

# The Consumer s Guide to Medi-Cal LTC Eligibility

F. Bentley Mooney, Jr.

## Disclaimer

This monograph is intended to convey information by which you may better understand the legal issues affecting your business and personal life. It is not intended as *personal* legal advice. Personal legal advice may be provided only after an examination of your objectives and of the pertinent facts and law.

## Introduction

Herman pushed open the glass double doors of the doctor s office, stepped out into the fading colors of dusk, then hesitated by the steps leading to the parking lot. The voice was bouncing through his head like a bad commercial: I m sorry, Herman. She has Alzheimer s Disease. You can keep her at home for a few more months, but then she ll need long term care. You d better budget four or five thousand dollars a month, because those places don t come cheap.

Herman s hand gripped the bannister with a slight tremor. I just retired six months ago. One cruise, then this! We had so many plans. And how can I add four or five thousand dollars a month to our living expenses?

In the mid-1980s, Congress became aware that many -- one out of six Americans -- work hard, live frugally, and succeed in establishing a dignified standard of living as retirement age approaches, only to have that independence destroyed by the costs of long term care. To reach out to those left penniless by this *blitzkrieg*, Congress added several provisions -- optional to the states -- by which to become eligible for long term care under Medicaid without total loss of economic security. These provisions authorize certain transfers and do not count certain resources. The new provisions were added expressly to permit eligibility without spend-down, even permitting avoidance of lien recovery for benefits paid.

All levels of government experienced continuing budgetary stress over the 15 year period ending in the late 1990s. During that time, characterization of these broken seniors shifted from "fine Americans, humbled by unfortunate circumstance" to "greedy geezers feeding at the public trough." *But Congress saw fit to leave the eligibility planning rules in place.* We must therefore assume that the criticism is for public consumption while the *real* policy remains one designed to meet these serious social needs.

Platitudes are inadequate and unappreciated. After all, the economic survival of your loved one is at stake! Find the solution!

## Scope of the Problem, Trend

Medicare provides acute care and limited benefits at the skilled and intermediate nursing home level. It leaves wholly unaddressed the enormous costs of long term care.

The terms used to describe *levels* of long term care are *skilled*, *intermediate* and *custodial*. They represent descending levels of medical services intensity. *Skilled* nursing facilities are those for which patients require registered nurses for at least two shifts daily to provide medication and emergency medical attention. *Custodial* care facilities are those for which patients *do not* require that level of attention from registered nurses, but *do* require assistance with dressing, bathing, eating, etc. *Intermediate* care facilities provide elements of both. But most facilities have dropped their intermediate licenses, because reimbursement from Medicare and Medicaid is near those for custodial services; intermediate care cannot be provided at a profit in the absence of private resources to make up the difference.

Medicare pays less than 2% of long term care costs nationally, insurance even less. As a result, the costs of long-term care are paid mainly from *savings*, reducing thousands of people to abject poverty every year.

The cost averages about \$40,000 a year, and in most larger cities ranges from \$36,000 to more than \$70,000. As far back as 1981, the cost of long term care nationally was \$24 billion. The number of Americans over age 64, the primary users of these services, jumped from 29.9 million in 1983 to 35.3 million in 1990; 40.1 million were over 64 by 2000 and 66.3 million will be there in 2025. From 1985 to 1995, the revenues of long term care facilities grew at a rate of only 3% per year, while the older population grew by 1\_% per year in the same period.<sup>1</sup> The number of long term care facilities, though, dropped by 23% This resulted in larger, consolidated long term care facilities, most of them operated by chain organizations. Since 1985, the length of long term care stays is down, and most facilities now serve *niche* markets; e.g., post-hospital care, rehabilitation, ventilator care, etc. In short, care is moving in two directions: rehabilitation, and long term care of the profoundly disabled.

Of the roughly 40 million Americans over age 64 in 2000, nearly six million need -- or *will* need -- long-term care, according to the National Center for Health Statistics.

Complicating all this is the situation facing the baby boomers, now often referred to as "the sandwich generation." These are the first to face the need to help parents for whom government programs may prove inadequate, and at the *same* time be required (or expected) to assist children through school and in getting started in life. With baby-boomer wives as well as husbands employed outside the home, few of them can stop work to care for an enfeebled parent.

If *Medicare* will not pay for long term care, and *insurance* is inadequate, unaffordable or unavailable, where do we turn to avoid the prospect of becoming both an economic and an emotional burden for our children as we grow older? We turn, from necessity, to *Medicaid*. While Medicare provides almost nothing for this category of expense, Medicaid can be all you need.

