Medicaid Planning: Latest Developments

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I. Introduction

In general, Michigan has been considered a "kind" state in regard to nursing home Medicaid. Many other states have leapt to implement the severe Medicaid laws mandated by the federal government. These laws relate to citizenship requirements, gifting penalties and estate recovery. Michigan is the only state yet to enact the 1993 federal mandate to file liens on homes through "estate recovery." The traps and administrative difficulties surrounding transfer penalties with the Federal Deficit Reduction Act of 2005 (DRA) are not yet implemented in Michigan.

Michigan has the highest percentage in the country of public dollars spent on long term care in nursing homes – over 80% on nursing homes. Commentators have criticized the current Michigan system as having an "institutional bias" – with a growing number of Michigan citizens preferring assisted living over the preference of most consumers to receive help in their own homes.

Changes in Medicaid and access to alternative care settings, however, are in the works in Michigan. We are on the brink of a sea of changes in Michigan on our care for the elderly and disabled -- both publicly and privately. The pressure comes from mandates by the federal government, the Michigan budget crisis and the exponentially growing need for care. Some relief has occurred through the Veterans Administration, especially for home care and assisted living. A summary of the varying levels of VA benefits are attached as **Exhibit A**.

This course outlines the changes to these programs and practice tips. It evaluates our fundamental role to the clients we serve: the elderly, the community spouse, the child with a disability and the caregiver child. A sampling of the proposed Michigan regulations implementing the DRA is attached as **Exhibit B**.

II. Extensive Changes Underway in Medicaid

A. The Deficit Reduction Act (DRA)

The DRA. Congress signed into law the DRA on February 8, 2006. This was the first significant change in federal Medicaid law since the Omnibus Reconciliation Act of 1993 (OBRA 1993). On July 27, 2006 the Centers for Medicare and Medicaid Services (CMS) of the federal government issued a series of letters to guide state Medicaid directors to help them interpret and implement the DRA.

As of April 2007, twenty states have implemented the DRA and many others are moving toward implementation. Implementation has been difficult and confusing – as the CMS

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[1] A special thanks to my associate, Christina L. Borowicz, Esq. for her assistance on Veterans Benefits.

guidelines offer little direction and few details. Commentators criticize the guidelines as merely reciting the statutory language leaving implementation by state agencies uncertain. One Court has recently called Medicaid a "serbonian bog."[2] This applies especially to the changes under the DRA, as there are plenty of punishing traps for the unwary in which applicants can sink and find it difficult to get out.

Michigan has decided to implement the DRA in two sequential steps:

1. The FIRST STEP is effective April 1, 2007 in Michigan. This step addresses the following requirements:

- **Citizenship and Identity Verification.** Under the DRA, all states were to verify citizenship and identity for Medicaid recipients and applicants as of July 1, 2006. Michigan delayed implementation of this requirement due to efforts to limit inappropriate denials and terminations of benefits experienced in other states. Fortunately, Michigan DHS has designed methods to eliminate this hardship for most Michigan residents. DHS will run electronic cross checks with vital records to determine if applicants and recipients were born in Michigan.

  Practice tip: Most of our clients were born in Michigan and will be protected from the hardship of proving citizenship. The Department of Community Health (DCH) estimates that 60-70 percent of Medicaid applicants and recipients were born in Michigan and will be protected in this way.[3] *The main problem will be for our elderly residents who were born out of state and do not have their birth certificate or a passport. Eligibility will be delayed until this verification can be produced.*

- **Elimination of Retroactive Funeral Planning.** Michigan no longer allows a Medicaid applicant to shelter assets retroactively in a funeral plan. Previously, a Medicaid applicant (or recipient) who had excess assets could place those assets in an irrevocable funeral plan and still obtain eligibility retroactively as much as 90 days.

  Practice tip: This is a real loss in the ability to clean up an excess asset in prior months. Clients cannot sit on the discovery of an excess asset – such as an inheritance check or award check from Social Security for back benefits. They will now need to spend down or shelter the asset in the month of receipt.

  ***Practice tip*:** Clients who weren't aware they were already asset eligible still have the ability to apply retroactive as far back as three months.

  > **Example:** This occurs most frequently in spousal situations where the nursing home admissions coordinator misrepresents to the community spouse that they alone would "assist" her in obtaining Medicaid for her husband. Instead, in blind trust, she continues to spend down assets she otherwise would have kept. Retroactive applications allow us to reach back

[2] *Hutchings v. Roling*, Nos. ED 85999 and ED 86019 (Mo. Ct. App. April 4, 2006).

[3] Michigan Poverty Law Program News Release, Issue 33, Spring 2007, www.mplp.org.

and save as much as $18,000 for the community spouse, which she unnecessarily paid to the nursing home.

Practice tip: Irrevocable funeral contracts and burial planning remain a viable way to shelter excess assets, but this must be done before or during the month of eligibility. This is often the last step in a spend-down as the money is locked.

- **Elimination of Rental Property Exemption.** The practice of using income-producing rental property to exempt real estate is eliminated (with the exception of real estate with an equity value of $6,000 or less).

Legal effect: This most affects sheltering the family cottage and traditional rental properties.

