMNA is $1,900, Jane is allowed to retain $1,200 of Ted's monthly income, which added to her $700 of trust income giving her a total monthly income at the MMMNA level of $1,900.

If there are other family members living in the household in addition to the community spouse, a family monthly income allowance is allotted to them in a similar way.

Spousal Assets

In general, a couple must spend all its countable assets in excess of the eligibility limit on the care of the nursing home spouse, except for a protected resource amount (PRA) reserved for the community spouse. (All noncountable assets are of course retained by the couple.) The amount of the PRA is set by each state within federal guidelines. All states must allow the community spouse to retain all countable assets up to a minimum amount ($21,912 in 2009). States have the option of also allowing the community spouse to keep half of assets in excess of the minimum up to a certain limit. This limit cannot be higher than a federal maximum ($109,560 in 2009), but states may set a lower level -- for example, a state might let the community spouse retain half of the couple's assets up to $50,000.

In addition, if the entire income of the nursing home spouse is allotted to the community spouse and this is insufficient to bring the community spouse's income up to the MMMNA level, the community spouse may retain enough of the couple's assets to generate enough income to reach the MMMNA level.

Transfers of Assets

Some individuals do not "spend down" their assets to the Medicaid eligibility limit, instead, they give them to family members or others. In some cases, the donor continues to access the assets through the cooperation of relatives, or at least to enable others to benefit from them.

Medicaid rules addresses this practice Medicare recipients transferring assets for less than their value (assets are given away or sold for less than they are worth) or more commonly, by a person before she applies for Medicaid. This rule applies to recent gifts or transfers prior the Medicaid application date, during the so-called "look-back period". Under the DRA, the look-back period for transfers made on or after February 8, 2006 is now 60 months (five years). For most transfers made before that date, the old look-back period of 36 months (three years) still applies. The look-back period for transfers involving most trusts has been, and remains, 60 months.

If a Medicaid applicant transferred assets during the look-back period, Medicaid benefits will be withheld for an amount of time referred to as the penalty period or disqualification period. The length of the penalty period for nursing home care is determined in this way: The value of the transferred asset is divided by the state's average monthly private-pay rate for nursing facility care. (This rate is set by each year by the state based on charges to private patients within the state.) The result of this calculation is the number of months that Medicaid benefits are withheld. This forces the Medicaid applicant to pay long-term care costs out of his own pocket roughly equal to the amount of the improperly transferred asset, which generally makes the transfer financially disadvantageous. There is no limit to the length of a disqualification period.

Karl gave assets worth $90,000 to his children five months before entering a nursing home and applying for Medicaid. This transfer falls within the look-back period, so benefits must be withheld. The $90,000 is divided by the monthly private-pay rate (in his state $4,500), resulting in a 20-month penalty period - - that is, Karl must pay for nursing home care out of his own funds for 20 months. (And since nursing home costs will probably increase over these 20 months, Karl may actually pay more than $4,500 toward the end of the penalty period and as a result spend a total of more than the $90,000 he transferred to his children.)

Before the DRA (and this rule still applies to transfers made before February 8, 2006), the penalty period began the first day of the month in which me transfer occurred, leaving a loophole in the transfer of asset rules.

In January 2005 Jerry gave $50,000 to his daughter. Fourteen months later, in March 2006, he entered a nursing home and applied for Medicaid. This transfer fell within the 36-month look-back period, and in theory Jerry was subject to a penalty period of 10 months (based on his state's average monthly private pay rate of $5,000). However, this penalty period began on the first day of the month in which the transfer occurred -- January 1, 2005 -- and ended 10 months later, on October 31, 2005. So in fact, the penalty period had already elapsed by the time Jerry applied for Medicaid, and he suffered no penalty. (If he had applied earlier, say in June 2005, he would have been subject to a penalty period, but only up to October 31, 2005.)

Under the DRA, for transfers taking place on or after February 8, 2006, the penalty period begins on the first day of the month in which the Medicaid applicant enters a nursing home and otherwise meets Medicaid eligibility requirements.

In January 2007 Jane gives $50,000 to her son. Fourteen months later, in March 2008, she enters a nursing home and applies for Medicaid. This transfer falls within the look-back period, and Jane is subject to a penalty period of 10 months (based on her state's average monthly private-pay rate of $5,000). This penalty period begins on the first day of the month in which Jane enters the nursing home and qualifies for Medicaid -- March 1, 2008 -- and ends 10 months later, on December 31, 2008. So Jane, unlike Jerry, will have to pay for her nursing home care for 10 months.

