

MEDICAID AND PLANNING FOR LONG-TERM CARE COSTS

Hartford Study Group

January 23, 2008

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I. LONG-TERM CARE SERVICES AND COSTS

A. **Range of Long-Term Care Services.** The phrase “long-term care” describes the help needed by people who have problems living independently due to chronic medical problems or severe disabilities. Most long-term care is provided informally by family members or friends and through community programs such as Loaves and Fishes meal centers.

B. **In-Home Services.** In-home services range from respite care for family caregivers to visits by home health nurses to housekeeping to 24 hour live-in care and may be supplemented with adult day programs. The costs will vary according to the hours of service and the type of provider. According to the 2007 MetLife Market Survey of Adult Day Services and Home Care Costs, the average charge for a home health aide in Oregon was around \$20.00 per hour.

C. **Community-Based Care Facilities.** Adult foster homes care for five or fewer residents, with the owner or live-in resident manager preparing meals, cleaning, doing personal care, and providing 24 hour coverage. Adult foster homes for the elderly and people with physical disabilities are licensed by the Oregon Department of Human Services (DHS) Seniors and People with Physical Disabilities office, www.oregon.gov/DHS/spwpd or by the county. Residential care facilities and assisted living facilities are licensed by DHS to provide room, board, care, and services for six or more residents, with 24 hour coverage. According to the 2007 MetLife Market Survey of Nursing Home and Assisted Living Costs (which combines all of the community-based care facilities under the heading of “Assisted Living”), the average charges for community-based care facilities in Oregon was around \$2,700 per month.

D. **Nursing Homes.** Nursing facilities or nursing homes are licensed by DHS to provide regular nursing services as well as personal care and assistance with the activities of daily living (ADLs). The 2007 MetLife Market Survey of Nursing Home and Assisted Living Costs found that the average nursing home charges in Oregon were \$5,430 to \$6,634 per month.

II. PAYMENT OPTIONS

A. **Medicare.** Medicare is the federal health insurance program for people age 65 and over, people who have received Social Security disability benefits for at least two years, and certain people with kidney disease or ALS. See www.medicare.gov. Medicare does not pay for most long-term care. Medicare Part A (Hospital Insurance) covers in-patient hospital stays, hospice care, and a maximum 100 days of skilled nursing facility (SNF) care following a hospital stay of at least three days. There is a co-payment of \$128.00 per day (in 2008) after the first 20 days. Medicare Part B (Medical Insurance) covers physician services, laboratory tests, ambulance transportation, durable medical equipment, and certain in-home services for a homebound person

who needs intermittent skilled care. Prescription drug coverage is available through private Medicare Part D plans.

B. Medicare Supplement Insurance. Medicare supplement insurance or “Medigap” policies typically pay part or all of the deductible and co-payment charges for Medicare-covered services. Medicare beneficiaries who enroll in a Medicare Advantage plan have to get all of their medical services from that Medicare Advantage plan except for emergencies when they cannot get to a plan provider.

C. Long-Term Care Insurance. Insurers offer long-term care insurance policies to individuals who meet the underwriting standards. A few employers (including the federal government) offer group plans. Long-term care insurance policies sold in Oregon must cover all levels of long-term care, not just nursing home care, and they cannot exclude particular illnesses, such as Alzheimer’s Disease. Policies have different benefit “triggers,” i.e. how much help someone has to need before coverage begins; exclusion or waiting periods; daily benefit amounts; coverage periods; and premiums. The premiums for tax-qualified long-term care insurance policies can be deducted as a medical expense within certain limits tied to the age of the taxpayer, and the benefits generally are not taxed.

D. Veterans Benefits. The federal Department of Veterans Affairs (VA) pays Aid and Attendance cash benefits for eligible veterans (and certain spouses of veterans) who need long-term care. The eligibility criteria include dates of service, degree of physical and mental impairment and financial need. The VA also operates some facilities itself and has contracts with local nursing homes. See www.va.gov. The Oregon Department of Veterans’ Affairs operates the Oregon Veterans’ Home in The Dalles, a nursing home that accepts both Medicare and Medicaid reimbursement. See www.oregon.gov/ODVA.