Example: In the past, the children could rent the family cottage from mom and dad to protect it. As long the rental income cleared more than 6% of the equity value in the property after expenses, it was exempt. Now other types of ownership arrangements will have to be considered, as discussed below.

2. The SECOND STEP (more serious) is projected to be effective July 1, 2007 in Michigan. This step addresses the following issues, especially divestment (or transfer) rules:

- **Look-Back Period Extended to Five Years, §6011(A) of the DRA.** The "look-back" period (the period during which asset transfers must be reported) will be extended from three years (36 months) to five years (60 months) from the date of application. Following CMS guidance several states have opted to phase-in the look-back period first in February 2009 over a two-year period. One month will be added to the 36-month look-back each month beginning February 2009. Other states are applying the 60-month look-back period immediately. As of this writing, it is not yet clear which approach Michigan will take.

Practice Tip: Clients need to be warned about the five-year look-back and to keep bank records when they have made gifts. Bank microfiche record requests can run as much as $5.00 a statement.

Practice Tip: Clients need to know the divestment rules continue to trap indirect gifts as adding or removing a name from an asset (as adding a child's name to real estate) or selling something for less than fair market value – not just direct gifts of cash or stock.

Legal Effect: Gifting to protect assets will most likely occur sooner by seniors in lump sums, rather than over protected periods of time. Such gifting, however, is more risky, as it exposes the property to greater dangers of loss over a longer period of time. Children receiving such gifts need to be self-sufficient, stable and honorable. Some elder law attorneys regularly use "gift trusts" to hold and protect the asset against such losses. Outside of Michigan, State Medicaid programs have

successfully attached written side agreements to hold the assets for the benefit of the parent.

Practice Tip: Safer transfer strategies remain available for families undergoing caregiving arrangements or for families of a child with special needs, which generally strengthen the overall care situation. These situations continue to have special exemptions from divestment penalties for payments or gifts of the house, as detailed below.

- **Commencement Date of Penalty Period, §6011(B).** The commencement date of the penalty period (called "period of ineligibility") is changed for gifts made on or after February 8, 2006. The pre-DRA law began the penalty period when the gift was made. Under the DRA, the penalty period does not start until the elder is in the nursing home, applies for Medicaid and can show she is eligible for Medicaid (meaning she is out funds).

Legal effect: This forces the return of gifted funds. If those gifted funds are lost or unavailable, the result can be catastrophic. If the elder can't pay and the nursing home has no source for reimbursement, severe hardship can occur.

Practice Tip: Elders who have made gifts need to be warned that the penalty period is entirely different, forcing a return of the asset for any transfers within 5 years of a nursing home admission and application for Medicaid. Gifts spent by a family member on education or their home may jeopardize the parent's eligibility if they cannot be returned. Relatives refusing to return a gift or remove their name will cause a jam.

- **Partial month penalties on gifts started, §6016(A).** Penalty periods are determined by taking the gift amount and dividing it by the average cost of nursing home care in Michigan, currently, $5,938.

1. **Prior to the DRA**: fractions have been "rounded down." A $10,000 gift calculated as a 1.9 month penalty, resulting in a penalty of only 1 month.
2. **After the DRA**: fractions are no longer rounded down. A $10,000 gift will result in a penalty of 1 month and 28 days in a 31 day month.

Legal Effect: With the DRA the penalties are extended further and smaller gifts are now captured. There is no "holiday" or birthday exception. Practically, this rule will be difficult to enforce. Seniors and their family members have a hard enough time understanding current divestment penalties – let alone the absurdity of penalizing even small gifts. Administering partial month penalties will be very difficult.

- **Hardship exception expanded in light of the severe penalties, §6011(D).** In light of the hardships from the new divestment rules, Congress offered states "considerable flexibility" in determining the circumstances for relief from the divestment penalties due to "undue hardship." The CMS guidance requires a showing of "efforts to recover" transferred assets and a "deprivation of a life

necessity". During the "pendency" of a hardship request, the DRA provides for a "bed-hold" payment. The "pendency" period, however, is unclear under the CMS guidelines.

Effect: We have yet to see how states, including Michigan, implement this standard – and the litigation involved with the ambiguity. Ohio had a very difficult time implementing the DRA as it at one point required the applicant for "under hardship" to file a civil lawsuit to recover the asset. Altogether, the exception offers little consolation to the chilling effects of the transfer rules.

Practice Tip: Since 1993, when divestment penalties began, there has been an exception to penalties when proof existed that the transfer was "for another purpose". As more gifts will be caught in the system with more severe penalties, the "other purpose" exception and the "hardship" exception are likely to be utilized more successfully and more often.

- **Caps placed on the exempt residence, §6014.** Prior to the DRA, a homestead of any value was exempt and not counted in determining eligibility. The DRA will not exempt the homestead insofar as the equity value of the homestead exceeds $500,000. Some states have chosen to increase this cap up to $750,000. This is the first time Michigan rules will have placed a limit on the value of an exempt homestead.

Effect: Minimal. Few persons needing Medicaid in Michigan have a residence with equity over $500,000. Many of those clients can work out alternative arrangements to Medicaid.

