|  |
| --- |
|  |

**Medicaid and Long Term Care**

**What Is Medicaid?**

|  |
| --- |
| Medicaid is a welfare assistance program for low-income individuals and is also the largest payer of long-term care expenses in the country. The Medicaid program is jointly funded by federal and state governments. *Since each state’s rules can vary,* guidelines on eligibility differ from state to state for Medicaid benefits.  In general, an individual can keep only up to $2,000 to $3,000 worth of assets, while a spouse’s protected assets are one-half of the couple’s countable assets up to the maximum, which is indexed annually. In many states the 2013 maximum was $115,920.  In addition, a monthly income allowance is permitted for people who apply for Medicaid and the amount of income varies by state. Spouses are generally allowed to keep their income, and if it falls below a specific amount, which varies by state and is indexed annually, income from the *disabled spouse* (i.e., Medicaid participant) can be directed to the *community spouse* (i.e., income from the spouse on Medicaid can be directed towards the spouse not on Medicaid.).  **What is the Problem?**  To understand the state of Medicaid today, it is important to understand the costs of the program and the expenses state legislatures face every year. In good economic times, there is generally enough revenue to fund the program and little or no budget alteration is needed. But when times are tough (and these past few years have seen America in its most precarious financial situation in decades), the job becomes exceedingly difficult. Cuts to Medicaid are difficult to make, yet that is what virtually every state has had to do over the last few years to one degree or another.  In regard to long-term care and Medicaid, only seven percent of Medicaid beneficiaries utilized the program for help with long-term care expenses, but they were responsible for 52 percent of Medicaid expenditures. If Medicaid were a business and its chief financial officer looking to cut expenses to get out of the red, long-term care expenses would likely be the place to start.  Other Medicaid long-term care numbers bear this out:  **•** One-third of elderly Medicaid enrollees used long-term care services, but they accounted for 86 percent of all Medicaid spending on the elderly.  **•** Fifteen percent of beneficiaries classified as disabled used long-term care services, but they accounted for 58 percent of all Medicaid spending on the disabled.  This trend is unlikely to reverse itself. Desperate states may be forced to take frantic measures; they can actually opt out of the Medicaid program if they desire. They are required to participate only if they want federal funding. Some states are crunching the numbers to see whether they can abandon the Medicaid program and all it entails and instead construct their own, less costly health insurance programs for the poor.  Elected and appointed officials in several states, including Washington, Texas, South Carolina, Wyoming, and Nevada, have publicly floated the idea. Wyoming found that Medicaid accounts for 63 percent of its nursing home revenue.  Governors are constantly lobbying the federal government for leeway in administering the programs in an attempt to trim the number of Medicaid beneficiaries. The current percentage of Americans on Medicaid is the highest since 1987.  Just a few years ago, the state of Virginia actually proposed a bill in its legislature (Virginia House Bill 345) that required it to withdraw from Medicaid upon passage of the Patient Protection and Affordable Care Act (PPACA).  How did it come to this? What is Medicaid and what are the objectives of this public system? |

**Medicaid Eligibility**

|  |
| --- |
| Medicaid eligibility rules are sufficiently vague and subjective to make qualification easier than one might expect in the hands of a capable elder law attorney. Frankly, this is where some of the thornier ethical issues surrounding Medicaid lie.  The Medicaid program was intended for poor people, not people who are poor on paper. Many long-term care Medicaid beneficiaries are in the middle- to upper-income classes and, without assistance to obtain eligibility, they would never be in the program. This slippery means of qualifying is not illegal, but one can see from the numbers that it has caused overuse of the program with the relatively few people accessing it for long-term care aid responsible for spending a disproportionate share of public monies for their long-term care expenses.  The federal government has tried in the past to tighten up some of the vague language through which people can easily qualify. Each federal move has been countered by an analysis of the law and the identification of a new loophole, launching another round of what is referred to as “Medicaid planning.” The government then responds with more regulation, and so on. It’s like a chess match without a timer.  The Deficit Reduction Act of 2005 was the boldest move by the federal government to date in this ongoing battle to preserve Medicaid for the truly needy. In addition to reauthorizing the Long-Term Care Partnership Program, the Deficit Reduction Act made several changes to Medicaid eligibility:  **•** The look-back period on a Medicaid application is now five years for everything. It used to be five years only for transfers involving trusts, and three years for all other transfers; now, Medicaid will be checking your client’s finances a full *five* years from the date of application.  **•** The penalty period assessed for individuals deemed ineligible for Medicaid benefits because of a transfer within the look-back period now begins with the date of Medicaid *application*. Previously, the ineligibility period started on the date of *transfer*. That’s a significant difference. Now every financial transaction made in the previous five years is scrutinized and any penalties are assessed according to the date of application. This change dealt a substantial blow to some Medicaid planning strategies for those trying to qualify as “poor on paper.”  **•** A cap was placed on the amount of home equity allowed when determining Medicaid eligibility. The cap is currently $536,000, although states can opt for $802,000, providing they apply for permission from the Department of Health & Human Services. The majority of states have used the $500,000 limit (as indexed for inflation) as they do battle with their own Medicaid budgets. Some states (Idaho and Nebraska, to name two) have chosen the $750,000 limit (as indexed for inflation), probably in recognition of the number of farms in those states whose equity value can be calculated on the high side. This rule was enacted to counteract the Medicaid planning technique of putting the majority of assets into a protected asset—the home—from which money could be easily accessed via a home equity line of credit. This was a less risky move than transferring assets out of one’s name.  **•** Any annuity that has a deferred or balloon payment is counted as an asset. Or, if it has gone into an irrevocable payment mode, the annuity will be considered an asset transferred at less than fair market value and will be subject to a qualifying penalty period. Further, a Medicaid applicant must name the state as remainder beneficiary on all annuities or as second remainder beneficiary behind a spouse, disabled child, or minor child under the age of 21.  **Note**: Medicaid is called *Medi-Cal* in California and *MassHealth* in Massachusetts.  Many elder law attorneys cried foul when this law was finalized, and there have been repeated attempts to repeal it. Although there is concern that some legitimate Medicaid claims might fall through the cracks, lawmakers hoped that these changes would discourage people who could otherwise pay for their care or transfer the risk to a third party (by purchasing insurance for it).  The idea was to ease some of the growing financial pressure on the states trying to administer the program and long-term care expenses are the major culprit in the rise of these expenditures. Solve that problem, states reason, and perhaps the whole program can be salvaged.  People often forget that Medicaid is a publicly financed program: it is paid for with tax dollars. Individuals who find their way into this program when they have the resources to afford other solutions hurt those who do not have such options and who depend on this aid. Every day state legislators and administrators wrestle with their Medicaid budgets. This is why most states have embraced the Long-Term Care Partnership Program as a way to help reduce this financial burden.  Following is a listing of what one can keep today and still qualify for Medicaid:  **•** An individual’s principal residence if home equity is below the threshold of $536,000 in 2013 (or $802,000 in some states); it can be above these limits if a spouse or child (under age 21 or blind and disabled) lives in it. The home equity limit is indexed for inflation.  **•** An automobile  **•** Personal property up to reasonable limits  **•** Jewelry (such as an engagement or wedding ring)  **•** A small amount of life insurance cash value  **•** Burial plots  **•** If married, the healthy spouse can keep (in 2013) 50 percent of total assets up to $115,920  **•** Long-term care partnership policy proceeds  The obviously vulnerable assets here are the liquid ones: cash, checking and savings accounts, investments, stocks, individual retirement accounts, pensions, etc. These assets would have to be transferred out five years ahead of filing for Medicaid assistance. |