Certain types of assets transfers are permitted. These include transfers to a spouse, or to a third party for the sole benefit of the spouse; transfers to certain disabled individuals or to trusts established for those individuals; transfers for a purpose other than to qualify for Medicaid; and transfers where Medicaid determines that imposing a penalty would cause undue hardship.

Estate Recovery

As we've seen, a Medicaid recipient is allowed to retain noncountable assets such as his home, as well as countable assets up to the eligibility limit. When a recipient dies, he leaves these assets in his estate, and Medicaid generally seeks to recover from the estate the money it paid to the recipient in benefits. This is referred to as estate recovery, and it normally applies to recipients in nursing homes and to those who began receiving benefits for home-based and community-based care after age 55.

Upon death, Medicaid may recover assets left by the decedent in his probate estate -- as well as jointly held property that passes automatically to the surviving joint owner or property held in a trust. Medicaid may not recover a decedent's home before the death of a surviving spouse, and in some cases the home may be protected from recovery and preserved for surviving children or siblings. For example, in some states, homestead provisions protect a primary residence from creditors, including Medicaid, and allow it to pass to heirs unencumbered. The states differ considerably in how they administer Medicaid estate recovery and how estate recovery provisions interact with state probate laws, so there is much variation in what assets different states actually recover.

Medicaid Benefits

For those who qualify for Medicaid, the benefits provided are extensive. Benefit provisions vary from one state program to another, but federal guidelines require all states to provide a minimal benefit package, including hospital inpatient and outpatient care, physician care, and many other services. In the area of long-term care, all states are required to pay for nursing home care, and they must also pay for home healthcare for those who are "nursing home eligible" (those who would need nursing home care if they did not receive home care). And although federal guidelines do not require it, an increasing number of states also pay benefits for home and community-based services. These services may include personal care, home health aide services, rehabilitation, therapies, respite care, adult day center care, homemaker services, and other services. In addition, a few states pay for long-term care services received in an assisted living residence.

Unlike Medicare, with its highly restrictive conditions for payment of nursing home or home care benefits, Medicaid generally meets the need for long-term care (for those who qualify). Medicaid pays benefits for personal and supervisory care even if skilled care is not also needed, and the program covers ongoing care needed to cope with a chronic impairment, not just care required for a short time to facilitate recovery from an acute illness or injury. However, there are some important limitations to Medicaid long-term care benefits:

- Medicaid coverage of home and community-based services, while expanding, is still limited. Not all states extend this coverage beyond the federally required home care for recipients who are nursing home eligible. In states that do provide such coverage, eligibility may be restricted and funding is often limited. • While a few states offer benefits for care in an assisted living residence, they generally pay only for long-term care services (such as assistance with ADLs), not for room and board.
- Medicaid covers nursing home care only if it is provided in a Medicaid-certified facility. (Most nursing homes are Medicaid-certified, but not all.)

The Disadvantages of Relying on Medicaid

For the poor, Medicaid is usually the only way to meet long-term care needs. Those who are not poor but are considering spending down in order to obtain Medicaid benefits should be aware of several disadvantages to this approach.

Spending down generally leaves a person with extremely limited assets and income and results in the loss of financial independence. An elderly person who has worked hard and been self-supporting her whole life becomes indigent and must depend on the government for her needs. Spending down also means that hard-earned assets cannot be used for such purposes as helping grandchildren go to college, and they cannot be left to heirs.

In addition, the types of long-term care available to a Medicaid recipient are often limited. Benefits for home and community-based services are not offered everywhere, eligibility for them may be restricted, and funding is generally limited. And only a few state programs pay benefits for care in assisted living residences. Consequently, some Medicaid recipients who could be cared for at home are forced to enter a nursing home.

Finally, a Medicaid recipient may have a more limited choice of long-term care facilities, and the facilities generally considered the most desirable may not be available to her. High-quality nursing homes can easily fill their beds with higher paying non-Medicaid patients, so they do not accept Medicaid recipients. Nursing homes that do admit Medicaid patients often assign only a limited number of beds to them, and the most popular of these facilities often have long waiting lists for Medicaid recipients. Consequently, Medicaid recipients often end up in facilities that, although certified by Medicaid and perfectly adequate, are found by others to be less desirable for various reasons. Another consideration is that, if fewer facilities are open to a Medicaid recipient, she may have to go wherever a bed is available, which might be distant from her family and friends.

In summary, those who rely on Medicaid to meet their long-term care needs lose their assets and their financial independence and often have limited choices of types of care and facilities.