Practice Tip: In situations where alternative arrangements to Medicaid cannot be worked out, consider an equity line of a reverse mortgage to reduce the equity value. This is possible when there is still a title owner in the residence as a Community Spouse.

- **Medicaid Annuity benefits are restricted, §6012.** The abusive use (and sale) of otherwise legitimate Medicaid annuities has provoked much attention by Congress and even various state Attorney Generals and Insurance Commissioners. The abuse came from "balloon" annuities meant only as an inheritance preservation device, which paid very little to the nursing home resident and a large balloon payment to the heirs. This "betting" on the short death of the nursing home resident has twisted the original intent of Congress to protect seniors who had 'annuitized' an asset into a fixed monthly income stream for themselves. The legitimate purpose of the Medicaid annuity remains especially viable for a spouse at home who annuitizes assets otherwise lost to nursing home care to preserve an income stream for herself. Congress' original purpose has also been served when a disabled and/or minor child receives the benefits.

***Background History to Annuities*:**

1. **No allowance of Medicaid Annuities prior to 1996.** Michigan had a three-year "waiver" from the allowance of any irrevocable annuity from the OBRA-'93 rules exempting certain annuities. Sheltering assets in any irrevocable annuity at that time was subject to divestment penalties and scrutinized under a five-year look-back. In 1996 the waiver expired and Michigan changed its regulations to allow for an irrevocable annuity which complied with OBRA 1993 regulations. Specifically, the annuity must be:

- Irrevocable **–** meaning you can't change the beneficiary to someone else;
- Payable to the nursing home resident (if single) or the community spouse (if married);
- For a term certain – meaning you can't surrender or "commute" the policy any earlier than its term; and
- With payments ending before the life expectancy of the annuitant – meaning it was meant only as a pension-like income stream for the nursing home resident or spouse – not the children.

Practice Tip:
Anything else in the annuity contract causes the annuity to be considered "divestment." Riders have been necessary to override otherwise offensive fine-print terms in standard contracts.

2. **Michigan Insurance Commissioner cracks down on balloon annuities and inappropriate representations about annuities in October 2002.** Annuity sales under the guise of "Medicaid planning" alone occurred. Certain financial seminars preyed upon seniors' fear of nursing home spend-downs and touted "Medicaid-friendly" annuities. Some practitioners regularly planned "balloon" annuities or annuities which only paid annually. The Michigan Insurance Commissioner issued a bulletin about curbing inappropriate sales of such balloon annuities and annuities with manipulative payments. In addition, the bulletin meant to stop misrepresentations about "Medicaid-friendly" annuities.

3. **The DRA removes use of annuities on the life of a single nursing home resident, but preserves annuities benefiting a community spouse or minor and/or disabled child.** Congress, however, preserved its original intent in continuing to allow annuities which protect an income stream for the elderly spouse at home and/or minor child or child with a disability. This has traditionally worked quite well for the elderly community spouse at home to supplement her income and obtain Medicaid quicker by annuitizing otherwise countable assets.

   Specifically, the DRA adds new restrictions with Medicaid annuities as follows:

- The state Medicaid program must be named as the primary beneficiary, unless there is a community spouse and/or a minor or disabled child.

- When there is a community spouse and/or a minor or disabled child, the state must be named as secondary beneficiary (no longer the healthy adult children).
- New disclosure requirements about annuities exist for both initial applications and annual applications for recertification of any interest the applicant or community spouse has in an annuity.
- This simple change made it impossible for otherwise healthy adult children to benefit -- removing any incentive for the abusive type of Medicaid annuities designed solely to preserve inheritances.

Confusion existed on the original terminology with the DRA, using the word "annuitant" in referring to the nursing home spouse, when in fact the annuitant could be the community spouse. A recent amendment by Congress distinguished "annuitant" by requiring that any benefits received by "the institutionalized spouse" must be paid to Medicaid.

- **Long Term Care Insurance Partnership rewards the self-insured and encourages purchase of LTC policies, §6021.** The DRA codified a test program which had been implemented in four states rewarding purchasers of long term care insurance with easier asset rules under Medicaid. Now 22 states have filed for approval of these plans. Michigan is likely to join the bandwagon. These plans offer a dollar-for-dollar credit toward the amount of countable assets that can be kept for the amount of medical assistance paid by long term care insurance. For example, $100,000 of long term care insurance benefits allows an individual to keep $100,000 more of otherwise countable assets. There is also an easing of the $500,000 home equity limit to the extent long term care insurance pays.

***Effect*:** Long term care policies will be purchased more often and earlier by people as a standard insurance. Clients with any existing illnesses or diagnosis of dementia will be locked out of this benefit.

Practice Tip: Assist clients in reviewing the need for insurance and the stability of the insurers on an earlier basis. Help clients understand the complex options, costs and types of insurers. Many popular insurers such as CNA had to increase premium costs for existing contracts, whereas others such as MetLife, Genworth and John Hancock have decided not to raise premiums on their existing contacts.