## Other Options

One thing we cannot escape is that Medicaid — or *Medi-Cal* as the California adaptation of the program is called — is *welfare*. It is means-tested, and implies a certain loss of dignity. Therefore, if a useful alternative is available, we should *consider* it.

**LTC Insurance.** Long term care insurance was first made available in the late 1970s. The insurance companies' early *experience* taught them that underwriting this business requires caution in every respect.<sup>2</sup> Most applicants were found to be over 70 years of age and already showing signs of debilitating disease. Because the insurance companies cannot operate profitably by insuring people clearly about to become claimants, premiums for full coverage quickly jumped to unaffordable levels. Those premium levels were held down only by waiving coverage for pre-existing conditions. Private insurance remains, though, one of the most promising vehicles for spreading the costs of long-term care widely enough to economically meet the requirements of those in need.

California offers its *California Partnership for Long Term Care*. It sets feature and quality standards, along with fair pricing levels for this kind of insurance, *and* for adult day care, in-home, board and care and assisted living. The incentive offered is a liberalized Medi-Cal Property Reserve, increasing the value of assets the Applicant may retain while on Medi-Cal by a sum equal to the aggregate insurance benefits.

**Life Insurance Arrangements for Nursing Home Care.** Given a promising new market, insurance industry ingenuity knows few human limits. For example, First Penn-Pacific Life Insurance Company and others are approved in California to sell a life insurance policy that pays nursing home expenses from *death* benefits, without having to first *die*. There is no requirement that you first be admitted to an acute care facility in order to start the benefits. 100% of the face amount is available and there is no waiting period.

**Cash Accumulation Plans.** Cash accumulation plans range from reserving a specific fund of cash for long term care, to special *purpose* plans. Among the former are IRAs, annuities and home equity conversions. Among the latter are Individual Medical Accounts and VEBAs -- Voluntary Employee Benefit Associations. Here are some short descriptions:

— IRAs are creatures of federal tax law, used for tax-favored accumulation of cash during the working years. They are structured as trusts or custodial accounts for the exclusive benefit of the

account holder and beneficiaries.<sup>3</sup> IRAs can be established by contributions, or by the rollover of sums received from qualified plans or other IRAs. Non-rollover contributions are limited to \$2,000 per year, and are deductible for income tax purposes if the account holder is not a participant in a qualified retirement plan. A penalty applies to distributions made prior to attaining age 59½, and distributions have to begin the year after turning age 70½.

— **Roth IRAs** are another form of IRA.<sup>4</sup> Annual contributions are *also* limited, but they are not deductible.<sup>5</sup> The advantage of the Roth IRA is that, unlike a regular IRA, qualified distributions are completely excluded from taxable income,<sup>6</sup> there are no required distributions, and in fact, you can continue to contribute to the account after age 70½.

— **Annuities** and life insurance without the long term care feature mentioned a minute ago, fall into the same designated-fund category as IRAs and Roth IRAs. The problem is that the savings accumulated are generally too small to be useful. A survey conducted in 1984 jointly by the American Council of Life Insurance and the Life Insurance Marketing and Research Association disclosed that the median amount of life insurance (death benefit, not cash value) was only \$13,000 for men and \$5,000 for women. Cash surrender values are generally less than one-half the death benefit, sums that hardly begin to fund long-term care costs.

— **Home Equity Conversions** are financing transactions intended to liquidate the equity while permitting the homeowner to continue living there. The most discussed transactions are reverse mortgages and sale-leaseback arrangements. In the reverse mortgage, the lender pays monthly installments to the owner, and the installments are secured by a deed of trust on the home. The aggregate installments are limited to the usual percentage of value in more typical real estate loans, and have to be repaid or renegotiated when the owner lives out her life expectancy or on sale of the property, whichever first occurs.

In the sale-leaseback, the owner sells the property to an investor and leases it back for a term usually measured by the owner's life expectancy. The lease payments and carrying costs can affect the price, depending on whether it is higher or lower than market rates.

A similar transaction is the sale of a *remainder* interest, with the purchase price taking into account the ongoing maintenance costs carried by the seller as holder of the reserved life estate.

