# The COLORADO GUIDE to MEDICAID

Including a discussion of the
Medicaid Rules,
Five-Year Look-Back,
Gifting Strategies,
Asset Protection,
and
Aid and Attendance

THE HUGHES LAW FIRM
A PROFESSIONAL CORPORATION
1974

# Introduction

The Deficit Reduction Act of 2005 (DRA) was signed into law by President Bush on February 8, 2006. This legislation contains new and harsh restrictions on the treatment of transfers without fair consideration for the purpose of qualifying for Medicaid. The DRA also places a cap on the exempt equity value of a Medicaid recipient's principal residence, changes the law on Medicaid's treatment of annuities and entry fees for Continuing Care Retirement Communities (CCRCs) and permits all states to adopt Long Term Care Insurance Partnership Programs.

These changes under the DRA became effective in Colorado as of February 8, 2006, the effective date of the act, except for (1) the imposition of the cap on home equity, which applies to all Medicaid applications filed on or after January 1, 2006; and (2) the new rules on treatment of promissory notes, the mandatory imposition of the "income first" rule, the combining of transfers, the mandatory counting of fractional penalty periods and the transfer exemption for certain purchases of life estates, which are effective April 1, 2006. Colorado's Medicaid regulations have already been amended to incorporate these new changes in the law.

This article discusses the basics of Medicaid long term care eligibility and planning in Colorado under federal and state law now that the DRA has been enacted.

# Medicaid Basics

Medicaid is a financial needs based medical assistance program cooperatively funded by the federal and state governments. The criteria for Medicaid eligibility are governed under both federal and state law, so these criteria differ somewhat from state to state.

Medicaid provides much more comprehensive coverage of medical costs than does Medicare. For instance, federal Medicaid law does not require beneficiaries to pay deductible or co-insurance amounts. Medicaid will also cover a broader range of medical services. Most significantly, Medicaid, unlike Medicare, will cover unskilled attendant care and custodial care expenses, both in the home and in a long term care facility.

To be eligible for Medicaid long-term care benefits, including benefits under a Home and Community Based Services (HCBS) waiver program, an individual generally must pass three tests: the medical test, the income test, and the resource test.

### *The Medical Test*

To be eligible for Medicaid long-term care or HCBS benefits, a beneficiary must be over age 65, blind or "disabled", as that term is defined in §1382c(a)(3) of the Social Security Act., and the beneficiary must also require a nursing home level of care. This is determined according to the beneficiary's ability to perform the following "activities of daily living" (ADLs):

| | |
|---|---|
| Mobility | Toileting |
| Bathing | Transferring |
| Dressing | Need for supervision |
| Eating | |

Generally, if the person requires significant assistance with any two ADLs, or if the person has a very significant need for supervision, he or she will be considered in need of a nursing home level of care. Whether the person requires assistance with the requisite ADLs is determined by a functional needs assessment.

### *Treatment of Assets: The Income and Resource Tests*

Assets consist of income and resources. Assets are considered income in the month they are received. Assets held beyond the month in which they are received are considered resources.

Income and resources are either considered available if they are actually received; or if the Medicaid recipient has a legal interest in the income or resource ***and*** the recipient has the actual ability to make the income or resource available for maintenance and support. Otherwise, the income or resource is considered unavailable and is not counted in determining Medicaid eligibility.

Available income and resources are either considered countable or exempt. Generally, all available income and resources are considered countable, unless they fit into one of the specific exempt categories provided under the law.

### *The Income Test*

For Medicaid long-term care or HCBS benefits, the income cap applicable to an individual beneficiary is 300% of the maximum SSI benefit, or $2,205 per month in 2017. The income of the individual's spouse is not counted in determining the individual's eligibility for Medicaid long term care or HCBS. Reverse mortgage payments are not counted as income, but may be considered resources if they are held over to the month after they are received. Payments to the nursing home from long term care insurance policies are also not counted as income.