- **Continuing Care Retirement Communities ("CCRCs"), §6015.** CCRCs may now require residents to use ***all*** their assets in the CCRC ***without*** a guarantee of lifetime care. The entrance fees and asset deposits at these facilities can be very expensive; facilities now can keep the funds without guaranteeing care. Prior to the DRA, it was illegal for a CCRC to require prepayment of care fees. The DRA allows CCRCs to require residents to spend down their declared resources before applying for medical assistance. The CCRC entrance fee is also considered an available resource under the DRA.

Legal effect: Contractual terms on refund of deposits will become even more tricky.

Practice Tip: Scrutinize the CCRC contract for its deposit requirements. Consider the CCRC's ability to handle difficult care or behaviors – their real specialty is independent and assisted living, not usually dementia or specialized medical care.

- **Purchase of life estates are now divestment except for actual residency more than one year**. A common Medicaid planning technique outside of Michigan, in states where Medicaid would lien the home under "estate recovery," was to purchase a life estate in the home of a relative. This technique enabled the sheltering of the proceeds invested in the relative's home and the avoidance of "estate recovery" in states where they only lien probate assets. As there was nothing to probate upon the death of the life tenant, no lien by Medicaid could occur unless the program also could lien "non-probate" assets. Such programs are called "enhanced" estate recovery, discussed below.

  This new rule under the DRA punishes this technique when the elderly person has never actually resided in the home. The DRA requires that the individual purchasing the life estate must have lived in the other individual's home for a period of at least one year after the date of the purchase. Otherwise, the purchase of the life estate will be treated as divestment.

Practice tip: Life estates in the relative's home will have particular benefit when the parent moves into the caregiver child's home for a period of at least two years. After two years of caregiving, the parent's name can be removed without divestment penalty or estate recovery.

- **Home and community based waiver services are encouraged.** The DRA authorizes states to include home and community-based services as an optional Medicaid benefit without having to apply for a "waiver" from the federal rules.

Effect: Numerous national and state studies consistently have illustrated these home and community programs to be the clear preference of elderly and disabled persons -- and more cost effective than nursing homes. The number of "slots" allocated for these services have been scarce or cut in the past with long waiting lists. However, we are likely to see an increase in funding, as discussed below.

- **Adjustments to the Community Spouse's Income Allowance are restricted.** Requires all states to apply the so-called "income-first" rule to community spouses who appeal for an increased resource allowance based on their need for more funds to be invested to meet their minimum income requirements. Their rule requires the income of the nursing home spouse to be factored into the income of the Community Spouse before allowing an increased allowance. Other states have not allowed the Community Spouse to keep more assets in light of the Community Spouse's income alone being lower than the minimum income requirements.

Effect: There is not an effect in Michigan as this rule has consistently been the law.

B. Estate Recovery.

Michigan – the last holdout state and still counting. All 49 other states have implemented some form of estate recovery program. Congress has mandated that states implement such programs since 1993. Without implementation of estate recovery, Michigan could technically lose its federal Medicaid funding, which is approximately $4 billion annually.

Recognizing the unpopularity of such a program, for the longest time it was difficult to find a state legislator willing to sponsor the bill. Since March 27, 2007, as of this writing, Medicaid estate recovery bills have been pending in the Michigan House and Senate, but they have yet to enact it. **See Exhibit C** for copy of SB 374.

- **What is Estate Recovery?** Federal Medicaid law requires that a state must attempt to recover from Medicaid recipient's estates whatever benefits it paid for the recipient's care in a skilled nursing facility or other medical institution. Recovery does not apply to Medicaid benefits paid for home and community-based services, or related hospital and prescription drug services. Recovery cannot begin until after the death of the recipient and his or her spouse, or as long as there is a child of the deceased who is under 21 years old or who is blind or disabled.

- **How does the recovery work?** States are required to recover funds from the Medicaid recipient's *probate* estate (property held in the recipient's name only). Each state can define by law what is included in a probate estate. States have the option of also seeking recovery against property in which the recipient had an interest but which passes outside of probate ("enhanced estate recovery"). This could include jointly held assets, assets in a living trust and life estates. Given the rules for Medicaid eligibility, the only property of substantial value that a Medicaid recipient is likely to own at death is his or her home. States that have not opted to broaden their estate recovery to include non-probate assets may not make a claim against the Medicaid recipient's home if it is not in his or her probate estate.

  The current Michigan bill (SB 374) is the more aggressive, broad based program of "enhanced estate recovery," which can lien both probate and non-probate assets.

- **How does this affect the residence?** In addition to the right to recover from the estate of a Medicaid beneficiary, state Medicaid agencies would be able to place a lien on the residence owned by a Medicaid recipient during her life unless certain dependent relatives are living in the property. If the property is sold while the Medicaid beneficiary is living, not only will she cease to be eligible for Medicaid due to the cash she would net from the sale, she would also have to satisfy the lien by paying back the state for its coverage of her care to date.

- **Who is exempt from this lien on the residence?** Exceptions to the lien against the residence are cases where a spouse, a disabled or blind child, a child under age 21 or a sibling with equity interest in the property is living in the home.

Medicaid estate recovery only allows for recovery of the marital home after the death of the at-home spouse.

