

ELDER LAW

AND

LATE LIFE FINANCIAL PREPARATION

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WARNING: This outline is not intended to provide legal advice. It is intended to provide a broad overview of a very complex system. Every person's situation is different. You should consult with a qualified expert to review your own personal situation before utilizing any estate planning or Medicaid planning strategies.

I. FINANCIAL MANAGEMENT

When a person is incompetent, another person must manage their assets and income, sign contracts on their behalf, open their mail, pay their bills, apply for their insurance benefits, obtain information from financial and medical providers and handle their business affairs. Contrary to what many people believe, a spouse does not have the automatic legal right to act on their behalf in the event of incapacity. The personal representative (executor) of their estate also has no legal right to act until after death. People use a variety of methods to provide for financial management in the event of incapacity. These are described below.

A. **What is the Effect of Joint Ownership?**

1. Many people plan for incapacity by holding all of their assets in joint name with a spouse, adult child, or other relative.
2. The joint owner of a bank account (checking, savings, money market, CD, etc.) has all the same rights over the account that the primary owner has. Each joint owner has access to 100% of the assets in the account. This is usually true, even if the account title reads "and" not "or." Therefore, the joint owner of a person's checking account or savings account will have access to their money to pay your bills if they are disabled.
3. The joint owner of a bank account has no obligation to account to the primary owner and has the legal right to withdraw all of the money for his or her own benefit.
4. Other assets, like real estate, stocks, bonds, and many other investments require the signature of all joint owners. With these types of assets, joint owner will not have the ability to manage or liquidate those investments without the primary owner's signature. This is true even if the joint owner is the spouse. The primary owner also may be unable to manage the asset without the signature of the joint owner, and in some cases, the joint owner's spouse.
5. The joint owners' creditors may be able to make a claim against jointly owned assets. Jointly held assets may also become an issue if the joint owner gets a divorce. Since joint ownership is actual ownership of an interest in the property, these assets may be claimed by the joint owners creditors or soon to be ex-spouse.
6. Upon the death of a joint owner, the jointly owned property generally passes automatically to the surviving joint owners regardless of what is

directed in a Will or other estate planning document. The joint owner has no obligation to use the jointly held assets to pay the deceased person's debts.

7. Joint ownership may also have Medicaid qualification consequences.
8. Joint ownership with a spouse is often useful and appropriate where the couple's joint estate is less than \$1,000,000. Joint ownership with people other than a spouse can be problematic.
9. Joint ownership may have estate tax, capital gains tax, or income tax consequences.
10. Ladybird deeds, beneficiary designations, pay on death or transfer on death accounts can all avoid probate without all the risks of joint ownership and without being treated as divestment by Medicaid.

B. What is a Durable Power of Attorney?

1. A power of attorney is a document by which you can appoint an agent to legally act on your behalf.
 - a. A "durable" power of attorney remains effective in the event of your disability or incapacity.
 - b. Consequently, it can be used to avoid the expense, delay, and public nature of a formal probate court conservatorship proceeding if you become disabled.
 - c. Under Michigan law, the agent's powers are generally limited to those powers specifically mentioned in the document.
 - d. The agent generally can't use the power of attorney for "self-dealing transactions" or transactions which benefit the agent, including gifting, unless the document specifically allows this.
 - e. The agent can be required to account for all transactions handled under the authority of the durable power of attorney.
2. A durable power of attorney can be designed to:
 - a. Become effective only if you become disabled (a "springing" power which may cause problems of proof of disability); or
 - b. Be effective immediately without proof of disability.
3. You can choose anyone or more than one person to act as your agent but:
 - a. Your agent should be someone you trust and who has good business judgment; and

- b. Name a successor agent in case your first choice cannot act.
4. Your durable power of attorney should be witnessed and notarized so that it can be recorded if it is used in connection with real estate.
5. You should periodically sign a new durable power of attorney to decrease the possibility that it will not be recognized.
6. Third parties like banks, brokerage firms, title companies, etc. are not required to rely on the Agent's power under the durable power of attorney. However, if a third-party chooses to allow the Agent to act, and does not review the document to determine whether there are any limits on the Agent's authority, the third-party is acting at their own risk.

C. Conservatorship

1. If you have not planned in advance, someone will have to petition the probate court for a protective order or to appoint a conservator to manage your financial affairs.
2. A protective order is a limited order for a limited time addressing a limited situation. For example, a person might get a protective order granting authority to sell jointly held real estate and directing how the proceeds should be distributed.
3. A conservator is a person appointed by the court to be responsible for managing money and property on behalf of an incapacitated person. It could be a family member or it could be an independent person if the family cannot agree or there is no willing or appropriate family member to act.
4. Evidence must be presented at a probate court hearing that you are unable to manage your property and affairs effectively for reasons such as mental illness, mental incompetency, or physical illness or disability. In some counties, a physician must testify regarding your mental capacity. Poor money management skills or poor judgment about which friends and family members to trust are not grounds for a conservatorship. The person must be truly unable to manage their property or affairs.
5. The court appoints an independent, trained, guardian ad litem to visit with the alleged incapacitated person, and to recommend to the court whether a conservatorship is appropriate, and whether the person asking to be appointed is appropriate. The guardian ad litem will also determine whether there is any less restrictive alternative.
6. The court will appoint a conservator based on a statutory priority. The spouse has first priority, followed by parents, followed by adult children. If there is no appropriate family member to act, the court may appoint a public guardian/conservator.