— **The Medical Savings Account** is aimed precisely at funding medical expenses. Contributions are deductible in a manner similar to IRAs. Interest earnings are tax-deferred until the account holder reaches 65. There is no penalty on withdrawal so long as the distribution is to pay for some *health* care expense. There is no contribution offset for participation in IRAs or qualified plans, and maximum annual contributions are \$1,462 for an individual and \$3,375 for a family.

VEBAs are *employer*-sponsored accumulation vehicles, so I will not spend any time on them.

**Other LTC Financing Vehicles.** Among the remaining means of financing long-term care costs, *two* stand out: *Social/HMOs* and *life care communities*.

These organizations provide *services*, rather than *indemnity* payments to other health care providers. Since they provide both the costs and the *services*, it is in *their* interests to operate economically.

— **Social HMOs** provide a package of medical and long term care services, enlarging (to the extent of long-term care) the benefits available under Medicare. The members pay a monthly fee, most of which is reimbursed by Medicare. While enrolled in the Social HMO, members must receive all their hospital and medical services through that provider.

Supporters of the Social HMO approach contend that they can allocate needed health care services to their members humanely and efficiently, that they can prevent *overutilization* by serving as both provider and gatekeeper, and that their case management approach permits better management.

— **Life Care Communities** are also known as *continuing care communities*. They provide not only the hospital, medical and long-term care obtainable from Social HMOs, but *housing* as well. This package of services is provided in exchange for an entrance fee (generally ranging from \$7,500 to \$100,000) and monthly *service* fees (generally ranging from \$1,000 to \$3,000).

Most life care communities are organized in housing complexes of 200 to 250 units. They include in the package: emergency medical care, long term care, meals, recreational programs, transportation and *other* services. New members are generally able to walk and care for themselves in their own apartment or townhouse. As physical condition begins to deteriorate, they are moved to assisted living or long term care sections for higher levels of care.

The entrance fee was largely non-refundable in the early years. These days, it is refunded *pro rata* for death or departure in the first five years.

Life care communities offer quite a few advantages: a positive social environment, organized activities and lifetime residential and health care. Because only people in good health view life care communities as a sound financial move (believing they will live long enough to beat the system), residents are generally in better health and live longer than their non-resident peers.

Social HMOs, life care communities and other service programs not yet conceived, offer important potential for effectively meeting public needs for long term care. Today, their case management approach is a proven *method* for providing extended care *economically*, in a risk-

sharing, prepaid mode of operation.

### ***Avoid Medi-Cal if Possible***

People spend their working lives preparing to retire at a dignified standard of living. Where possible, planning for long term care should be conducted with that same goal in mind.

That goal may not matter much if *finances* dictate the choices, or if the mental condition of the disabled loved one is such that *no* luxury can be appreciated; but where there *is* a choice, consider avoiding Medi-Cal altogether: the planning requires asset transfers that can be disturbing to the disabled person; and the anxiety is compounded by moving from familiar surroundings into a long term care facility.

The life care community may be feasible, even if the disabled person owns a home and little else. If a home loan, sale or remainder interest sale will produce enough cash for the entrance fee, and if the home can be rented for an amount sufficient to cover debt service and other home-related expenses, and if other income is sufficient to fund the monthly charges, the life care community may be the perfect *choice*.

If the disabled person placed in a life care community or Social HMO program is legally competent, routine estate planning should be undertaken. That ordinarily includes a living trust to gain skilled management of property interests and a durable power of attorney for sympathetic representation in making vital health care choices.

If that person is unmarried and *not* legally competent, a probate conservatorship proceeding should be started. The conservator is vested with substantially the same legal powers as the trustee and the attorney-in-fact. The major differences are that the conservator has to obtain court approval of the estate management each year and the conservatorship estate has to be distributed in a probate administration proceeding at the death of the conservatee. With court approval, though, estate planning can be undertaken in order to establish a trust by which to avoid probate administration.

### **What Medi-Cal Covers**

Medi-Cal automatically pays for hospital-medical services for those who qualify for Supplemental Security Income. It provides medical coverage to those who qualify for a cash grant welfare program. Medi-Cal also provides in-home support services. Each of these areas come with eligibility rules different from those for long term care.<sup>7</sup> These materials are limited to the long term care program.

In addition to a full range of medical, hospital and *skilled* nursing benefits, Medi-Cal provides

long term *custodial* care and prescription drugs, benefits *not* found under Medicare. A long list of equipment, supplies and services are included in the Medi-Cal payment rates.

