

ALERT: IMMEDIATE CHANGES TO MEDICAID

Special points of interest:

- **Drastic changes to Medicaid will occur in July, 2007**
- **Many Michigan residents will not qualify for Medicaid under the new rules**
- **Long term care insurance may be an important part of your estate plan.**

I. Introduction

The basic framework of Medicaid is to provide medical care for indigent persons throughout the country. Medicaid is a federally funded program that is administered by the states. The federal government sets minimum standards that must be implemented by the states in order for them to continue to receive Medicaid funds. Exactly how the federal standards are implemented varies from state to state.

Most people will tangle with the labyrinth of Medicaid rules in the context of nursing home care. Medicaid is the primary source of funds to pay for long term nursing care for those persons who cannot afford the cost of care themselves. Medicaid is certainly not just for "poor" people since the average cost for nursing home care is nearly \$6,000 per month and rising.

The purpose of this article is help you understand the basic eligibility rules for Medicaid so that you can appreciate the scope of change that is taking place in this area of law. These changes will affect tens of thousands of residents in Michigan, and countless more family members.

Last year, the federal government

passed the Deficit Reduction Act (DRA) which contained sweeping changes to Medicaid. Michigan regulators are just now beginning to implement the changes required by the DRA, and full-scale implementation will begin to occur on July 1, 2007.

II. Medicaid Eligibility

Medicaid eligibility is based on upon a person's *assets and income*. In order to receive Medicaid benefits, a person must meet both the asset and income eligibility rules. However, in this article, we are going to concentrate on the *asset* rules since this is the area of greatest change, and is likely to affect the most people. To further simplify things, we are going to limit our discussion to the eligibility rules for a *single* person, rather than a married couple. The rules are slightly different for married persons, but the concepts are the same.

The first step to determine whether a person is eligible for Medicaid based on assets is to divide their property into *exempt* and *non-exempt* categories. *Exempt* assets are those items that are not considered in the calculation to determine Medicaid eligibility. In other words, you can own exempt

assets of any value and still qualify for benefits. On the other hand, *non-exempt* assets are considered for Medicaid eligibility, and must be spent down to \$2,000 before a person may qualify for benefits.

Exempt assets include a personal residence, automobile, certain cash-value life insurance contracts, income producing property with a net return of at least 6%, prepaid funeral contracts, household goods, and several other categories of assets. Non-exempt assets generally include liquid financial assets that can be used immediately to pay for nursing care. In order to be eligible for Medicaid, a single person cannot own more than \$2,000 in non-exempt assets.

Most people can easily understand the concept of asset eligibility. No one would deny nursing home care to a person who has spent their life savings down to \$2,000, and now needs public assistance. But what happens when a person has *given* away his or her assets and has nothing left? Are they also entitled to benefits at public expense? What about the person with \$1 million in exempt assets – should they also receive assistance?

You can see the problem. Many lawyers and financial planners have made a career out of helping people qualify for Medicaid in a way that is not necessarily favorable to public treasury. The government is now closing many of the “loopholes” favored by planners.

III. Divestment

Any transfer of property for less than fair market value (i.e. a gift) is referred to as a *divestment* for purposes of Medicaid. The concept of divestment is the key to understanding Medicaid eligibility. So, just remember that **divestment is giving away property for less than its fair market value.**

When Medicaid was first enacted in the 1960's, there was no prohibition against divestment. You

could give away everything you owned, and be immediately eligible for Medicaid. However, as the costs of Medicaid soared, states were required under federal law to deny Medicaid eligibility to persons seeking nursing home care who made gifts to qualify for Medicaid.

The penalty for divestment is to disqualify the gift-giver from Medicaid eligibility for as long as the gifted money would have paid for his or her nursing home care. This penalty applies to transfers made at the time of application, and to transfers made within a “look-back” period of 36 months.

The method to calculate the divestment penalty is simple in theory: divide the total amount of a divestment by a *divestment divisor*. The resulting number is the number of months that a person will be ineligible for Medicaid assistance. The divisor is set by the government and is equal to the average monthly cost of nursing home care in the state.

For example, if the divisor is \$5,500, then a divestment (i.e. gift) of \$100,000 made within 3 years of the of the application for Medicaid would result in a “penalty period” of 18 months ($\$100,000 / \$5,500 = 18.18$) during which the applicant would be ineligible for Medicaid.

Under current regulations, the divestment penalty period begins to run when the gift is made. In other words, if a person made a \$100,000 in December, 2004, then he or she may qualify for Medicaid in June, 2006, because the penalty period would run for 18 months from the date of the gift.

The divestment penalty seemed like a good way to prevent people from giving away property to become eligible for Medicaid. However, it contained an enormous loophole for Medicaid planners.

The problem lies in the fact that the divestment penalty period begins to run when the gift is made. This means that a person with \$200,000 in liquid

assets can give away \$100,000 and still be eligible for Medicaid 18 months later. The reason is that while they are waiting for the divestment penalty to expire on the \$100,000 gift, they can use the remaining \$100,000 to pay for their own care. By the time the divestment penalty has expired, they would have spent their liquid assets down to less than \$2,000 and become immediately eligible for Medicaid. This sort of planning was done all the time, and is not exactly what the government had in mind. The DRA changes everything.