If the individual's monthly income exceeds $2,205 per month, but is still less than the state's applicable average monthly cost of nursing home care, he or she can still qualify for Medicaid in Colorado by using an "Income Trust," or "Miller Trust." All of the individual's current monthly income will need to go into an Income Trust each month. From the trust, the trustee can pay the individual's monthly income allowance ($81.95 for 2017); any monthly amount payable to the community spouse under applicable spousal impoverishment protection regulations; trust administration costs of no more than $20; and pre-approved Post Eligibility Treatment of Income (PETI) deductions (if any). The balance of the individual's current monthly income will be paid from the Income Trust to the nursing home as the individual's monthly patient contribution amount. The balance of the individual's covered nursing home costs for the month will be paid by Medicaid.

Normally, when a person qualifies for Medicaid in the nursing home or for HCBS, that person also will be entitled to full Medicaid coverage for hospitalizations, doctor visits and other expenses not necessarily associated with long term care. However, if a person's income exceeds the income cap for long term care benefits or HCBS and the individual must use an Income Trust to qualify, Medicaid will *only* cover that individual's long term care or HCBS expenses. If, for example, that person needs to go into the hospital, those additional expenses would *not* be covered by Medicaid.

For individuals who qualify for both Medicare and Medicaid, Medicaid will no longer pay for prescription medications covered under Medicare Part D. This is true, even if the individual elects not to enroll in Medicare Part D!

Individuals who qualify for Medicare and who will require an Income Trust to qualify for Medicaid long term care or HCBS benefits should maintain their coverage under Medicare Part A and Part B to cover other medical expenses; and these individuals should enroll in and maintain their coverage under Medicare Part D to cover their prescription medications. Further, if any individuals have a Medicare supplemental, or "Medigap" policy, or access to coverage under a group health plan, they should continue to pay the premiums to keep those policies in effect, even after they go on Medicaid. Otherwise, a hospital visit, a routine doctor's visits outside the nursing home or the need for prescription medications could present an unexpected and significant expense that Medicaid will not cover.

***The Resource Test***

The general rule regarding resource eligibility is that a Medicaid recipient cannot have "countable" resources of more than $2,000. This figure may seem unrealistically low, but please keep in mind that the following are <u>not</u> countable resources:

1. **Primary Residence.** The Medicaid recipient's equity in his or her home is considered an exempt resource if that equity is valued at less than $560,000 or the recipient's spouse or minor, blind or disabled child continues to live there; and if the home was the Medicaid recipient's principal residence; and (a) the recipient (or spouse) actually lived in the home immediately prior to being institutionalized and a spouse or dependent relative continues to live there; or (b) the recipient (or spouse) left the home before being institutionalized, but the recipient intends to return home.

2. **Vehicles.** The Medicaid recipient is entitled to one vehicle, regardless of its value.

3. **Personal Property.** Personal property is exempt, regardless of its value, so long as it is not property held for investment purposes.

4. **Life Insurance.** If the total face value of all life insurance policies the Medicaid recipient owns does not exceed $1,500, then the policies are exempt regardless of their cash surrender value. If the face value of all policies exceeds $1,500, then the total amount of the cash surrender value is countable toward the $2,000 resource limit. Term life insurance policies are always exempt, regardless of face value.

5. **Burial Insurance.** Irrevocable burial insurance is exempt regardless of its dollar value. Revocable burial insurance is exempt to a maximum of $1,500, but this exemption is reduced on a dollar for dollar basis to the extent that the person has life insurance, other than term life insurance, that was exempt under the rule described above. Also, the value of burial spaces and grave markers for the applicant and immediate family are exempt.

6. **Retirement Accounts.** Self-funded retirement accounts of the Medicaid recipient and the recipient's spouse are countable, but may be reduced for taxes that will be charged upon withdrawing the funds.

7. **Annuities.** A commercial, irrevocable and non-assignable, actuarially sound annuity that pays substantially equal payments of the annuitant's lifetime (i.e., an immediate annuity) is considered an available resource until it is annuitized. Once annuitized, payments from the annuity are considered income in the month received. The use of a "Medicaid friendly" annuity is an important technique to convert an "available resource" to an income stream that can protect a large amount of cash through a "half-a-loaf" gifting plan. Colorado's state regulations provide that such an annuity may be considered a transfer without fair consideration under certain circumstances, but see the later section entitled The New "Medicaid-Friendly" Annuity for new planning opportunities.