7. Fifty-six days after the conservator is appointed, the conservator is required to create an inventory of the assets the conservator will be managing. The conservator must give a copy of the inventory to the incapacitated person. The conservator must keep the incapacitated assets separate from the conservator's assets, must keep complete and accurate records, and must file an annual account with the court and the account must be approved at a hearing at least every three years. Family members, even estranged family members, are entitled to a copy of the accounting, and notice of the hearing.
8. The conservator does not assume personal liability for the debts of the incapacitated person. However, if the conservator mismanages or embezzles the incapacitated person's money, the court can impose personal liability. Courts frequently require that the conservator post a bond, paid for out of the incapacitated person's money. Courts also restrict the conservator's ability to deal with significant assets, like real estate, without further court order. The conservator is not allowed to use the incapacitated person's money to benefit the conservator.
9. The conservator cannot sell or dispose of the incapacitated person's real estate or interest in real estate without approval of the court. The court must hold a hearing with notice to all interested parties (as set forth by court rule) and consider evidence of the value of the real estate and whether the sale is in the incapacitated person's best interest.
10. Michigan law has recently tightened its conservatorship laws. The laws now tend to favor the independence of the individual at issue. Therefore, before a court will order a conservatorship, it must be proven that there is no "less restrictive alternative" to a conservatorship. Less restrictive alternatives include: protective order, durable power of attorney, jointly held assets, assets in living trust, or a representative payee for social security payments.
11. The conservator has an obligation to encourage maximum self-reliance and independence of the incapacitated person. The conservator must follow the prudent investor rule, including diversification of investments.
12. The court and conservator must take into account the incapacitated person's estate plan.

D. Social Security Representative Payee.

1. The Social Security Administration will not accept a durable power of attorney. Social Security requires the appointment of a representative payee. You can get information on representative payees by visiting the Social Security Administration's site, www.ssa.gov/payee.
2. Adult Social Security beneficiaries generally have the right to manage their own Social Security benefits. If you have a representative payee and

want to become your own payee, you should contact the Social Security Administration. Be prepared to provide letters or other documents from your physician, psychiatrist or other professional about your ability to manage your own benefits. If you think your Representative Payee is mismanaging your benefits you can also contact the Social Security Administration.

3. If the person cannot manage his or her own benefits due to a physical or mental condition, the Social Security Administration can appoint a Representative Payee. In order to assign a representative payee for a particular person, the SSA must make a finding that the person cannot manage or direct the management of his or her benefit payments.
4. Evidence must be provided to the Social Security Administration in the form of medical opinions, statements from relatives, friends or persons having care and custody of the Social Security recipient. The Social Security Administration will appoint a Representative Payee based on the recipient's best interest.
5. The representative payee must use benefit payments for the use and benefit of the beneficiary in his or her best interest, must notify SSA of any event that will affect the amount of the benefits the person should receive, and must submit a written accounting of benefits to SSA as requested. The representative payee will receive all SSA correspondence on behalf of the recipient.
6. The preferred order of choice for selecting a representative payee is: (1) Spouse, legal guardian or relative who demonstrates strong concern for the personal welfare of the beneficiary; (2) Friend who demonstrates strong concern for the personal welfare of the beneficiary, (3) a public or nonprofit agency or institution having custody of the beneficiary, (4) a private for-profit institution having custody of the beneficiary.
7. If a person's Social Security benefits are directly deposited into a bank account, a Representative Payee may not be necessary when there is a joint account holder or durable power of attorney over the account.

E. What is a Living Trust?

1. A living trust is an agreement between you as the "grantor" and someone you select as the "trustee."
 - a. It is called a "living" trust because you transfer assets to it during your lifetime.
 - b. Because the assets are in the trust, they can be managed by the trustee if you become disabled, thus avoiding the expense, delay, and public nature of a formal probate court conservatorship proceeding.

2. Your living trust can accomplish other goals after your death, such as:
 - a. Avoiding probate;
 - b. Minimizing federal estate taxes;
 - c. Managing assets for children and preventing minor children from receiving an inheritance at too early of an age;
 - d. Providing for a spouse while protecting the ultimate inheritance of children from a prior marriage;
 - e. Providing for disabled children or elderly parents without disqualifying them from governmental benefits to which they may otherwise be entitled;
 - f. To allow for continuation and management of business interests and to facilitate orderly disposition of a family owned business.
3. Even if you have a living trust, it is a good idea to also have a durable power of attorney and a will to cover assets which may not get transferred to the trust.
4. If you intend to use your living trust to avoid probate, all of your property must be transferred to the trust before your death.
5. NOTE: Generally, executing and funding a living Trust will not cause your assets to be exempt for Medicaid purposes.