IV. Changes Imposed by the DRA

The following changes to the Medicaid eligibility rules will take effect on July 1, 2007:

1. **Look Back Period.** The look-back period is increased from 36 months to 60 months. This means that all divestments made within 60 months of applying for Medicaid may result in penalty period. It also means that an applicant (or spouse) now will be required to provide 5 years worth of financial records to support the application. This could be a significant burden for persons who have diminished capacity.

2. **Start Date for Divestment Penalties.** The start date for divestment penalties is the real issue under the DRA. Under the old divestment rules, the penalty period started from the date that a divestment was made. The DRA moves the start of the penalty period forward to the date when:

1. A person is actually in a nursing home; and
2. Has applied for Medicaid; and
3. The application otherwise would have been approved, except for the imposition of the transfer penalty.

To make matters worse, this change will be imposed retroactively to February 8, 2006, when the DRA was passed. As a result, persons who intend to apply for Medicaid cannot continue to divest assets and hope to qualify for benefits. The state has

not yet written regulations to deal with gifts to charitable organizations.

Under these new rules, if a person gave away \$50,000 (in any combination of gifts) within 5 years of needing care, he or she would incur a penalty period of 9 months (using the current divestment divisor). However, the penalty period would not begin to run until the person was actually in a nursing home, and had applied for Medicaid, and had received approval from the Medicaid agency that he or she met all the requirements of Medicaid eligibility except for the imposition of the transfer period. Therefore, somebody would have to come up with \$50,000 to pay for the person's care until he or she becomes eligible for Medicaid.

Another example will illustrate the impact of these changes: A Medicaid applicant gave \$4,000 to his grandson for college in each of the last 4 years, and he paid \$7,500 for his daughter's car three years ago. The sum of these transfers is \$22,700, and would make no difference to his Medicaid eligibility under the old rules. Under the new rules, this amount would result in a penalty of four months, and one day, beginning only when the applicant actually enters a nursing home and applies for Medicaid.

3. **Annuities.** The purchase of an annuity must meet certain requirements, or be treated as divestment.

- a. The DRA requires the state to be named as the first beneficiary of the annuity, and the State is entitled to repayment up to the total Medicaid provided to the annuitant. Michigan has elected not to impose this requirement at the present time. However, it may elect to do so in the future.
- b. The annuity must be irrevocable and non-assignable;
- c. The annuity must be actuarially sound, which means that it must be based upon an approved life expectancy chart.

d. Payments must be made in equal amounts during the term of the annuity, without deferral and without balloon payment made at the end.

e. The DRA requires all Medicaid applicants or recipients (and spouses) to disclose any interest the individual or spouse has in an annuity, regardless of whether the annuity is irrevocable or is treated as an asset.

4. **Limit on Homestead Value.** An applicant's equity in his or her house may not exceed \$500,000 and remain exempt. Equity in excess of \$500,000 would have to be spent down to qualify for Medicaid. Presumably this could be accomplished with a reverse mortgage.

5. **Income Producing Real Property.** Real estate owned by an applicant that produced a net return of 6% was exempt for purposes of determining Medicaid eligibility. Beginning July 1st, it will be considered non-exempt and subject to spend down.

6. **Prepaid Funeral Contracts.** Buying a prepaid funeral contract was a common divestment technique, and did not affect eligibility for Medicaid. These contracts are no longer considered exempt assets.

These changes will reduce the number of people eligible for Medicaid, and will certainly delay eligibility for many more. That leaves only personal savings, family members, or insurance to pay for nursing care – and having sufficient means to pay for nursing care is the key to gaining entry to the best facilities.

V. Long Term Care Partnership Program

The DRA also allows all states to implement a "Long Term Care Partnership Program". These programs were formerly limited to California, Connecticut, Indiana and New York. Michigan has not yet enacted such a program, but may do so in the future.

Participants in the Long Term Care Partnership program can qualify for Medicaid without spending themselves into poverty. To participate in the Partnership, you must:

1. Buy a long term care insurance policy under the program, and
2. Live in the state while receiving long-term care services, and
3. Receive and exhaust the benefits under the policy for long-term care services.

What's the benefit of participating in the Partnership? Participants can apply for Medicaid benefits without using all of their own assets. Each dollar paid by the insurance company is a dollar of assets they can keep in addition to the minimums permitted by the state's Medicaid rules.

For example, suppose the long-term care policy has paid \$50,000 in benefits; in that case, the insured person can keep \$50,000 in investments or savings and still qualify for Medicaid. Without a Partnership long-term care policy, they would have to spend virtually all of that \$50,000 before becoming eligible for Medicaid.

Long term care insurance may now be more important than ever – especially if Michigan enacts a Long Term Care Partnership Program. Can you afford to wait until Michigan enacts such a program? Maybe, but you may not qualify for insurance at that time, and you may not be able to afford it.

There are many more changes that will be implemented in July, 2007, but they are beyond the scope of this article. Planning techniques to qualify for Medicaid have been reduced, but many may still be available. The new regulations have not even been issued yet, so more changes may be forthcoming. I will keep you posted. JPT.



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