The DRA provides that entry fees paid to a Continuing Care Retirement Community (CCRC) are now considered countable resources to the extent that these fees (a) are refundable upon death or the termination of the CCRC contract, (b) are available to pay for the resident's care when his or her other resources are no longer sufficient, or (c) do not confer an ownership interest in the CCRC.

# Spousal Impoverishment Protections

In the case of a married couple, when one spouse is applying for Medicaid long term care or HCBS benefits and the other spouse is not, federal law provides special resource and income protection for the spouse not applying for benefits. Under these Spousal Impoverishment Protection rules, the spouse who will receive Medicaid long term care or HCBS benefits is called the "institutionalized spouse;" the spouse not receiving benefits is called the "community spouse."

***Resource Protection: The Community Spouse Resource Allowance (CSRA)***

The community spouse can retain a certain amount of countable resources without affecting the institutionalized spouse's Medicaid eligibility. The amount retained is called the Community Spouse Resource Allowance (CSRA). The CSRA for 2017 is $120,900. The CSRA is in addition to both the $2,000 the institutionalized spouse is entitled to retain and the exempt resources discussed above.

***Income Protection: The Minimum Monthly Maintenance Needs Allowance (MMMNA) and the Monthly Income Allowance (MIA)*:**

The MMMNA is the amount of monthly income the community spouse needs to pay for his or her basic needs within the community. Medicaid sets limits on this amount, which are adjusted on July 1 each year. The current MMMNA amount limits are:

Basic Allowance $2,003 effective July 1, 2016

Plus Excess Shelter Allowance $979

House Payment/Rent plus Maintenance Fee plus Insurance plus Taxes plus Utilities (actual or $601, whichever is larger),

Plus Family Allowance

Equals the MMMNA (which cannot exceed $3,023 in 2017)

The MIA is the amount of the institutionalized-spouse's income that is contributed to the community spouse if his or her income does not equal the MMMNA (MMMNA – the community spouse's income equals the MIA). If the MIA amount is not sufficient to increase the community-spouse's income to the MMMNA amount, the community spouse may request an increase in his or her CSRA. The institutionalized spouse's income must be applied first to determine if there can be an increase in the CSRA. This "income first" rule, which has long been applied in Colorado, is now mandated in all states under the DRA.

The amount of the increase in the CSRA is measured by the cost of a commercial, irrevocable, immediate annuity that will make monthly payments equal to the amount by which the community spouse's monthly income, after inclusion of the MIA, falls short of the MMMNA. However, the community spouse is not required to use the increase in the CSRA amount to actually purchase such an annuity.

## Transfers of Assets

Medicaid imposes an ineligibility period for an institutionalized individual if the individual or the individual's spouse disposes of assets for less than fair consideration at any time during the "look-back" period. The look-back period is the sixty-month (five-year) period prior to the application for Medicaid for outright transfers and for certain transfers into or out of a trust. (For transfers that were completed before February 8, 2006, the look-back period for outright transfers is only thirty-six months, except for certain transfers involving trusts, which carry a sixty-month look-back period.) The term "assets" includes all income and resources of the individual.

Upon application, the county will determine if an applicant transferred resources without fair consideration within the five-year period prior to filing his or her Medicaid application.

The period of ineligibility is calculated as the amount of the transfer divided by the average cost of nursing home care in Colorado ($7,854 for 2017). Under the DRA, states are required to impose partial months of ineligibility, and may no longer "round down." Therefore, if this calculation is not a whole number, then the decimal amount is multiplied by 30 days to determine the additional daily penalty period. For example, if a penalty period is calculated at 4.2 months, this would amount to a penalty period of 4 months and 6 days (30 days x .2 = 6 days).

The DRA also permits states to aggregate all transfers on or after April 1, 2006 during the five-year look-back period in calculating a single penalty period, based upon the total amount of all such transfers.

Under the old Medicaid rules, the penalty period began running on the first day of the month in which the transfer was made. However, under the new law applicable to transfers made on or after February 8, 2006, the penalty period does not begin until that *later* of the first day of the month in which the transfer was made *or* the first day the applicant is receiving services in a nursing home or under HCBS *and* the applicant is eligible for Medicaid, but for the transfer. Eligibility "but for the transfer" must be based on a submitted Medicaid application. This means that before the penalty period begins to run, the applicant's resources must already have been spent down to eligibility levels and a Medicaid application must be filed and approved, but for the applicable transfer penalty.