- **How much will the program save?** The Governor's Fiscal Year 2007-2008 estimates $10.0 million gross, but only $4.6 million net yearly savings. This conforms with the national average of net recovery, which is only one tenth of one percent of the Medicaid budget ($4 million out of $4 billion costs in Michigan).

- **When will it be enacted? Will it go retroactive?** Of all years in which estate recovery bills have been introduced in Michigan, no bill has gotten this far. If it is enacted, it would likely be done within the next year. Once the program goes into effect, it will probably apply to all current and future recipients of Medicaid, but not past recipients of Medicaid.

- **Is the state considering any alternatives to an estate recovery program?** The Governor's Task Force has explored an alternative approach that would establish an estate preservation program in lieu of estate recovery. Such a program would establish a fee on each monthly mortgage payment in exchange for a guarantee that if the property owner ever needed Medicaid, the federal government and the state Medicaid program would never take their home. Basically, this would be an inexpensive insurance program, projected however to be more financially successful. No bill to this effect, however, has been introduced.

Practice tips: Consider the exceptions to divestment and estate recovery, which overlap:

- Pursue Co-Ownership arrangements with a Caregiver Child either of the parent's home or the child's home when they are able to live together. Divestment rules – even after the DRA – do not penalize the transfer of the home to a child who resides in the home and provides nursing care for a period of **two** years as verified by a physician's letter. The same exception exists under federal estate recovery regulations.
- Transfer the house to a disabled or blind child or in the form of an OBRA'93 Medicaid Payback Trust if the child herself participates in SSI-type Medicaid.
- Transfer the house to an adult child under age 21 or a sibling with an equity interest in the home who has lived in the home for at least one year.

C. Single Point of Entry.

House Bill 5389, "Single Point of Entry". Effective January 4, 2007, Governor Granholm signed into law a bill passed unanimously both by the Michigan House and Senate creating "one-stop" shops for families on information and assistance on access to long term care services. It was a key recommendation of the Governor's Long Term Care Task Force. This law requires the Department of Community Health (DCH) to create and monitor local or regional Single Point of Entry (SPE) agencies. Among other duties, the SPE sites must:

- Provide consumers and any others unbiased information promoting consumer choice for all long-term care options(including home care and assisted living).

- Assess eligibility for all Medicaid long-term care programs using a comprehensive level of care assessment provided by DCH.
- Assist financial determinations of eligibility for publicly-funded long-term care programs (as nursing home Medicaid and Home and Community Based Waiver Services).
- Develop a long-term care support plan under a "person-centered process".
- Authorize access to Medicaid programs for which the consumer was eligible and that were identified in the consumer's long-term care support plan.
- Initiate contacts to hospitals and care providers.
- Authorize access to Medicaid programs.

Last June the governor and DCH announced the selection of four SPE demonstration sites in Michigan. These awards are for a 27-month demonstration period designed to test the value and effectiveness of the single entry point concept. The four demonstration sites include:

- Upper Peninsula - $5.4 million - submitted by U.P. Commission for Area Progress
- Detroit - $13.1 million - submitted by Detroit Area Agency on the Aging (AAA)
- Southwest Michigan - $7.18 million - submitted by Region IV AAA
- Western Michigan - $9.15 million - submitted by HHS Health Options and AAA of Western Michigan.

Legal effect: This ambitious attempt by the government to link a fragmented system of private consumers and private providers appears very similar to "managed care" for Medicaid for the elderly. A managed care system already exists for mental health and developmental disability Medicaid. In its best sense, it can streamline navigation of multiple care systems. In its worst sense, it bureaucratizes an already fragmented system with agencies jockeying to monopolize funding. In effect, it may actually restrict access to services.

Practice tips: Families will still need a private, confidential resource to weigh their options without fear of being categorized and restricted. The complexity of resources, assessments and need is too much for any one governmental agency to handle.

D. Expansion of MI Choice.

Possible 42% increase in MI Choice Funding. The Governor's Long Term Care Task Force places this type of home and community-based waiver program as a high priority. As of April 2, 2007, the Michigan House Department of Community Health Subcommittee recommended to add $42 million to the Fiscal Year 2008 budget. According to the AAA Member News, the amount is $10 million more than the Governor's budget. It recognized there has not been an increase in funding in five years and now has a waiting list of over 4000 people.

Advocacy tip: Encourage efforts to make this program accessible and available as it is generally our client's preference to remain at home when safety and access are not issues.

E. Prescription Drug Coverage: Medicare Part D and Medicaid.

Annual open enrollment period relieves frustration with Medicare Part D Plans. Effective January 1, 2006 Medicare began offering private insurance plans for prescription drug coverage under Medicare Part D. Clients have been frustrated by the lack of flexibility in changing plans, especially if the program does not cover needed drugs.

> ***Practice tip:*** There is an annual opportunity to switch and enroll in plans without penalty called the "annual coordinated election period." This election period begins November 15 and ends December 31 each year. Information is available on the Medicare website, www.Medicare.gov.

Medicaid now only has limited prescription coverage. Since January 1, 2006 Medicaid no longer pays for prescription coverage except when Medicare Part D is not available or does not cover the prescription. However, Medicaid excludes coverage of various psychotropic medications such as valium and similar drugs to treat seizures, acute anxiety and muscle spasms.