**Drawbacks**

|  |
| --- |
| There is a trade-off, however. When individuals put themselves in the hands of Medicaid, people who are accustomed to having their own way may be in for a surprise. First, the asset transfer must be irrevocable: in short, you cannot access that money. You can, however, transfer it to a child and have your bills directed to them to pay. One agent told me that he knew a couple who transferred all their liquid money away to their son, only to see him divorced a couple of years later and half of their assets going to their former daughter-in-law.  Second, a Medicaid recipient may not be able to go to the facility that they want for long-term care. Medicaid works only with providers who accept Medicaid reimbursement (the lowest of any third-party payers), which could limit one’s choice. Third, a Medicaid recipient will likely have roommates. People whom you might never have associated with in your former life are now your companions for the rest of it.  Recent changes to the Medicaid program have made it more attractive for those trying to qualify for Medicaid assistance. In the past, one of the biggest drawbacks to qualifying for the Medicaid program for long-term care assistance is that Medicaid would traditionally reimburse only for nursing home care, the least desirable (to consumers) of all long-term care services. But in the last decade, Medicaid has been mandated to cover the more desirable benefit of home care. This has gained the interest of more consumers who in the past would have dismissed Medicaid as a financing option.  The home care movement in Medicaid stems from the 1999 U.S. Supreme Court ruling on *Olmstead* v. *L.C.,* which held that the unnecessary institutionalization of people with disabilities is a form of discrimination. Thus began a steady shift of Medicaid beneficiaries from nursing homes to their own homes. Advocates say it saves Medicaid money because home care is less expensive. Opponents of this trend state that it merely extends the length of a Medicaid claim because you are giving people something they want—home care—versus a nursing home, and thus are inviting earlier application. States simply see larger Medicaid expenditures every year.  Many of the wealthier people who take the Medicaid planning route do so even though the easier (and affordable) alternative might be to pay for long-term care insurance instead. Most advisors in this area likely counsel their clients to consider long-term care insurance first before orchestrating any financial moves to improve their eligibility for Medicaid.  Medicaid planning takes on added importance, however, if one cannot qualify for long-term care insurance coverage. An individual must satisfy a number of medical underwriting criteria to buy a long-term care insurance policy. Although there are many long-term care insurance solutions, an individual should consult an elder law attorney if he or she cannot qualify for long-term care insurance to create a prudent financial strategy for long-term care. |

**Looming Threats**

|  |
| --- |
| But Medicaid is currently facing nearly insurmountable financial problems, despite the best efforts of the American Recovery and Reinvestment Act of 2009 (ARRA), which boosted federal funding for Medicaid to the states through June 30, 2011). The new health care law also increases Medicaid enrollment with (again) some financial help from the federal government to get it going.9  But these are temporary band-aids on a situation that cries out for long-term fiscal solutions. The federal government may be able to artificially prop these programs up for a time, but states face tougher decisions ahead. It seems likely that long-term care expense reimbursement would be a promising area to trim to balance a state budget.  Today, Medicaid accounts for 40 percent of all long-term care spending. And because this serves only a small number of beneficiaries overall, look for states to consider making eligibility for reimbursement of these expenses much harder for potential applicants. Many will apply to the Department of Health & Human Services for an exception. Others will seriously consider opting out. Either way, the budget issue will be dealt with—in the interest of balancing the numbers. |