There is no limit on how long the penalty period can be. Any transfer that occurred during the five-year look-back period will be imposed in full.

When the amount transferred is large enough to trigger a penalty period of five years or more, the applicant must make certain to retain sufficient means to pay privately for nursing home care during the entire five-year look-back period. If the applicant does not apply for Medicaid until after the five-year look-back period has expired, no transfer penalty will be imposed.

Even when the amount transferred results in a penalty period of less than five years, it is important for the applicant to ensure a means to privately pay for his or her support and care during the penalty period. Prior to February 8, 2006, this was usually accomplished by employing a "half-a-loaf" strategy.

The half-a-loaf strategy essentially involved making a gift of a portion of excess resources, knowing that a penalty period would be imposed. Since the length of the penalty period could be determined in advance, and the penalty period always began to run as of the first day of the month in which the transfer was made, it was relatively simple to calculate how much the applicant could safely give away (the "transfer amount"); and the amount the applicant would require to hold back (the "hold-back amount") to pay for support and care during the penalty period.

The hold-back amount could simply be held in an interest-bearing account until needed. If the transfer and hold-back amounts were calculated correctly, the hold- back amount would be exhausted at the same time as the penalty period expired, allowing the applicant to qualify for Medicaid at that time.

The harsh treatment of transfers under the DRA makes gifting under the traditional half-a-loaf strategy very dangerous if not done correctly. Since all non- exempt resources of the applicant must be spent down to the $2,000 level before the penalty period starts to run, the applicant could be left in a nursing home with no means of payment during the penalty period.

To avoid the harsh consequences of gifting under the DRA, some means must be used which will both provide for private payment during the penalty period and not be considered an available resource that will *delay* the start of the penalty period past the date on which long term care services begin. Using a strategy that would meet these new requirements could still allow for half-a-loaf planning if the hold- back amount could be structured in such a manner as to avoid being considered an available resource. These strategies might involve the use of Medicaid-exempt annuities, which will be discussed in more detail later.

### *Exempt Transfers*

The following specific types of transfers will not incur a penalty period:

1. Transfers between spouses.

2. Transfer of the home to either (a) the Medicaid recipient's child who is under 21, blind, or permanently and totally disabled, (b) the recipient's sibling who has an equity interest in the home and who was residing in the home for at least one year immediately before the date the individual entered the nursing home, or (c) the recipient's son or daughter who was residing in the home for at least two years immediately before the date the individual entered the nursing home and who provided care that permitted the individual to reside at home rather than in an institution. Applicants are required to obtain letters from their doctors stating that the care that the son or daughter provided allowed the individual to remain at home instead of in a nursing facility.

3. Transfer of any assets (other than the home) either directly or to a trust established solely for the benefit of the Medicaid recipient's child who is under age 21 or is blind or permanently and totally disabled, or to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

4. Transfers of assets into a Medicaid-exempt Special Needs Trust or Pooled Trust (so long as the transfers are completed before the beneficiary reaches age 65) and transfers of income into a Medicaid-exempt income trust (Miller Trust).

5. Transfers where the individual can justifiably show that the Medicaid recipient intended to dispose of the assets, either at fair market value or for other valuable consideration, the assets were transferred exclusively for a purpose other than to qualify for Medicaid, or all assets transferred for less than fair market value have been returned.

The DRA adds or revises three additional categories of exempt transfers:

1. Transfers to purchase actuarially-sound, irrevocable and non- assignable immediate annuities payable to the Medicaid recipient if the state is named as the death beneficiary up to the amount of Medicaid benefits paid to the annuitant. The state may be named as a second death beneficiary behind the recipient's surviving spouse or minor or disabled child.

2. Transfers as loans if the repayment term is actuarially sound, payments are in equal amounts for the life of the loan (no deferrals or balloon payments) and there is no provision for cancellation on the death of the lender.

3. Transfers to purchase a life estate in another person's home if the purchaser actually lives in the home for one year after the purchase.