F. Avoiding Probate.

1. Probate can be avoided by not holding assets in your individual name. If all you own is in the form of beneficiary assets and joint assets, there will be no probate.
 - a. Since the surviving joint tenant becomes the sole owner of the joint assets, probate will not be avoided on the death of that joint tenant.
 - b. Holding all your property jointly can have adverse personal, estate, gift and income tax consequences.
2. If you transfer all of your assets into a living trust before death, you will avoid probate.
 - a. A living trust keeps financial and personal information out of the public record. This is particularly important where a family business is involved.
 - b. You may serve as initial trustee of your trust so that you retain control and your trust may be changed by you.

II. HEALTH CARE DECISIONS

A. **Why Plan?**

1. Most people do not die of a sudden illness or injury. Rather, most people die after a prolonged chronic illness. Numerous medical decisions must be made during the course of such an illness.
2. If you are competent, you have the right to accept or reject medical treatment based on the common law right of self-determination and the federal constitutional right of privacy.
3. That right should not be lost by incapacity, but most people become incapacitated at some point in the process.
 - a. A surrogate decision-maker should be designated.
 - b. The surrogate decision-maker should determine what you would have wanted.
 - c. If there is no evidence of what you would have wanted, the surrogate decision-maker must determine what is in your best interests.

B. **Guardianship.**

If you have not designated a surrogate decision-maker, someone may have to petition the probate court to appoint a guardian to make personal care decisions for you.

1. Evidence must be presented at a probate court hearing that you are impaired by reason of mental illness, mental deficiency, or physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, to the extent that you lack sufficient understanding or capacity to make or communicate informed decisions concerning your person. Many courts required a letter from a doctor or specialized medical testimony.
2. The person who is alleged to be incapacitated is entitled to an independent medical examination, an attorney, and jury.
3. The court appoints an independent, trained, guardian ad litem to visit the person and report back to the court on whether the guardian ad litem believes that the guardianship is necessary, why no less restrictive alternative is appropriate, and whether the person asking to be appointed seems appropriate. The cost of the guardian ad litem must be paid by the incapacitated person's assets, or by the petitioner.

4. The court will appoint a guardian based on a statutory priority. The spouse has first priority, then the parents, then adult children. If no family member is available or appropriate, the court may appoint a public guardian. If a public guardian has been appointed, this person's opinion and direction takes priority over the family. The public guardians frequently have very large caseloads, and are only required to visit the person quarterly.
5. The court may order a full guardianship where the guardian has the authority to make absolutely all decisions for the incapacitated person or a limited guardianship where the guardian only makes certain decisions, for example, where the person should live.
6. Unless restricted by a court order, the guardian has the authority to authorize medical treatment, review medical records, make placement decisions, determine who is allowed to visit the person, who is allowed to attend case conferences, consent to release of information and a broad range of other powers. Whenever meaningful communication is possible, the guardian must consult with the incapacitated person before making major decisions. The guardian generally is not responsible for actually transporting the person to the doctor or other appointments.
7. The court may order the costs of the petition for guardianship paid out of the incapacitated person's funds, or may order the petitioner to pay it out of their own pocket.
8. A separate authorization is required for involuntary commitment in a mental health facility. The guardian generally does not have this power. The guardian does have the power to consent to electro-convulsive therapy.
9. Michigan does not yet have a clear standard for withholding or withdrawing medical treatment from a patient who is not competent and who has not given an advance directive regarding medical treatment or appointed a surrogate decision-maker. The fact that a person is elderly does not necessarily mean that extraordinary measures will be avoided.
10. In order for the court to appoint a guardian, the court must find by clear and convincing evidence that the person is unable to make informed decisions and that the appointment of a guardian is necessary as a means of providing continuing care and supervision. Evidence of bad decision making, or a diagnosis of dementia alone will not be enough to justify a guardianship.
11. If the incapacitated person has signed a medical power of attorney or patient advocate form, and the advocate is fulfilling their duties, the guardian cannot exercise any of the powers held by the patient advocate.