### **What it Does Not**

Other than shaves or shampoos performed by the nursing home staff as part of patient care, Medi-Cal participants have to pay *personally* for beauty shop services, cosmetics, denture cleaning, combs and brushes and the usual personal things.

After considering all the private options, long term care under the Medi-Cal program may be the logical *choice*. If so, we have to address the basic aim of Medi-Cal eligibility planning: to *get it without first going broke*.

### **Eligibility Requirements**

**Durable Powers of Attorney.** Before discussing the complexities of Medi-Cal eligibility planning, a fundamental need must be addressed. When the health issue is Alzheimer's or Parkinson's Disease, it is particularly important (a) to learn as much as possible about the infirmity, and (b) to put in place durable powers of attorney for property and health care as soon as possible. It takes time for these diseases to strip the victim of legal capacity, so signing these instruments while your loved one remains in the early stages provides everyone in the family peace of mind and saves money.

The durable power of attorney is a creature of statute that sanctions a twist on the generic form. Let's track it through to this modern application.

A generic power of attorney is a written instrument given by a *principal* to an *agent* (the latter historically called the "attorney-in-fact") authorizing the agent to perform certain specified acts on behalf of the principal. It may be as detailed as collecting income, maintaining books of account, managing property, paying bills, reporting taxes and accounting periodically to the principal, or it may be as simple as authorizing grandparents to obtain emergency medical care for a grandchild they are taking on a vacation trip.

The power of attorney may have a specified term, or may provide that it continues until revoked. It terminates upon the expiration of any specified term, or by operation of law on the death or incompetence of the principal, whichever first occurs.

All or most states have enacted statutes authorizing and recognizing *durable* powers of attorney. These are powers of attorney that continue in effect if the principal becomes incompetent. To be durable, a specific provision is required. Here is a typical provision:

By this document I intend to create a durable power of attorney for health care as authorized by the *California Probate Code*. This power of attorney shall remain in force despite my subsequent incapacity."

A variation on the durable power of attorney is now in common use: the *springing* durable power of attorney. Here, the terms of the authority granted are set when signed, but the authority of the agent is delayed until the day arrives when the principal is no longer competent or otherwise able to express an opinion on the subject matter. In effect, the principal has granted *no* authority while able to act on the subject matter personally: the agent merely stands in the wings, ready to take over if, as, or when required. This is the usual form for a durable power of attorney for *health care*, and frequently employed for durable powers of attorney for *property*.

In the durable power of attorney for health care, the principal: (1) names the agent authorized to act on his or her behalf in dealing with health care providers, along with one or more alternate agents; (2) defines "health care decision"; (3) expresses his or her wishes in connection with life support systems, nutrition and hydration; (4) names a person (usually the agent) to serve as conservator of the person if one is ever needed; and (5) both authorizes and expresses his or her wishes with respect to releasing medical records, signing waivers and releases, autopsy, gift of body parts and burial arrangements.

Some people use a *Directive to Physician* on the matter of life support systems. Although it may be coordinated with the power of attorney, it adds little.

In the durable power of attorney for property, the principal (1) names the agent authorized to act on his or her behalf in dealing with creditors, investments, reporting taxes, managing property, etc., (2) specifies appropriate limitations on the powers delegated, and (3) names a person (usually the agent) to serve as conservator of the person if one is ever needed.

In both instances, printed form instruments are available through stationery stores and (health care) through the California Medical Association. The *problem* with printed forms is that they never cover all the needs. Here are some examples:

— The health care power may provide insufficient guidance to permit well-thought-out choices on life support systems and whether nutrition and hydration is desired after withdrawal of those systems.

— The property power never allows gifts in the manner required for most Medi-Cal eligibility planning. If gifts are permitted at all, they are authorized only if a gift pattern was followed by the principal in prior years, in amounts not to exceed the gift tax annual exclusion amount (\$11,000 per donee per year) and never to the agent. In most eligibility plans, the gift tax plays little or no role, and property transfers should be made to the agent (along with siblings or

other objects of the principal's bounty).

– The authorization to prepare and sign tax returns for the principal is inadequate in meeting the information and standards required by IRS. Therefore, by the time this is discovered, the principal may no longer have capacity to sign the IRS form (2848).

– The powers must be signed in a particular manner; *e.g.*, health care powers with two witnesses or acknowledged by a Notary Public, with additional requirements if residing in a health care facility at the time, and property powers acknowledged by a Notary Public. Many purchasers of printed forms fail to properly execute them, leaving them with an invalid power of attorney when it is too late to correct the situation.