## Spending Down

An individual will only incur a transfer penalty if the individual transfers (gives away) assets without receiving fair consideration in return. Therefore, an effective and safe method to reduce excess resources to Medicaid eligibility levels involves "spending down" at least a portion of excess resources. Spending down involves the use one or more of the following three strategies: (1.) converting non-exempt resources into exempt resources, (2.) converting non-exempt resources into exempt income, or (3.) transferring non-exempt resources for valuable consideration that would not be considered a resource or income.

Under the first strategy, the individual might use excess cash resources to make home improvements and repairs, purchase a new vehicle, purchase new furniture and appliances for the family home, purchase an irrevocable burial plan or fund a Medicaid-exempt trust. Under the second strategy, the individual could use excess resources to purchase long-term care insurance or a Medicaid-exempt annuity. Under the third strategy, the individual might use excess resources to pay off a mortgage or other debts, pay for travel, hire a care manager, pay professional fees for Medicaid-planning, disability-planning or estate-planning assistance.

For some individuals, gifting may not be necessary to achieve Medicaid-eligibility levels after spending down; however, many individuals will still have excess resources after spending down and may need to proceed with some gifting as part of their plan to achieve eligibility.

## Medicaid Estate Recovery

The State of Colorado, through its Medical Assistance Estate Recovery Program, can seek recovery for the amount of medical assistance provided to an individual over age 55 or provided to an individual in an institution, regardless of age. The State of Colorado is an interested party in that individual’s estate because of the assistance it provided to him or her. After the individual dies, the state must be notified of the death and be given notice of the individual’s estate proceedings. The state will then try to assert a lien against individual’s estate to obtain reimbursement for the assistance it provided to him or her. The state will file a claim against the individual’s estate to obtain the equity in the home and any other assets owned by the individual.

The State of Colorado can recover for the individual’s Medicaid only to the limit of his or her equity or interest in the home and any other property in the individual’s estate. The state cannot recover against any other owners of the property, including certain trusts. Further, a life estate and joint tenancy interest owned by the individual ceases at the moment of death and are not considered part of the individual’s estate, so these interests cannot be reached by a lien or estate recovery claim.

The fact that a Medicaid recipient may own property in joint tenancy with another person, such as a savings account, does not necessarily mean the property is "safe" from Medicaid estate recovery liens. When real property is held in joint tenancy and one joint

tenant dies, the property automatically reverts to the other joint tenant outside of the decedent's estate.

The only protection against estate recovery liens afforded a Medicaid recipient owning a residence under joint tenancy with another person is when the Medicaid recipient dies first. Then, the residence automatically reverts to the surviving "well" joint tenant and Medicaid cannot place an estate-recovery lien on that property. If the "well" joint tenant dies first, however, the residence passes to the Medicaid recipient, subjecting the entire residence to estate recovery after the death of the Medicaid recipient. Medicaid may still consider the property to be exempt as the recipient's principal residence for Medicaid-qualification purposes, but the home's vulnerability to estate recovery after the recipient's death points up the fact that Medicaid funds made available to unmarried Medicaid recipients are, in reality, only "loans". Another danger of holding property in joint tenancy is that the property will be subject to claims, judgments or liens by the other joint tenant's creditors.

To avoid the possibility of a Medicaid lien in a situation where the married couple owns the home in joint tenancy, it is advisable to transfer ownership of the residence to the community ("well") spouse exclusively. The community spouse can then provide for proper distribution of the residence through his or her will. The transfer to the community spouse will not incur any penalty periods since transfers between spouses are exempt. If there is no community spouse, transferring the home to a non-spouse, while retaining a life estate, is a much safer strategy than transferring the home into joint tenancy with the non-spouse.

## Medicaid's Treatment of Annuities
## The New "Medicaid –Friendly" Annuity

***The New "Medicaid-Friendly" Annuity***

Since April, 2012, we now have new annuity rules in Colorado that allow families to preserve hard-earned savings like never before.

Although these new rules give folks wonderful money-saving opportunities, they are complicated and difficult to use. Getting help from an elder law annuity expert is essential. A brief "read" of the following will demonstrate why.

Do your best sorting this out. If you believe you can benefit from the rules, call our Long-Term Care Helpline at (303) 409-3578. We'll help!