12. The guardian does not have the authority to handle real estate without a separate hearing and court order.

C. What is a Designation of Patient Advocate?

1. A designation of patient advocate is a document by which you can appoint an agent called a “patient advocate” to make health care decisions for you in the event you are unable to participate in medical treatment decisions. Sometimes, this is called a durable power of attorney for health care, or an advance directive, or a living will. Most general durable powers of attorney do not address health care issues.
2. Michigan is one of several states which statutorily authorizes appointment of an agent for health care decisions. The Michigan legislature enacted the Patient's Rights Act on December 18, 1990.
3. You must be competent to designate a patient advocate.
4. The patient advocate's authority is exercisable only when you are unable to participate in medical treatment decisions.
 - a. The determination of inability to participate in medical treatment decisions must be made in writing by your attending physician and another physician or licensed psychologist upon examination of you. If this determination has not been made and put into the medical record the health care provider relies on the advocates’ instructions at its own risk.
 - b. If you regain your ability to participate in medical treatment decisions, the designation of a patient advocate is suspended.
5. Your designation may include a statement of your desires on care, custody, and medical treatment.

Your patient advocate may make a decision to withhold or withdraw treatment which would allow you to die **only if you have expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision and that you acknowledge that such a decision could or would allow your death.**

6. You can choose any person who is at least 18 years old as your patient advocate and you can designate a successor if your first choice cannot act.
7. To be effective, the designation must be:
 - a. Written, dated and signed voluntarily by a competent person; and
 - b. Signed in the presence of two witnesses who cannot be your spouse, parent, child, grandchild, sibling, presumptive heir, known

devisee, physician, patient advocate, an employee of your life or health insurance provider, an employee of a health facility that is treating you, or an employee of a home for the aged where you reside.

8. You may revoke your designation at any time and in any manner sufficient to communicate an intent to revoke.
9. If you name your spouse as your patient advocate, that designation is suspended during the pendency of an action for separate maintenance, annulment, or divorce and is revoked upon a judgment, unless you have named a successor to your spouse as your advocate.
10. Your current desire takes priority over a previously expressed desire.
11. Your physician, hospital, and health facility are bound not only by your patient advocate's instructions but also by "sound medical practice." Sound medical practice would probably not condone euthanasia or assisted suicide.
12. Your patient advocate has legal authority to make medical treatment decisions for you. However, if there is a dispute over whether your patient advocate is acting consistently with your best interests (your known desires as expressed while you were able to participate in medical treatment decisions) a petition may be filed with the probate court requesting a court determination as to the continuation or removal of the patient advocate.
13. If you have a durable power of attorney for health care which was signed before December 18, 1990, it is valid but only if it specifically gives the power to refuse life-sustaining treatment or in some other language clearly and convincingly states that your agent may make decisions to withhold or withdraw treatment which would allow you to die. Most pre-1990 powers of attorney do not contain this language.

D. Do Not Resuscitate Procedures Act

1. If you do not want to be resuscitated if your heart and breathing stop, you may so direct in your Patient Advocate Designation.
2. State law requires licensed nursing homes, foster care facilities, homes for the aged, etc. to call an ambulance if you stop breathing or your heart stops. If you are at home, family members often call for an ambulance under these circumstances. State law requires the emergency medical technicians to start CPR, etc. unless a Do-Not-Resuscitate Order is in place.

3. If you are at home and an ambulance is called, or if you are in a facility other than a hospital, no doctor will be available to order the emergency medical personnel to avoid resuscitating you.
4. If a patient is at home, in a nursing home facility, or establishment other than a hospital, the Do Not Resuscitate Procedures Act requires that the patient have a Do-Not-Resuscitate Order to avoid CPR and other extraordinary measures to prolong life.

E. Family Consent Under the Social Welfare Act.

1. Under limited circumstances, when a person is receiving medical care through Medicaid, Michigan law provides that “If the person for whom the surgical or medical treatment is recommended is not of sound mind, or is not in a condition to make decisions for himself, the written consent of such person’s nearest relatives . . . shall be secured before such medical or surgical treatment is given.” MCLA 400.66h.
2. In practice, this is the way that most medical decisions are made.
3. Legislative efforts are being made to broaden family consent.

III. WHERE TO FIND FORMS AND INFORMATION

- A. Durable powers of attorney and medical powers of attorney are legal documents with important consequences and risks.
- B. Do-it-yourself documents can be helpful, but you won’t know whether there is a problem until it is too late to do anything to fix it.
- C. Resources and free forms can be found at www.michbar.org/elderlaw/faq.cfm. These include a durable power of attorney form, an advance directive form, alternatives to guardianship and other information. Other resources can be found at the Michigan.gov/miseniors under the publications heading. See also <http://courts.co.calhoun.mi.us> and michiganlegalaid.org and the Legal Hotline for Older Michigianians at elderlawmi.org.

IV. LONG-TERM CARE

- A. Approximately 43% of Americans who reached the age of 65 will use a nursing home prior to death. For married spouses over 65, chances are 75% that one spouse will need nursing home care. An average stay in a nursing home is 2.8 years.
- B. The cost of long-term care, e.g., nursing home care, is generally not covered by Medicare or private health insurance.