III. Strategic Planning and Legal Tools in light of the Changes

With the ever-changing laws applying to the costs of long-term care, it is necessary for traditional estate plan attorneys to assist clients on a more ***dynamic*** level. Here are my recommendations in light of all the difficult challenges our clients face under the changing laws:

A. Return to the Fundamentals.

Who is it we help? These law changes are meant to curb financial abuses designed only to preserve inheritances or only to abdicate care and costs to the public. Public critics of elder law and Medicaid would like to minimalize our service to those abuses, which have been prevalent in the Medicaid annuity industry and certain financial seminars.

Rather, our ethics and daily practice require us to clarify the person we serve and to strengthen that person's well-being. "Person-centered planning" – popular for a long time in the special needs community – is now legally recognized as a right of the elderly in their care planning under our "Single Point of Entry" systems.

In particular, the changes impact the following clients as follows.

1. The Elderly Client. – The real loser in the process is the single "middle class" elderly client who was not aware of the traps of Medicaid laws. Last minute planning through gifts to healthy children is gone, except for children who assume the difficult task of caregiving. Unless there is a VA benefit, long term care insurance or financial wealth, this client dearly needs our help to access quality care, assess financial need and obtain benefits. This is especially problematic if there has been any asset transfers or the client fears loss of her home. Caregiving arrangements – bridging payments for safe care at home or in assisted living – will become increasingly important for this client.

2. The Caregiver Spouse – Spouses continue to have the Community Spousal Resource Allowance which allows the spouse to keep one-half of the countable assets as of the "snapshot date." The snapshot date is the first day of admission of the Medicaid

applicant spouse to the hospital or nursing home for a continuous period of thirty days. The 2007 minimum allowance is $20,328; the maximum allowance is $101,640.

In addition, extra funds still can be sheltered in the home of the community spouse, personal items and even an irrevocable annuity or spousal annuity trust, subject to the limitations described above.

Community spouses also continue to be allowed the Community Spousal Income Allowance. The 2007 minimum income allowance is $20,328. The maximum amount is $101,640.

Specialized estate planning is still necessary for the Community Spouse, to whom all countable assets except $2,000 must be moved within one year of the Medicaid Spouse's eligibility. Care must be taken to ensure the assets do not go straight into the name of the Medicaid Spouse, who most likely is unable to handle those assets. Receipt of such assets will destroy Medicaid eligibility.

Straight disinheritance of the Medicaid Spouse by the Community Spouse's revocable living trust will most likely be contested more often, especially as an estate recovery program is implemented in Michigan. For at least 10 years in other states there have been successful contests by Medicaid in other states of such disinheritance of the Medicaid spouse, even when the Medicaid spouse validly waived his rights to elect against the estate plan.

Testamentary Trusts providing for the Medicaid Spouse, but not destroying eligibility continue to work under the DRA. They will most likely become the more popular mechanism for spousal protection disinheritance– which is basically a special needs trust for the nursing home spouse established through the Community Spouse's Will.

3. The Child with a Disability. All planning techniques remain the same. Tremendous flexibility continues to exist to protect assets without divestment penalty and without estate recovery for the benefit of a child with a disability. The reason for such flexibility is simple: preventing the "double jeopardy" situation, which is much more costly to all of society. Handling the house for that child under estate recovery will entail greater scrutiny, as the state will maintain a claim on the house after the child's death.

Federal law under Medicaid and our current state regulations provide no penalty for gifts of assets, including the house, directly to a child with a disability. The disability needs to be verified through a determination by Social Security, or to the extent that does not exist, by Michigan DHS directly.

The legal dilemma occurs when the child himself cannot have more than $2,000 in countable resources due to need for SSI-type Medicaid or other means-tested government benefits. In that case, the "Medicaid Payback" special needs trust remains the proven method and answer.

Plans of care for both the elderly parent and the child with a disability continue to be of paramount importance. The elder law and special needs attorney plays a crucial role in assessing the proper estate and financial planning steps to support that plan of care.

4. The Caregiver Child – Special exceptions continue to exist under both the divestment regulations and estate recovery for the child who assumes the caregiver role.

Caregiving contracts will continue to provide an exception to divestment providing a written obligation and payment occurs at the time services were rendered.

If a caregiver child lives with the parent in a co-ownership arrangement in either the parent's home or the child's home, the house may be able to be protected from estate recovery. Analysis must be made of the property tax, homestead exemption, capital gains tax and inheritance implications with the client.

B. Sharpen the Saw. Remember we serve our clients best in the following roles, which we can always improve and sharpen:

1. Strategist and Planner – Reactionary planning is very limited today. No longer is planning simple to the layman or financial planner – there are too many legal traps for the unwary. Multiple strategies will be needed, using wise financial planning, long term care insurance and other benefits/services such as respite and VA benefits. Creative caregiver arrangements and care plans will continue to be rewarded.

2. Toolmaker – Form documents are actually hurtful. Estate planners need to focus more on disability, less on death. Financial durable powers of attorney and trust documents need to have specific authority for caregiving contracts, gifting, retirement plans, annuities and real estate transactions.