### *Medicaid's Treatment of Annuities*

The state regulations on treatment of annuities are found in Section 8.100.7.I & 8.100.7.J, Volume 8 of the Colorado Department of Health Care Policy and Financing Medicaid Staff Manual, 10 C.C.R. 2505-10. In that section, an annuity is now defined as:

> ". . . a contract between and individual and a commercial company, in which the individual invests funds and, in return, is guaranteed fixed substantially equal installments for life or a specified number of years."

Under Colorado Medicaid regulations, once an irrevocable and non-assignable annuity has been annuitized and the annuitant is receiving regular distributions, the annuity is no longer considered as part of the asset pool for purposes of determining Medicaid eligibility. Instead, the monthly distributions are considered income to the annuitant each month they are reviewed. However, an annuity that is revocable and assignable will be treated as an available resource, even if it has been annuitized.

### *Treatment of Annuities Payable to the Medicaid Recipient or the Community Spouse and Purchased on or After February 8, 2006*

Purchasing an annuity that makes monthly payments to either the Medicaid recipient or the community spouse will not result in a transfer penalty, regardless of the size of the annuity payment, so long as the annuity meets the following criteria:

1. The annuity must have been purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; and

2. The annuity must be irrevocable and non-assignable, or it will be treated as an available resource, even if it is annuitized; and

3. The annuity must name the state as death beneficiary, at least up the amount of Medicaid benefits paid to the Medicaid recipient during his or her lifetime. The state must be named as first death beneficiary, unless the recipient has a spouse or a minor or disabled child, in which case that spouse or child may be named as first death beneficiary with the state as second beneficiary, if the spouse or child dies before the recipient, or disposes of his or her remainder interest without fair consideration; and

4. If the annuity is payable to the Medicaid recipient:

    a) The annuity must be "actuarially sound," meaning it must be designed to pay out completely during the Medicaid recipient's remaining life expectancy (as determined by the appropriate life expectancy table – male or female – issued by the Office of the Chief Actuary of the Social Security Administration); and

b) The annuity must make substantially-equal payments over the entire period of the annuity; OR
c) The annuity is a qualified individual retirement annuity under IRC §408(b), or (q), or the annuity is purchased from a qualified individual retirement plan under IRC §408(a), (c), (p,) or (k), or IRC §408A.

At first glance, it would seem futile to purchase such an annuity for the Medicaid recipient since virtually all of the annuity payments after the Medicaid recipient enters the nursing home (or begins receiving long term care services at home) will be used to pay for long term care expenses. However, such an annuity could be a very effective planning tool whenever the Medicaid recipient makes gift transfers on or after February 8, 2006, to qualify for Medicaid, because such an annuity will allow planners to continue using "half-a-loaf" strategies under the strict provisions of the Deficit Reduction Act of 2005 regarding treatment of transfers without fair consideration.

For example, the annuity would be purchased with all of the Medicaid applicant's excess resources remaining after completion of the applicant's "spend down" and other gift transfers, and would be structured to pay out for a term not to exceed the penalty period from the transfers, or 60 months, whichever is shorter. Further, the monthly payments from the annuity would be designed to pay for the applicant's monthly long term care expenses in excess of the applicant's other income during the penalty period or look-back period. Finally, the annuity should not be annuitized until the applicant (1) enters the nursing home or begins receiving long term care services at home, (2) qualifies for Medicaid (except for the transfer), and (3) files his or her Medicaid application.

Once annuitized, such a "bridge" annuity would no longer be countable as a resource, and would not, by itself, delay the start of the penalty period once the Medicaid applicant is in a long term care setting and receiving services, since the applicant would have no more excess resources and would qualify for Medicaid, but for the transfers. The annuity payments could then provide for the Medicaid applicant's nursing home or other long term care expenses during the penalty period or look-back period. Once the bridge annuity is exhausted and the penalty period or look-back period has expired, the applicant could begin receiving Medicaid long term care benefits in the nursing home or at home through Home & Community Based Services ("HCBS") or the Program for All-inclusive Care for the Elderly ("PACE").