- C. Often, when a person needs long-term care it is too late to plan to retain control of finances and health care.
- D. Long term care options may include: in-home care, adult day care, adult foster care, homes for the aged, dementia care, and nursing home care.
- E. Costs vary based on the amount of care needed. Traditional nursing home care costs between \$60,000 and \$90,000 a year.
- F. Know the terminology for various types of housing alternatives. Research the facility where you or your parents wish to live.
 - 1. Nursing homes vary in the services they provide. Assisted Living facilities also differ widely in the services they provide.
 - 2. “Assisted Living” is just a marketing phrase. There is no legal definition. Assisted Living facilities may provide one or all of the following services: independent living, assisted care, Alzheimer’s units and/or nursing care.

V. MEDICARE V. MEDICAID

- A. **Program Basics.** Medicaid and Medicare are two different governmental programs. Eligibility for Medicaid is based on financial need. To qualify, a person must have limited assets and income or high medical expenses. Eligibility for Medicare is generally based on having attained age 65; or being totally and permanently disabled for more than 24 months.

Medicare and Medicaid are frequently confused. Both are governmental programs providing funding for medical and health care services. However, Medicaid and Medicare differ significantly regarding eligibility, administration, funding and coverage.

- B. **Medicare.** Medicare is a federally-funded, federally-operated program. Medicare is administered by the Health Care Financing Agency. It is designed to provide hospital and medical care to people 65 and over. Dependents of Medicare beneficiaries and certain disabled people may also qualify for Medicare. Medicare benefits are frequently subject to co-pays, deductibles, coverage limitations and conditions.
 - 1. Medicare Part A is “hospital insurance” which generally covers medically necessary costs of in-patient hospital care, limited post-hospital skilled nursing care and certain intensive home-health care needs and hospice. People who are 65 and who receive Social Security retirement benefits or Railroad Retirement benefits will generally be automatically enrolled in Medicare Part A.
 - 2. Medicare Part B is optional, although most eligible beneficiaries elect Part B coverage. Part B covers non-institutional medical needs in general, e.g., outpatient care, physician services, medical equipment, and diagnostic

tests. The Medicare Part B premium is deducted automatically from a person's Social Security check. You also pay a deductible each year before Medicare starts to pay its share. Current deductible and premium rates can be found at www.medicare.gov.

3. Medicare Part D is private prescription drug insurance. You can change your plan during open enrollment each year from November 15 through December 31. There are many plans available. The website at www.medicare.gov can assist you with determining which plan is best for you through the interactive drug plan finder. Prior to using the program you should make a list of all the drugs you currently need.

C. **Medicaid.** Medicaid is jointly funded by the states and the federal government. It is operated by the state in compliance with both state and federal law. Medicaid is "means- tested." Benefits are available only to persons whose income and assets are below certain financial guidelines.

D. **Coverage of Long Term Care in Nursing Homes.** A major difference between Medicare and Medicaid is in their coverage of long-term nursing home care.

1. **Medicare.** Medicare does not cover long term care or custodial care designated to help a person with the basic activities of daily living. Medicare only covers "skilled" nursing home care in specific facilities for limited periods of time.
 - a. Medicare coverage of skilled nursing care is subject to numerous conditions. Coverage is available only if the individual required three full days of hospitalization no more than 30 days before admission to the skilled nursing facility and needs skilled nursing care or rehabilitation care services for the condition which resulted in the hospitalization on a daily basis, which services can only be provided on a practical basis in a skilled nursing facility.
 - b. Skilled nursing care is defined to include only that care which is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of professional or technical personnel" such as registered nurses, LPNs, physical therapists, occupational therapists, and speech pathologists or audiologists."
 - c. If the patient requires skilled care, and meets other Medicare requirements, Medicare Part A will pay for up to 100 days of post-hospital skilled nursing care during a spell of illness. During the first 20 days, Medicare pays for all covered medical and nursing-related expenses. For the 21st through the 100th day, the patient (or the patient's Medicare supplemental insurance) must pay a significant co-pay, currently \$238 per day. This is sometimes covered by a Medicare supplemental policy. However, many new

Medicare Choice plans have a high deductible of approximately \$150 per day. No Part A coverage is available after the 100th day of a spell of illness.

- d. Patients frequently lose Medicare coverage for skilled care if they fail to make progress in their therapy due to cognitive impairments or physical limitations. The patient's eligibility is continually monitored by the facility's utilization review committee and the state's Medicare fiscal intermediary.

2. **Medicaid.** If a person meets the Medicaid eligibility requirements, Medicaid will pay indefinitely for custodial, intermediate and skilled care in a licensed nursing facility.

- a. Medicaid generally does not pay for in-home care, adult day care, adult foster care, homes for the aged, assisted living or other alternative residential settings.