E. Oregon Project Independence. Oregon Project Independence (OPI) provides in-home care and respite care to help people who are over age 60 or who have been diagnosed with Alzheimer’s Disease remain in their homes. OPI uses a sliding-fee scale based on income. See www.oregon.gov/DHS/spwpd/ltc/inhome.shtml.

F. Medicaid. Medicaid is a joint federal-state program that provides medical assistance for people who meet the applicable income and resource limits. 42 USC §1396; 42 CFR 430.0 et seq; www.cms.gov. People who are eligible for SSI or for certain other government benefits are automatically eligible for Medicaid, and people who need long-term care services can qualify under a category that uses higher income limits. See 42 USC §1381 et seq; 20 CFR 416.101 et seq; www.ssa.gov. Each state makes choices about certain features of its Medicaid program. Oregon’s medical assistance program is administered by the state Department of Human Services (DHS). ORS 414.065 et seq; OAR chapters 410, 411, and 461. DHS’ office of Seniors and People with Physical Disabilities (SPWPD) is responsible for making eligibility determinations and providing case management for people who are aged 65 or older or who are physically disabled through local SPWPD offices and through county or regional Area Agencies on Aging (AAAs). The federal and state Medicaid laws and rules change from time to time. Information

in this outline is based on the laws and rules in effect at the time when the outline was prepared.

III FINANCIAL ELIGIBILITY FOR MEDICAID

A. **Impact of DRA 2005.** Congress made major changes to the Medicaid financial eligibility requirements in the Deficit Reduction Act of 2005 (DRA 2005). Most of the changes noted below were implemented in Oregon during 2006.

B. Income

1. **Income Limit for Long-Term Care.** An individual is not be eligible for Medicaid assistance for long-term care services if his or her gross monthly income (before deductions for Medicare Part B premium, etc.) is over 300% of the SSI federal benefit rate for a single person living in the community. The income limit for 2008 is \$1,911 per month. A few types of income, notably VA Aid and Attendance benefits, are not counted in determining eligibility but are counted in the post-eligibility process. A person who is over the income limit can qualify for Medicaid if his or her income is placed in a Medicaid income cap trust. The income of the person's spouse is not counted in determining eligibility.

2. **Post-Eligibility Treatment of Income.** After a person is found eligible, he or she is required to use most of the monthly income to help pay for long-term care. Certain deductions from income are permitted under the Medicaid rules, including a personal needs allowance for a nursing home resident (\$30 per month for most nursing home residents in 2008) or a standard allowance for a person living at home or in a community-based care facility (\$638.70 per month in 2008, out of which residents of community-based care facilities pay \$494.70 for room and board); a community spouse income allowance for a married person; and supplemental medical insurance and other medical costs not covered by Medicaid.

C. Resources

1. **Resource Limits.** The resource limit for a single person is \$2,000. If the person is married, resources that belong to either spouse or to both spouses will be counted. The resource limits that apply to married couples are discussed below.

2. **Exempt Resources.** Certain assets, such as the person's home (subject to a \$500,000 equity limit under DRA 2005), household goods, one car or truck, and an irrevocable funeral or burial plan, are generally exempt and not counted in determining eligibility.

3. **Countable Resources.** Most other resources, including bank accounts, investments, IRAs, the cash surrender value of life insurance policies, other vehicles, and real property, are countable resources and have to be spent down to the applicable resource limit before the person will qualify for Medicaid assistance. Annuities purchased on or after July 1, 2006, that do not meet the DRA 2005 requirements are countable resources.

D. Gifts and Transfers

1. **Look-Back Period Changed.** DRA 2005 changed the look-back period to five years for all transfers. In Oregon, if the person (or the person's spouse or agent) gives away money or property or transfers assets for less than fair market value on or after July 1, 2006, and requests Medicaid assistance within five years of making the gift or transfer, the person will not be eligible for Medicaid for a period of time based on the value of what was given away.

2. **Penalty Period for Transfers.** DRA 2005 also changed the date when the penalty period begins. For gifts and transfers made on or after July 1, 2006, the penalty period will not begin until the person is otherwise eligible for Medicaid. The length of the period of ineligibility is calculated by dividing the amount that was given away or transferred by the average private pay cost of care set by the state, currently \$5,360 per month for Oregon. DRA 2005 prohibits the state from rounding down the penalty period to the next whole number.