A word of caution here: if the annuity income, together with the applicant's other income, exceeds the average monthly cost of nursing home care in the applicant's region of Colorado, the applicant will be ineligible for Medicaid due to excess income such that the penalty period would not begin to run. Therefore, the payments from the bridge annuity to the applicant must be designed so that those payments, together with the applicant's other income, will be just *under* the monthly regional average nursing home cost. That way, the applicant would still be "income eligible" using an income ("Miller") trust.

This is where today's "half-a-loaf" gifting strategy is different than the strategy used before the newest Medicaid law change went into effect on February 8, 2006. The new law now dictates that the applicant's remaining income and resources should *not quite* be enough to privately pay for long term care during the transfer penalty. As a result, it is extremely important to ensure that individuals receiving the gift transfers (usually the children) understand that they must agree to be responsible for payment of the applicant's small monthly shortfall until the applicant qualifies for Medicaid. Otherwise, the applicant could lose his or her source of care (either home care or nursing home care.

It is also important to note that a bridge annuity that complies with Colorado's current annuity regulations will often be designed to pay out over a fairly short period of time, often less than two years. An annuity issuer will charge a separate fee for these super-short-term annuities since the issuer will not have use of the annuity premium long enough to generate a profit. Bridge annuities for periods of three or more years are usually available without this separate fee.

An irrevocable and non-assignable annuity, (a "Medicaid-compliant" annuity), payable to the community spouse, can also provide additional income to the community spouse without affecting the institutionalized spouse's Medicaid eligibility. The annuity must name the state as the primary death beneficiary, at least up the amount of Medicaid benefits paid to the institutionalized spouse during his or her lifetime. This means that the annuity will need to have a guaranty period to meet the "death beneficiary" requirement. Although the annuity should be designed to pay out for lifetime of the well spouse at home ('community spouse"), there is rarely a compelling reason for any guaranty period to be more than the 60 month look back period for transfers without fair consideration.

In many cases, some or all of the institutionalized spouse's income will be lost to the community spouse after the institutionalized spouse dies. For example, the institutionalized spouse may have chosen a "life only" option on his or her retirement pension in order to receive a greater monthly pension payment. However, in such a case, the pension benefit would no longer be available after the institutionalized spouse's death. Purchasing a Medicaid-compliant annuity for the community spouse is now an outstanding solution to this dilemma, and offers the community spouse a very attractive vehicle for "spending down" excess resources instead of making disqualifying gifts, while still qualifying the institutionalized spouse for Medicaid!

For more information about this and other elder-law topics, give us a call at **(303) 409-3578.**

## Long Term Care Insurance

Payments to the nursing home from a long-term care insurance policy are not treated as income for Medicaid purposes and the policy itself is not counted as a resource. Long term care insurance is an excellent way to ensure that an individual will be able to meet future nursing home costs during any penalty period that might result from transfers of assets.

Many healthy but elderly folks may qualify for long-term care insurance. Purchasers should make sure that the policy will provide sufficient payments to cover nursing home costs not covered by monthly income, cover the costs of an assisted living facility as well as in a nursing home and continue long enough to cover the period during which Medicaid will not be available (i.e., either the penalty period or the five-year look-back period for transfers, whichever is shorter).

## Colorado Long-Term Care Partnership:

The Colorado Long-Term Care Partnership is a public/private arrangement between long-term care insurers, Colorado's Medicaid program, the Division of Insurance, the Department of Human Services and the citizens of Colorado. It enables Colorado residents who purchase Long-Term Care Partnership insurance to have more of their assets protected if they later need the state Medicaid program to help pay for their long-term care. Colorado is using this approach to give its citizens greater control over how they finance their long-term care and to help shore up the public safety net against upcoming demographic pressures.

Colorado Long Term Care Partnership (n.d.) In Colorado "*The Official Web Portal.*" Retrieved from https://www.colorado.gov/pacific/ltcpartnership ©2015 State of Colorado

## Reverse Mortgages

Payments from a reverse mortgage are not counted as income for Medicaid eligibility purposes. For married couples planning for Medicaid eligibility, a reverse mortgage on the couple's principal residence could provide the means to pay privately for the institutionalized spouse's care during the penalty period or look- back period resulting from gift transfers. If the couple's equity in their principal residence is greater than $560,000, a reverse mortgage could also be used to reduce the value of that equity to allow the principal residence to qualify as an exempt resource.