- b. Under the Omnibus Budget Reconciliation Act of 1990, some states, including Michigan have obtained an authorization from the federal government to create limited home and community-based programs which permit Medicaid payments for certain home and community-based care which allows a person to remain outside a nursing home. The rules applying to Medicaid recipients in these programs are similar to the rules applying to nursing home Medicaid recipients. These programs are called community-supported living arrangements or home and community-based "waiver" programs. To apply for Medicaid waiver, the you need to contact the Area Agency on Aging.

E. **Medicare Supplemental Insurance.** Many Medicare recipients purchase a "medigap" or Medicare supplemental insurance policy to help cover deductibles, co-pays, prescriptions, and other items and services not covered by Medicare. Medicare supplemental insurance integrates with Medicare. If a patient does not qualify for skilled nursing care under the Medicare standards, the Medicare supplemental policy will also deny coverage. Consequently, Medicare supplemental policies usually limit coverage for nursing home care to those types of care covered by Medicare.

Some larger employers provide continuing health coverage for retired employees, and sometimes, their spouses. These policies are usually similar to the Medicare supplemental policies available for purchase by individuals. Employer-provided health insurance can be changed, cut-back or eliminated at the discretion of the employer, although union plans may contain some protection against such cuts. Some employer plans eliminate supplemental health insurance coverage for a retired employee's spouse if the retiree chooses a payout option which terminates pension benefits at the retiree's death.

F. Medicare Part D.

1. Creditable Coverage
2. No Creditable Coverage, but Low Current Drug Costs
 - a. What if I don't enroll?
 - i. 1% per month penalty
 - ii. Must wait until next open enrollment period to be eligible. Can be a problem if new medical problems develop during the year.
 - iii. Most other assistance programs have been eliminated.
 - b. What if I did enroll?
 - i. Need to review the program you chose at the beginning of next open enrollment period.
 - ii. If new medical problems develop, may need to use exception process to get appropriate medications covered by the plan.
3. Need for annual review.
4. Medicare D and Medicaid Auto-Enrollment
 - a. People receiving Medicaid and Medicare are called "dual eligibles." Medicaid will no longer cover medication costs for "dual eligibles." Instead, Medicare will automatically enroll dual eligibles in a Medicare D plan.
 - b. Can be a problem for people whose spouse or disabled children are receiving a Medicare Part B supplement or other insurance benefits from an employer plan. Typically plans state that, if a person enrolls in Medicare D, ALL benefits under the employer plan are terminated.

VI. LONG-TERM CARE INSURANCE

A. What is Long-term Care Insurance?

It is a type of insurance intended to cover a portion of the cost of long-term care. It generally covers only care in nursing homes and home care. Many people purchase long-term care insurance to protect themselves, their spouse and their children from the risk that long-term care costs will substantially reduce their estate.

B. How Do Long-term Care Policies Work?

Long-term care policies vary substantially. However, they generally pay a fixed dollar amount each day you received care. They supplement a person's other income to help pay for the cost of long-term care. Other policies pay a set percentage of the cost of care. Some will pay up to a specified dollar amount.

C. How Long Does the Coverage Last?

It depends on the type of policy. Some policies will cover a portion of the cost of care no matter how long the person is in a nursing home. This type of policy is usually relatively more expensive. Other policies cover care for a limited period of time like two years.

D. What Other Features Are Important to Consider?

1. Deductible or Elimination Periods - This is the period from the beginning of a nursing home stay until the policy begins payment. The longer the elimination period the cheaper the policy. You should consider the amount of money you can afford to pay out of your own pocket before insurance payments begin. This should guide you in choosing an elimination period.

2. Pre-existing Conditions.

If you have pre-existing health problems at the time you apply for long-term care insurance, it may be more difficult to qualify for insurance. Additionally, a nursing home stay due to your pre-existing condition soon after purchase of the policy may not be covered.

3. Renewal Options. Can your policy be cancelled even if you pay your premium on time?

4. Inflation Riders. Can you purchase coverage to automatically increase the benefit you receive to provide for inflation?