*Without* a power of attorney for property, an incapacitated person must be subjected to a probate conservatorship proceeding in order for someone (the conservator) to have authorization to manage his or her property (although recent statutory changes provide a default procedure for dealing with the absence of a health care power). This is the case even *with* the power of attorney if authority to file tax returns is missing or inadequate. At bottom, start early and obtain custom-drafted instruments from a skilled elder law attorney, citing these issues for coverage. A conservatorship is expensive and unwieldy, and it shifts to a busy judge the responsibility for making your financial decisions.

Moving on to eligibility-specific information, the disabled person (who I will call the *Applicant*) is generally entitled to have the state pay the full cost of long term care when (1) *nonexempt assets* are within the allowed value (the term for which is *Property Reserve*) and (2) the Applicant is *institutionalized*. You need *both*, although the planning often precedes institutionalization by months or years, with application following.

The *Property Reserve* is \$2,000 for the Applicant and \$3,000 *combined* when both Applicant and *spouse* are applying for long term care coverage.

The asset categories are *counted* assets, *exempt* assets and assets *deemed unavailable*. I discuss them below.

As with *any* bureaucratic endeavor or arcane specialty, there are terms of art:

– If the Applicant is *married*, the non-disabled spouse is called the Individual's Spouse *prior* to his institutionalization, and is called the Community Spouse *after* institutionalization.

– She is entitled to retain counted assets of \$60,000, adjusted annually for inflation.<sup>8</sup> This is called the Community Spouse Resource Allowance. Community and separate property distinctions are ignored in determining the amount chargeable to the Community Spouse Resource

Allowance, so it matters not that the Community Spouse has *separate* property.<sup>9</sup>

– The eligibility determination is based on the assets held by the Applicant and Community Spouse in the month in which the application is received by the county.<sup>10</sup> That is called the *Snapshot Rule*, and its import is that the Community Spouse can receive and own assets in any amount, as long as they are acquired *after* the month in which the application is submitted.

– The phrase, *Eligible for a Day, Eligible for the Whole Month* refers to a Department of Health Services rule under which any fraction is dropped in calculating a period of Medi-Cal ineligibility.<sup>11</sup>

– The *Minimum Monthly Maintenance Needs Allowance* is an amount, originally set at \$1,500 per month and adjusted for inflation. It represents the minimum needed by the Community Spouse for a dignified standard of living, and is used in determining how much of the Applicant's income may be allocated to the Community Spouse in order to bring her up to that level (or as close to it as a 100% allocation will permit).

– The *Name on the Check Rule* came up under the *Medicare Catastrophic Care Act of 1988*. It means income is attributable to the spouse whose name appears on the check. It has an important effect on the reallocation of income from the Applicant under the Minimum Monthly Maintenance Needs Allowance, and applies without regard to any state laws relating to community property.<sup>12</sup>

– The *Personal Needs Allowance* is for Medi-Cal beneficiaries in long term care. The amount is \$35 per month (to be adjusted upward a few dollars in January 2002), and it is taken from income otherwise applied to the Applicant's Share of Cost. It is used to meet needs that are *not* funded by the long term care program.<sup>13</sup>

– *Share of Cost* is another key term. Although there is no *income* limit with respect to Medi-Cal eligibility, a long term care program participant cannot receive Medi-Cal benefits unless he spends almost all of his monthly income on long term care and medical expenses. The part of the income spent that way before Medi-Cal pays is called *Share of Cost*.

After redeploying assets as part of the eligibility planning engagement, passive income is received with the name of the Community Spouse or the trustees of a Special Needs Trust on the check. Therefore, only Social Security, Railroad Retirement and pension income remains (in most cases) with the Applicant's name on the check. From that amount, the Personal Needs Allowance and medical insurance premiums are deducted, then all or part of what is left can be allocated to the Community Spouse (if there *is* one, and if her income is less than the Minimum Monthly Maintenance Needs Allowance). The rest is the Applicant's Share of Cost.