3. **Loans as Transfers.** DRA 2005 adopted new standards for loans. If the person or the person's spouse makes a loan (or purchases a mortgage or loan) on or after July 1, 2006, the loan will be treated as a disqualifying transfer unless the loan payments are made in equal installments over the term of the transaction (with no deferrals or balloon payments), the total value is being repaid within the lender's actuarial life expectancy, and the contract is not canceled when the lender dies. A loan that is not a disqualifying transfer is treated as a resource (if the loan agreement is negotiable) and the payments (both principal and interest) are counted as income.

4. **Gifts and Transfers That Do Not Cause Ineligibility.** There are some gifts and transfers for less than fair market value do not result in a period of ineligibility. For example, there is no penalty for transferring assets to (or for the sole benefit of) the person's spouse or the person's blind or disabled (by the Social Security Administration's criteria) son or daughter. In certain limited circumstances, the home can be transferred to a son or daughter who has lived with and provided care for the person for at least two years.

IV MEDICAID SPOUSAL IMPOVERISHMENT PROTECTIONS

A. **Community Spouse Monthly Income Allowance.** The institutionalized/ill spouse who receives Medicaid assistance may be able to pay an allowance from his or her income to the community/well spouse. The amount is either the difference between the community spouse's gross income and the standard determined under OAR 461-160-0620(1)(e) or the amount set by court order. The standard, which changes annually in July, is \$1,712 per month, plus the amount by which the community spouse's shelter expenses exceed \$514. The maximum is \$2,610. Shelter expenses are rent or mortgage payments, property taxes, renter's or homeowner's insurance, maintenance charges for a condominium or cooperative, and the Food Stamp standard utility allowance (currently \$319 per month).

B. **Community Spouse Resource Allowance.** The countable resources belonging to either spouse or to both spouses (or in a revocable living trust created by either spouse or by both

spouses) are valued as of the date when the ill spouse began receiving care. The community spouse resource allowance or CSRA, which is the amount that the community spouse can keep, is the largest of the following:

- One-half of the combined countable resources as of the beginning of the continuous period of care, up to a maximum of \$104,400 (2008 figure);
- \$20,880 (2008 figure);
- A court-ordered CSRA calculated to generate income to raise the community spouse's income to a court-approved monthly income allowance; or
- An amount approved by the agency to generate income to raise the community spouse's income to the allowance calculated under the Medicaid rules. Under DRA 2005, the state requires the income of the ill spouse to be used to pay the community spouse income allowance before allowing an increase in the CSRA.

Resources being used to fund the CSRA have to be transferred into the name of the community spouse within 90 days after the effective date of the ill spouse's Medicaid eligibility.

V MEDICAID PLANNING OPTIONS

A. Spending Down. Countable resources can be spent down on care, living expenses, and other expenses for the person and the person's spouse. Resources can also be spent down by paying bills (including mortgages, deferred property taxes, and loans owed by either spouse or both spouses); to purchase exempt resources, such as an irrevocable funeral plan or a replacement car or a more accessible home; and to repair or remodel exempt resources.

B. Annuities

1. Changes to Annuity Rules. Although DRA 2005 made significant changes to the treatment of annuities, countable resources can still be converted into an income stream by purchasing a single premium immediate annuity that meets the requirements set out in the Medicaid rules. Private annuities, annuities with balloon payments, and annuities naming remainder beneficiaries other than those permitted under DRA 2005 are not permitted. An annuity that does not meet the requirements will be counted as a resource with a value equal to the total used to fund the annuity, plus any earnings, and minus any payments received and any surrender fees. The purchase of an annuity may also be a disqualifying transfer of assets.