5. Waiver of Premium Clauses. How long must you continue to pay the premium after you enter nursing home care?

E. Buying Long-term Care Insurance

1. Deal only with reputable agents and agencies.

2. Beware of high pressure sales techniques.

3. Understand the policy.

4. Ask hard questions. A reputable agent will be happy to answer them.

VII. MEDICAID PLANNING

- A. **Deficit Reduction Act – Major Changes in Our Medicaid Laws.** (Referred to as DRA) This change in federal law made significant changes to Medicaid law. States are required to implement these changes, but Michigan has just started to do so. Some of the changes Michigan has made are actually contrary to the federal law. Other problems arise in areas where the federal language is ambiguous. This leads to uncertainty as to how the laws will actually be implemented.
- B. **What is Medicaid?**
1. Medicaid is a government funded health care program which may help financially needy people pay for medical care. Medicaid also pays for certain services provided to disabled persons through Community Mental Health. Currently, it is the only health care program which assists people with paying for nursing home care. **Medicaid does not pay for homes for the aged, adult foster care, assisted living, and most home health care. The Medicaid Waiver program provides limited funds for home and community based services for a person who would qualify for Medicaid in a nursing home.**
 2. Medicaid is available only to people who meet certain assets and income requirements and the rules vary significantly based on whether or not you are married.
 3. Medicaid requires that you be “medically eligible” for nursing home care. In the past, a doctor’s letter or other medical evaluation has been sufficient for entry into nursing home care. The screening tool is completed at the same time as the Medicaid application. This new Medical Eligibility requirement may make it more difficult for people to obtain Medicaid while in a nursing home unless their needs are so significant that no other care setting would be appropriate. Note that a decision that a person is not medically eligible can be appealed.
 4. Planning for Medicaid is complicated and risky because it is controlled by both state and federal laws, which frequently change. In addition, the Medicaid program is administered by the Department of Human Services (DHS) formerly known as Family Independence Agency, a division of state government, pursuant to rules and regulations through the federal Center for Medicare/Medicaid Services (CMS). DHS policies and CMS policies also change frequently. Changes may or may not “grandfather” existing arrangements.
- C. **Assets Limits**
1. In determining whether a person applying for Medicaid can receive Medicaid benefits, the DHS looks at a family’s “nonexempt” assets and at assets which have been given away within the past 60 months.

- a. Exempt Assets. Certain assets are not counted in determining whether a person meets the asset limitations of Medicaid. These assets are:
- i. One homestead per family, including any adjacent real estate (This exemption used to be unlimited, however it has now been limited to equity in a house up to \$500,000. The limit will not apply if a spouse remains in the home). **However, a home which is held in the name of a living trust at the time of the Medicaid application is not considered exempt. It becomes exempt again as soon as it is removed from the trust.**
 - ii. One car per family. Proposed regulations which have not yet been adopted would prohibit the purchase of a vehicle after a single individual entered nursing home care and would limit the value of any car to \$25,000.
 - iii. Household and personal effects.
 - iv. Burial space, burial items and certain irrevocable prepaid funeral arrangements.
 - v. Certain trust property where the Medicaid applicant cannot compel distribution. (However, assets in a discretionary support trust set up by the Medicaid applicant or the applicant's spouse are generally not exempt.) A typical "Living Trust" will not protect assets. However, for married couples, holding a residence in trust until after a spouse enters nursing home care may be beneficial.
 - vi. Assets which are proven to be unavailable because no reasonable offers are received despite efforts to sell it.
- b. Countable Assets. Countable assets include most joint property, income-producing real estate, cash value of life insurance, most annuities, IRAs and retirement plan assets, bank accounts, securities and brokerage accounts, government bonds, tax-exempt investments, partnership or family business interests, cash in a safety deposit box or on hand.

2. Different Rules Apply to Married Persons.

- a. Single Person. A single person cannot qualify for Medicaid unless the value of his or her non-exempt assets is less than \$2,000.
- b. Married Couples. Since October 1, 1989, special rules apply to married couples where only one spouse is in a nursing home. (If both spouses are in nursing homes, each is treated under the single

person rules.) The rules are different if one spouse entered a nursing home before October 1, 1989.

- i. As of the first day of long term institutional care in a hospital or nursing home, all the couple's assets held under either or both of their names will be "pooled" and then divided by two to produce a "spousal share" upon which Medicaid eligibility is determined. The community spouse (that is, the spouse who is not in a nursing home) may retain the home and other exempt assets, plus the "community spouse resource allowance." The community spouse resource allowance is one-half of the combined asset pool up to a maximum community spouse resource allowance (adjusted for inflation) of about \$109,560 (for initial assessment dates in 2009). If one-half of the combined pool is less than \$21,912 the community spouse may keep \$21,912 as a minimum allowance.
 - ii. The determination of the community spouse resource allowance is made at the time that one of the spouses enters a nursing home. This is sometimes called the "snapshot" date.
 - iii. All major spending should be deferred until after a spouse enters the nursing home. Spending before the snap-shot may reduce the community spouse resource allowance.
 - iv. The spouse in the nursing home will be disqualified from receiving Medicaid until all nonexempt assets in excess of the community spouse resource allowance are spent.
 - v. Note that prenuptial agreements, asset titling and the couple's practice of keeping assets separate are ignored for purposes of this formula.
- c. Medicaid Spend-Down Strategies.
- i. Excess assets can be spent on either spouse, or may be sheltered by using excess assets to purchase exempt assets, to pay off debts, or to purchase certain exempt types of annuities.
 - ii. You can spend money on exempt assets by making needed repairs to your home, replacing your car, purchasing a television for the spouse in the nursing home, or purchasing burial plots or funeral home contracts.
 - iii. More complex planning may be accomplished by the use of annuities, divestment and trusts.