## Asset Transfers and the Penalty Period

Exempt assets are those which are *excluded* from the Property Reserve -- thus not counted in determining eligibility. Some are exempt without limit, and others are exempt only to stated amounts. Among those exempt without limit as to value, are:

- \_ The residence;<sup>14</sup>
- ¥ Heirloom jewelry;<sup>15</sup>
- ¥ One motor vehicle, if used primarily to transport the Applicant;<sup>16</sup>
- ¥ Furniture, fixtures, appliances and other household effects located at the residence of the Applicant;<sup>17</sup>
- ¥ Personal effects of the Applicant;<sup>18</sup>
- ¥ Recreational equipment (golf clubs, etc.);<sup>19</sup>
- ¥ Musical instruments;<sup>20</sup>
- ¥ Burial insurance;<sup>21</sup>
- ¥ Burial trust or prepaid burial contract;<sup>22</sup>
- ¥ Burial plots, vaults and crypts;<sup>23</sup>
- \_ *Maybe* rental real property used wholly or partly for self-support;<sup>24</sup> and
- \_ The assets of a business. Its equipment, inventory, licenses and materials are exempt as long as the business is earning a profit of 6% or more on net assets. As to that, working capital is also exempt for an amount up to three times average monthly business expenses.<sup>25</sup>

Other categories having *limited value* exempt status include life insurance cash values, if the aggregate death benefits are less than \$1,500.<sup>26</sup>

Assets "deemed unavailable" to the Applicant for Medi-Cal eligibility purposes, like exempt assets, are not considered in determining eligibility. These are assets which cannot be reduced to cash within a reasonable period of time, and those over which the Applicant has no control. Neither the statutes nor the cases define "availability." So we have to turn to federal law for

help. There, deemed unavailable assets include at least the following:

– The countable resources of an irrevocable trust are counted in determining eligibility if the trust was established *by* the Applicant, *by the spouse* of the Applicant, by an *agent* of the Applicant or by *court order*. On the *other* hand, the trust is deemed unavailable if created by someone *other than* the Applicant, spouse, agent or court order.

– The value of a "work-related" annuity -- that is a pension, profit-sharing, non-qualified deferred compensation, 401k, SEP or Keogh -- is deemed unavailable for eligibility purposes if the Applicant has no right to require a lump-sum distribution.<sup>27</sup>

– IRAs are deemed unavailable if minimum distributions are being made. They are also off-limits for benefit recovery purposes.

– The classification of commercial annuities as unavailable is now fully developed.<sup>28</sup> Basically, it is unavailable if the payout rate will liquidate the principal on or before expiration of life expectancy under the annuity tables published by Medicaid in Transmittal 64.

Asset *transfers* have to comply with certain rules:

– The gift of non-exempt assets within 30 months prior to application, and to anyone other than the Community Spouse, starts a period of Medi-Cal ineligibility we call the *Penalty Period*. The Penalty Period is calculated by dividing the state-wide average private pay rate for nursing homes into the net value of the gift after subtracting the Property Reserve.<sup>29</sup> The state-wide average figure is announced each year by the Eligibility Branch of the California Department of Health Services, around February. You also drop the fraction and back up the date of the gift to the first day of the month in which it was made.

– There is no Penalty Period for gifts to the Community Spouse, although we may have to deal with assets in her hands exceeding the Community Spouse Resource Allowance.<sup>30</sup>

– The gift of property classified as exempt for Medi-Cal eligibility purposes can be made before or after application without effect on eligibility, because it cannot be deemed "made for the purpose of qualifying" for Medi-Cal if it is not counted anyway.<sup>31</sup> That same logic applies to "deemed unavailable" assets.

The trick, then, is to redeploy *counted* assets into *exempt* or *deemed unavailable* categories, so they can be transferred without a Penalty Period. Where that cannot be *done*, we may be able to fall back on a petition to increase the Community Spouse Resource Allowance, the Minimum Monthly Maintenance Needs Allowance, or both. If not, or if excess assets remain, we take the hit and make the transfers with the Penalty Period, then wait it out.

## Typical Plan

The usual plan involves a widow who is competent, has a home paid-for, furnishings, \$50,000 in the bank and is either *in* long term care, or *needs* to be. The home has a low basis. The kids may be scattered, but all are concerned about their mother.

The widow may spend some of the cash to make repairs and improvements to the house, thereby shifting counted cash into an exempt residence. She may then prepay the funeral and burial expenses. Finally, she may give everything else to the children, and the children will re-gift those assets to a Special Needs Trust held for the benefit of their mother. Because the trust was created by the children from assets *they* owned, the trust is deemed unavailable to their mother. Gift of the cash usually triggers a Penalty Period, so the trust pays for the widow's living expenses or long term care expenses until that period expires. She then applies for Medi-Cal. From that point forward, the trust pays only for expenses not covered by Medi-Cal. The widow will usually sign an immediate or springing durable power of attorney for health care and one for property. The gift deed for the house will contain a reservation of the widow's personal right to live in the home rent-free, or to return there to live rent-free. This is something *less* than the life estate that would hand the Department of Health Services a right to put a *lien* on the house at her death to recover benefits paid, but it is enough to cause the house to be included in the widow's gross estate for *estate* tax purposes. That, in turn, will lead to a basis adjustment to its date of death value on death of the widow. The children can then sell it substantially without capital gain taxation.