3. Implementer – We will need to accompany clients more on the administrative details involving the five-year lookback and post-death issues with estate recovery.

4. Counselor – Marketing is less important than "being there" and servicing clients well. We will be called upon to provide more answers addressing more anxiety.

C. Be Prepared for the Need. Recent studies of the DRA implemented in other states show that elder law practices remain as busy, if not busier than usual. Studies also demonstrate the need for long term care assistance is only increasing.

Exhibit A

SPECIAL SUPPLEMENT

IV. VA BENEFITS OPEN UP

Welcome relief to veterans, spouses and dependents of veterans. Whereas Medicaid budgets are strained and the program will become more and more difficult to access, Veterans Benefits have become much more accessible. In fact, the VA benefit may be the difference between your client affording to remain at home or to stay at an assisted living facility. Because of strong funding and under-utilization, the eligibility rules are more flexible. They also extend to surviving spouses and qualifying dependents of a veteran.

A. The Varying Levels of the VA Benefits.

There are three (3) different levels of benefits which may be available to a veteran, a spouse of a veteran and/or a qualifying dependent of a veteran. Veteran's who have "service connected disabilities" are entitled to other benefits over and above those listed below. The benefits listed below are available to veterans, surviving spouses of veterans or qualifying dependants of veterans who do **not** have service-connected disabilities.

The Lowest Level. The lowest level of benefits which are available can be provided to veterans, surviving spouses of veterans or qualifying dependants of veterans who are either over age 65 or under age 65, but permanently and totally disabled according to VA standards. The VA will presume permanent and total disability based on the following:

- Applicant is in a nursing home for long-term care due to disability;
- Applicant is determined as disabled for purposes of disability;
- Applicant is unemployable as a result of disability reasonably certain to continue throughout the veteran's lifetime; or
- Applicant suffering from either a permanent disability which would render it impossible for the average person to follow a substantially gainful occupation, or any disease or disorder that the Secretary determines justifies a finding that the person is permanently and totally disabled.

Once again, if the applicant is over age 65, he/she need not be permanently or totally disabled. If over age 65, the applicant simply must meet the financial and military service requirements to be eligible for the benefit.

The VA uses a formula to determine the monthly benefit. The formula is calculated by adding together all sources of monthly income. If a couple is applying for benefits, then the VA will combine their monthly incomes. Once the VA determines the combined monthly income, they will subtract from that number the amount of **out-of-pocket** medical expenses. Medical expenses may include, but are not limited to, medications, caregivers, physicians visits, and living expenses in an assisted living facility or nursing home if it is deemed to be a "medical expense." Once the monthly out-of-pocket medical expenses are determined, the VA will subtract that amount from the

applicant's monthly income. Based on the remainder of that amount, the VA will supplement the applicant's monthly income to assist with medical costs.

At this level the applicant's monthly supplement will be determined as follows:

Applicant's Total Monthly Income

- (minus) Applicant's Total Monthly **Out-of- Pocket Medical** Expenses

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- Supplement for single veteran to bring monthly income up to $900
- Supplement a veteran and spouse to bring monthly income up to $1192
- Supplement surviving spouse or dependant of veteran to bring monthly income up to $610

The Intermediate Level. The intermediate level of benefits available to a veteran, surviving spouse of a veteran or qualifying dependent of a veteran is often referred to as "housebound status." "Housebound" does not mean the applicant is "bed bound," but rather implies that the applicant is unable to leave their residence without the assistance of another. Housebound may also imply that the applicant uses assistive devices on a regular basis including, but not limited to a wheelchair, walker or cane. The VA defines housebound as "being substantially confined to his or her dwelling and the immediate premises or, if institutionalized, the ward or clinical area, and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime."

The VA will use the same formula to determine the monthly benefit for the applicant. At this level, the applicant's monthly supplement will be determined as follows:

Applicant's Total Monthly Income

- (minus) Applicant's Total Monthly **Out-of- Pocket Medical** Expenses

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- Supplement for single veteran to bring monthly income up to $1013
- Supplement a veteran and spouse to bring monthly income up to $1395
- Supplement surviving spouse or dependant of veteran to bring monthly income up to $746

The Highest Level. The highest level of benefits available to a veteran, surviving spouse of a veteran or qualifying dependent of a veteran is often referred to as "Aid and Attendance." Essentially, an applicant is eligible for this level of benefits when he/she is considered to need the assistance of another on a regular basis to assist with basic care needs. The VA presumes the need for permanent Aid and Attendance based on the following:

- If the applicant is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; or
- If the applicant is a patient in a nursing home because of mental or physical incapacity; or
- If the applicant is unable to dress or undress him/herself, unable to keep him/herself ordinarily clean and presentable, requires frequent need of adjustment of any special prosthetic or orthopedic appliances which cannot be done without aid, inability of applicant to feed him/herself because of loss of coordination of upper extremities or through extreme weakness, unable to attend to the wants of nature, physical or mental incapacity which requires care or assistance on a regular basis to protect the applicant from hazards or dangers incident to his or her daily environment. It is not necessary that the applicant be unable to perform all of these activities, but rather it must be established that the applicant is so helpless as to need regular aid and attendance of another; or
- If the applicant is "bedridden," meaning the applicant has a condition which actually requires him/her to stay in bed. This does not include voluntary or prescribed "bed rest."