To qualify for a reverse mortgage, both spouses must be over age 62 and own their home. At least one of them will be required to continue living in the home, even after the institutionalized spouse goes into a nursing home. Individuals should look for a reverse mortgage that will provide the community spouse with a line of credit which he or she can draw upon each month to pay for the institutionalized spouse's nursing home or other long-term care expenses during the penalty period or the look-back period. Reverse mortgages can also provide a convenient source to pay for long-term care insurance premiums without having to worry about making any payments out of current income to either the long-term care insurance company or the reverse-mortgage lender.

Neither spouse will be required to pay back the mortgage so long as at least one of them continues to reside in the home. However, once *both* spouses have moved out of the home, the reverse mortgage will become due in full. This may require that the home be sold and that any proceeds remaining after repayment of the mortgage be paid to the spouses surviving at the time.

These remaining proceeds would be considered available resources and could result in one or both spouses becoming ineligible for Medicaid. However, if repayment of the reverse mortgage was due to the death of the community spouse or the community spouse entering a nursing home, the community spouse's CSRA of $120,900 (for year 2017) would also become an available resource. Be aware that spousal impoverishment protections will no longer apply when the community spouse dies or when both spouses are receiving long term care.

## Veterans' Benefits

The Department of Veterans' Affairs (VA) provides many valuable benefits for a variety of long-term care needs, including, but not limited to, nursing home care, respite care and adult daycare. Long-term care benefits are based on clinical and/or financial need, depending on the veteran's disability and financial situation.

Because Aid and Attendance is so complex, there is a separate, stand-alone guide we have prepared, please contact us for more information at **303-409-3578**.

## Conclusion

To become eligible for Medicaid, an individual must eliminate any resources in excess of resource-eligibility levels. This can be accomplished by "spending down" these excess resources, by making gifts of these excess resources or by a combination of the two.

Typically, an individual planning for Medicaid eligibility will want to preserve as many resources as possible, either for his or her family and loved ones or for his or her own supplemental needs once Medicaid benefits begin. Therefore, most Medicaid planning has traditionally involved making gifts.

Making gifts for purposes of becoming eligible for Medicaid can be potentially disastrous under the new laws. Medicaid planning has now become more difficult and dangerous, but it is not impossible.

A strategy is needed which will allow the penalty period to start running as soon as the individual enters the nursing home while, at the same time, providing a means of private payment for the duration of the penalty period and preserving a portion of the applicant's resources that satisfies the applicant's planning goals.

In many cases, an annuity, long-term care insurance or a reverse mortgage may provide a perfect solution. However, all of these strategies will not work in every situation. This is why it is so important that an *individualized* Medicaid plan be formulated on a case-by-case basis to fit the exact circumstances of each individual and that each individual's own Medicaid plan be followed exactly as designed.

Securing the services of an elder law attorney is critical to successful asset- protection and Medicaid planning. Under the new law, do-it-yourself Medicaid planning is simply out of the question. If you've read this far, you know this to be true. Avoid attorneys who only dabble in this field; proficiency requires a full-time commitment. Do your due diligence before retaining counsel and consider starting your search with attorneys who are members of the National Academy of Elder Law Attorneys. We know the really good attorneys that practice elder law in your area. Give us a call at (303) **409-3578** and we'll direct you to a specialist that won't waste your valuable time. For more information on this topic or related topics, visit our website at www.thehugheslawfirm.net.

*Thank you,*

*From everyone at the Hughes Law Firm*

# THE HUGHES LAW FIRM

A PROFESSIONAL CORPORATION

1974

4155 E. Jewell Avenue, Suite 500
Denver, Colorado 80222
**(303) 409-3578**
www.thehugheslawfirm.net

## Satellite Offices:

Arvada
Aurora
Broomfield
Colorado Springs
Ft. Collins
Lakewood
Lone Tree
Littleton
Park Meadows

NAELA™
National Academy of Elder Law Attorneys, Inc.
MEMBER

*Leading the Way in Special Needs and Elder Law*

©2015 The Hughes Law Firm, P.C.