If the widow is unmarried and incompetent, we must instead establish a probate conservatorship, then ask the court to exercise its substituted judgment powers to approve the plan. When approved, we terminate the conservatorship of the *estate*, leaving only a conservatorship of the *person*.

Just as often, the disabled party is married. There, the usual plan is to transfer everything to the Community Spouse, then redeploy into exempt categories to the extent practical, then transfer everything to a revocable living trust providing for the Community Spouse for life, remainders over to the children.

If the Community Spouse ends up with more counted assets than are allowed by the Community Spouse Resource Allowance, we look first to see if her income is less than the Minimum Monthly Maintenance Needs Allowance. If so, we petition for an increase in the CSRA, rather than take a reallocation of the Applicant's income. That is because a reallocation will end or reduce on his death; the probate court or state administrative law judge is required to *grant* that petition. If excess assets still remain, we may be able to raise the Minimum Monthly Needs Allowance *and* the

We may also be able to gift them to the children without penalty, depending on their source and on whether the Community Spouse received them before or after the Applicant's institutionalization. The last-ditch option is to use the excess to purchase an annuity in order to move excess assets into the deemed unavailable category.

If the Applicant-spouse is incompetent, we can petition the probate court for the exercise of its substituted judgment powers, without having to start a conservatorship proceeding, as long as the Community Spouse is competent and willing to serve as petitioner.

As you can see, there are a number of strategies available by which to qualify for long term care under Medi-Cal without first going broke. They are both legal and ethical. Note, however, that this planning requires a great deal of knowledge and experience with the system. You should seek the guidance of an experienced attorney in order to avoid the expense and stress of false starts.

### **Legal Assistance**

For those in California, my biographical sketch is attached. For more California strategies, order *When Health is Lost* at [www.bentleymooney.com](http://www.bentleymooney.com). To find a specialist in each of the other 49 states, contact the National Academy of Elder Law Attorneys at [www.naela.org](http://www.naela.org).

### **Endnotes**

1 National Center for Health Statistics, 1997.

2 2. With applicants in less than perfect health, several questions arise in submitting an application:

- Who is likely to take this applicant, given his or her state of health?
- Who is going to give this applicant a preferred rate, or at least a standard rate?
- What are the chances of favorable underwriting from the first choice carrier?
- If the first carrier rejects, will this applicant be able to obtain coverage elsewhere?

A carrier that declines 40% of the applications received and raises the rates for half of the others may not be a good place to start if the applicant has a problem, such as diabetes, hypertension or congestive heart failure. It is important to use an agent who has this information and knows how to use it.

In 1998, StrateCision, Inc., a Needham, Massachusetts developer of sales and training software for long term care insurance agents, surveyed 35 of the major long term care carriers regarding their underwriting practices. It found first that such an inquiry is viewed with same reluctance as borrowing underwear.

20 of the 35 refused to disclose anything about their underwriting practices, even after being assured that only summary statistics would be published. This, apparently, is a closely-guarded trade secret. As to the others, they accept 47% of the applications received at their preferred rates, although the company-by-company variations ranged from 3% to 74%. The necessary implication from this is that some carriers use the preferred rate as the norm, while others reserve it for those who fall from heaven with their pockets full of manna. The variation was less with respect to the rejection rate. The average was 15%, and ranged from 8% to 25%, with most in the range of 13% to 20%.

As to current trends, 26% thought underwriting was becoming more liberal, while 5% saw them as tighter. The others felt they were substantially unchanged. 32% opined that underwriting will be come easier on the applicant, while 5% expect it to be tougher. Again, the others foresee no change.

Looking at variation in current underwriting standards, using the underwriting guides of 23 larger long term care carriers, substantial uniformity is found in several areas. For example, applicants with AIDS, cirrhosis, multiple sclerosis, muscular dystrophy and Parkinson s Disease are routinely declined, whereas those with diabetes can be acceptable or uninsurable, depending on the type and the carrier. Knowing these differences at the time of application may make a difference between getting insured or getting rejected.