The VA will use the same formula to determine the monthly benefit for the applicant. At this level, the applicant's monthly supplement will be determined as follows:

Applicant's Total Monthly Income

\- (minus) Applicant's Total Monthly **Out-of- Pocket Medical** Expenses

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- Supplement for single veteran to bring monthly income up to $1519
- Supplement a veteran and spouse to bring monthly income up to $1801
- Supplement surviving spouse or dependant of veteran to bring monthly income up to $976

B. Applicant Qualifications

1. In order to qualify for benefits from the VA, the applicant must be either a veteran, the surviving spouse of a veteran or a qualifying dependent of a veteran.

2. The veteran must have served 90 days in active military duty in either World War I, World War II, Korean Conflict, Vietnam Era or the Gulf War (which continues through present.)

3. The veteran must have been honorably discharged from military duty and must have proof of such through presentation of the veteran's DD 214.

4. The applicant must meet the asset and income limitations as set out below.

C. Asset Qualifications.

Based upon information we have gathered about this benefit, it appears as though the asset limitation to qualify for this benefit is approximately $80,000 per household. Certain representatives from the VA will state that if the applicant is over the asset limitation, "further adjustment will need to be made." Instead of applying for the benefit at exactly $80,000, it would probably be best to apply when the total assets are below the exact asset limitation, at perhaps $70,000. The applicant's primary residence is not counted as an asset. However, a non-principal residence, such as a vacation home or timeshare, may be counted as an asset.

Planning tip: What is so beneficial about the VA benefit, especially in contrast to Medicaid, is that there is no "look-back" penalty for divestment. This means that if the applicant is above the $80,000 asset limitation, his or her assets may be gifted, spent or divested to anyone without penalty. As long as the current bank statement shows the assets as being below the threshold amount, the VA will not inquire as to how the assets reached that amount. Clients may consider gifting, funding educational plans, securing pre-paid funeral arrangements or entering into an irrevocable trust agreement.

Applying for this benefit, however, must be done with caution. With the changing Medicaid laws requiring a five (5) year look-back provision, spending down to reach the asset limitation to qualify for VA benefits must be done carefully. If there is **any** anticipated need for Medicaid, spend downs and gifting may only be done in accordance with Medicaid divestment guidelines.

D. Income Limitations.

There are yearly income thresholds for these VA benefits. The income limits are adjusted every December. Effective December 1, 2006, the family income limits are as follows:

1. **The Lowest Level** (over 65 or under 65 but permanently and totally disabled)

- Single Veteran: **$10,929**
- Veteran with dependent (spouse or child): **$14,313**
    - Each additional child add $1,866
- Surviving Spouse of Veteran: **$7,329**

- Surviving Spouse of Veteran with one child: **$9,594**
    - Each additional child add $1,866

2. **The Intermediate Level** (Housebound)

- Single Veteran: **$13,356**
- Veteran with dependent (spouse or child): **$16,740**
    - Each additional child add $1,866
- Surviving Spouse of Veteran: **$8,957**
- Surviving Spouse of Veteran with one child: **$11,219**
    - Each additional child add $1,866

3. The Highest Level (Aid and Attendance)

- Single Veteran: **$18,234**
- Veteran with dependent (spouse or child): **$21,615**
    - Each additional child add $1,866
- Surviving Spouse of Veteran: **$11,715**
- Surviving Spouse of Veteran with one child: **$13,976**
    - Each additional child add $1,866

Some forms of income are not counted toward the annual limit. This includes, but is not limited to, welfare benefits, some wages earned by dependent children and Supplemental Security Income.

E. Applying for the Benefit.

Certain documentation is necessary to apply for the benefit. While attorneys are prohibited from completing the documentation for clients, attorneys may advise client and offer guidance during the application process. The documents needed to apply for the benefit include the following:

- Original or Certified Copy of the veteran's DD 214 (Honorable Discharge Papers);
- Marriage License (for surviving spouse or dependent child of veteran);
- Birth Certificate/Court Record of Adoption (for dependent child of veteran);
- Certification Letter from physician stating medical needs of applicant;
- Statement from Assisted Living Facility or Nursing Home (if applicant resides in such a setting);
- VA Form 21-526 Veteran's Application for Compensation and/or Pension (for single veteran or veteran with spouse and/or dependents);

- VA Form 21-534 Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (for surviving spouse or dependent child of veteran).

Keep in mind that the VA does **not** recognize Powers of Attorney. Therefore, unless the applicant has a Guardian and/or Conservator, it will be necessary for the applicant to sign the application him/herself. The applicant may even sign the application with the mark of an "X" provided the application is witnessed by two (2) disinterested parties.

If the applicant does not have a Guardian and/or Conservator, the VA may also conduct an interview with the applicant and/or their representative (agent) who handles their finances. If the VA finds it necessary to conduct an interview, it may take a longer period of time to process the benefit. Currently, applications are taking approximately six (6) to eight (8) months to process, barring the need for an interview.