2. Annuities Purchased on or after July 1, 2006. An annuity purchased by the person or the person's spouse on or after July 1, 2006, must meet the following requirements (as set out in current OAR 461-145-0022) in order to be counted as income and not as a resource:

- Be irrevocable;
- Be nonassignable;
- Pay principal and interest out in equal monthly installments within the annuitant's actuarial life expectancy, using the Period Life Table of the Office of the Chief Actuary of the Social Security Administration. The Period Life Table can be found at www.ssa.gov/OACT/STATS/table4c6.html.
- Be issued by a company licensed to sell commercial annuities in the state in which

- the annuity is purchased;
- If the Medicaid applicant is the annuitant, name the annuitant’s spouse, the annuitant’s child under age 21; the annuitant’s blind or disabled child (using the Social Security Administration criteria); or DHS up to the amount of Medicaid benefits paid on behalf of the Medicaid applicant as the first remainder beneficiary;
- If the Medicaid applicant’s spouse is the annuitant, name the annuitant’s child under age 21; the annuitant’s blind or disabled child (using the Social Security Administration criteria); or DHS up to the amount of Medicaid benefits paid on behalf of the Medicaid applicant as the first remainder beneficiary; and
- If the Medicaid applicant’s spouse or child is named as the first remainder beneficiary, name DHS as the second remainder beneficiary in the event that the spouse or child transfers any of the remainder of the annuity for less than fair market value.

3. **Certain Retirement Plans and Annuities.** The remainder beneficiary limits described above do not apply to an annuity purchased by the Medicaid applicant (but **not** by the Medicaid applicant’s spouse) using funds from an IRA or another specified retirement plan. This type of retirement annuity is not counted as a resource if it pays principal and interest out in equal monthly installments within the annuitant’s actuarial life expectancy.

C. **Transferring Exempt Resources to the Community Spouse.** Transferring an exempt resource (such as the home) to the community spouse is not a disqualifying transfer. If the community spouse sells the home or another exempt resource that is in the community spouse’s name after the ill spouse begins receiving Medicaid assistance, the community spouse can use the proceeds from the sale to buy a replacement home or for other expenses without affecting the ill spouse’s Medicaid eligibility.

D. **Petition for Spousal Support.** If the amount of the community spouse monthly income allowance is not sufficient to meet the community spouse’s needs, the community spouse has the option of filing a support proceeding under ORS 108.110 asking the court to grant both a higher monthly income allowance and a larger CSRA to generate the higher monthly income allowance. The support proceeding is not a divorce or a legal separation.

VI OREGON LONG-TERM CARE PARTNERSHIP PROGRAM

A. **Long Term Care Partnership Programs.** New York , Connecticut, Indiana, and California have been operating programs that allow people who have long term care insurance coverage that meets certain standards to qualify for Medicaid while protecting a larger amount of resources. DRA 2005 gave the rest of the states the option of adopting similar programs. The 2007 Oregon legislature passed Senate Bill 191, which amended the insurance code and several statutes related to the state’s Medicaid program effective January 1, 2008.

B. **Qualified Partnership Policies (QPP) and Resources.** A person who purchases a

qualified partnership policy (QPP) in Oregon on or after January 1, 2008, (or a QPP issued in another participating state) can receive two types of resource protection. In the Medicaid eligibility determination process, an amount equal to the QPP payments that the person has received will be excluded and not counted as a resource. It appears that the person would not be disqualified from receiving Medicaid benefits if he or she gave that excluded resource away after being found eligible for Medicaid. In the estate recovery process, DHS will disregard resources in an amount equal to the QPP payments that the person has received, provided that the value of the QPP payments has not been transferred or exhausted.

VII LIENS AND ESTATE RECOVERY

A. Medicaid Estate Claim. DHS has a claim against the estate of a deceased Medicaid recipient for the amount of Medicaid assistance paid after age 55 or for a person who was permanently institutionalized. "Estate" is defined as any interest in money or property that the person has at the time of his or her death, an expanded definition that allows the state to make estate recovery claims against property which is not probated, such as joint bank accounts.

B. Limits on Collecting Claim. The claim cannot be collected while there is a surviving spouse or a minor or disabled child. However, DHS can make a claim against the estate of the surviving spouse up to the amount which the surviving spouse received when the Medicaid recipient died.

C. Not a Lien. DHS does not have the authority to file a lien against real or personal property to recover Medicaid assistance. The Medicaid agency does have a statutory lien on personal injury judgments and settlements for repayment of Medicaid and other assistance received following the injury.

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