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4 *IRC/408A(a).*

5 *IRC/408A(c)(1).*

6 *IRC/408A(d)(1).*

7 7. ACWDL #90-01, Question 3, provides for *no look-back period* when applying for coverage as medically indigent (such as SSI) or for In-Home Supportive Services. That means there is no Penalty Period for transferring assets in order to qualify for Medi-Cal. That changes, however, if the Applicant is institutionalized and seeks long term care coverage.

8 *All County Welfare Directors Letter (ACWD Letter) 89-93; 42 USC 1396r-5(f).*

9 42 USC 1396r-5(b)(2).

10 10. 42 USC 1396r-5(c)(4); draft *Code of Regulations* /50490.3(e). Beginning with the calendar month after the Applicant is approved for long term care under Medi-Cal, any assets acquired by the Community Spouse are not considered available to the Applicant. Therefore, if the Community Spouse, for example, then receives an inheritance, it will have no effect on the continuing eligibility of the Applicant.

11 *Code of Regulations* /50701(c); *ACWD Letter* 90-01, Question 29.

12 42 USC 1396r-5(b); (Draft) *Code of Regulations* /50512 attached to *ACWD Letter* 90-03 (January 8, 1990).

13 *Code of Regulations* /50605.

14 14. *Code of Regulations* /50425. The code section is the subject of certain ACWDLs, most recently Number 95-48. There, the Chief of the Medi-Cal Eligibility Branch made it abundantly clear to the county welfare directors:

– that the principal residence is exempt based on the Applicant's *subjective* intent to return, even though the *ability* to return may never exist;

– that the intent to return is indicated on the *Statement of Facts* (one of the Medi-Cal application forms for long term care) at Question 17A;

– that the county may not restrict the process of indicating the intent to return to the residence;

– that the county must not require *verification* of the Applicant's *ability* to return, unless the Applicant requests a deduction from Share of Cost for home maintenance expenses under *Code of Regulations* /50605; and

– that if the Applicant answers Question 17A indicating *no* intent to return and later expresses a wish to *change* that answer, *the county must accept that correction*. This last point is based on the fact that many do not understand the implication of stating no intent to return; *i.e.*, that it renders the residence non-exempt for Medi-Cal eligibility purposes.

15 15. August 3, 1990 *Department of Health Services Letter* Number 3, citing *Draft Code of Regulations* /50490.1 contained in *ACWD Letter* 90-01.

16 *Code of Regulations* /50461.

17 *Code of Regulations* /50465.

18 *Code of Regulations /50467.*

19 *Code of Regulations /50469.*

20 *Code of Regulations /50471.*

21 *Code of Regulations /50476.*

22 *Code of Regulations /50479; ACWD Letter 93-71.*

23 *Code of Regulations /50477.*

24 24. *Code of Regulations /50485; ACWD Letter 95-22.* From 1991 to 1995, practitioners relied on ACWDL #91-28 and draft Code of Regulations /50485(d) to shelter income-producing real estate. The regulation provides in relevant part, ...real property used in whole or in part as a business or as a means of self-support shall be exempt. On April 3, 1995, DHS issued ACWDL #95-22, to announce that, ... ACWDL #91-28 means self-employment rather than just an arrangement which provides financial support,... The result is that DHS views real property used simply for investment income as non-exempt.

This position notwithstanding, the language of the code section is clear and unambiguous in classifying as exempt any and all income-producing real property held as an investment, whether or not it is tied to self-employment. Depending on the confidence of the practitioner and the willingness of the Applicant to press the issue, it should be worthwhile to assert in the application that the property is exempt, take the denial to an appeal and make that argument to an administrative law judge, asking for reversal of the county action.

25 *Code of Regulations /50485.*

26 *Code of Regulations /50475.*

27 *Code of Regulations /50548(a), (e) and (f).*

28 28. The Rules leave us with three different sources of authority on the Medi-Cal treatment of annuities: the original proposed regulations from December 1995, some undated state training materials entitled *Treatment of Trust and Annuities for Medi-Cal Eligibility*, and now the Rules. In addition, *Draft 22 CCR /50402* on "availability" remains in effect, with continuing relevance for annuities not covered by the Rules.

- 29 *ACWD Letter 90-58.*
- 30 *42 USC 1396r-5(f).*
- 31 *ACWD Letter 90-01, Questions 7 and 8.*