- iv. The community spouse should remove the nursing home spouse's name from all assets except the account used to pay the nursing home spouse's rules. This may require a court order or durable power of attorney. The community spouse should also review his or her own estate plan to assure that the nursing home spouse will not be disqualified from Medicaid if the community spouse dies first.

D. **Transfer of Assets to Qualify for Medicaid**

1. In determining whether a person applying for Medicaid meets the asset test, DHS looks at the person's current assets and at all assets which have been given away within the past 60 months (5 years). This is the "look back period."
2. When a person applies for Medicaid, DHS the "look back period" to see if the applicant gave away assets or sold assets for less than fair market value for the purpose of becoming eligible for Medicaid. Under DRA the penalty starts of the day the applicant would have otherwise qualified for Medicaid. **Note that this is a substantial change from prior law.**
3. DHS generally does not allow people to qualify for Medicaid by giving away assets before applying rather than using the assets to pay medical bills.
 - a. For all divestments after February 8, 2006, the Deficit Reduction Act rules apply. Under these rules, all gifts made within the past five years are added together. All gifts, including gifts to charity, paying a child's bills, or adding another person's name to a real estate or brokerage account, are counted. Gifts which are exempt from federal gift tax (e.g., gifts of less than \$13,000 per person per year) are also counted.
 - b. If a person transfers assets which would have otherwise made him or her ineligible for Medicaid, and applies for Medicaid during the next 60 months, there is no maximum ineligibility period.
 - c. The number of months of the penalty is calculated by dividing the amount given away or transferred for less than fair market value by the average monthly cost of nursing home care (\$6,362 in 2009).
 - d. The penalty is calculated by dividing the total gifted amount by the average monthly cost of nursing home care. The penalty begins to expire only after the person enters nursing home care and runs out of money. This is called a "hanging penalty" since it hangs over your head until you run out of money
 - e. Example: Mary pays for her granddaughter's college tuition on February 15, 2006 in the amount of \$20,000. In April, she

contributes \$10,000 to her church building drive. In May of 2007, Mary enters nursing home care and spends down her countable assets to \$2,000. Mary will be ineligible for Medicaid until September 2007 since the \$30,000 she gave away would have paid for five months of nursing home care. Medicaid will not pay for her care for five more months. Unless she and her family find another source to pay for her care, she may be evicted from her nursing home placement.

4. Under federal law, even the transfer of exempt assets affects eligibility unless:
 - a. The state finds that:
 - i. The transfer was for fair market value;
 - ii. The transfer was made for reasons other than qualifying for Medicaid; or
 - iii. Denial of eligibility would cause undue hardship.
 - b. The transfer is the transfer of the home to the individual's:
 - i. spouse;
 - ii. child who is blind, disabled, or under age 21;
 - iii. brother or sister who has equity in the home and has been living there for at least one year before the individual began nursing home care; or
 - iv. adult son or daughter who has been living in the home and providing care that delayed the individual's need for nursing home care for at least two years before the individual began such care.
 - c. The transfer is for the sole benefit of the individual's spouse or blind or disabled child.
5. **Adding a name to a real estate deed, a bank account, or an investment may trigger a divestment penalty period. Withdrawal of jointly held assets may trigger a divestment penalty period. Disinheriting a spouse who is receiving Medicaid may also constitute a divestment. Giving away a vehicle is divestment.**
6. Paying a family member to provide care may be considered a divestment unless various extremely restrictive requirements are met.

7. There are potential risks and tax consequences to divestment:
 - a. Many facilities prohibit divestment as part of their residency contract.
 - b. Medicaid will not pay for a private room.
 - c. The gifted amount is not taxable to the recipient. However, any income earned by the transferred assets is taxed to the recipient at the recipient's income tax bracket. If the gift is more than \$13,000, a federal gift tax return must be filed. No gift taxes are due unless the total gifts during life exceed \$1,000,000.
 - d. The gift recipient will become the owner of the gifted assets for all purposes. Assets in the recipient's name may be subject to the recipient's creditor claims, divorce settlements, or may become unavailable in the event the recipient dies, becomes incapacitated, or simply refuses to handle the money consistent with any informal understanding or moral obligation.
 - e. With the new "hanging penalty" any gifting within five years of running out of assets to pay for nursing home care will create a penalty necessitating the return of gifted assets.

E. Income Limitations

1. General Rule. A person who is receiving Medicaid can keep only \$60 per month in income. However, if a person's medical costs exceed his or her income, Medicaid may pay the shortfall.
 - a. Any income above the \$60/month amount must be spent to pay a portion of medical care costs. This is called the "patient-pay" amount.
 - b. If both husband and wife enter nursing homes at the same time, any income in excess of \$60 per spouse will go toward their nursing home bills before Medicaid will kick in to pay the remaining amount.
2. Married Couple. Special rules apply to married couples where one spouse is in a nursing home.
 - a. According to current federal and state Medicaid law, income from investments solely in the husband's name is considered available solely to the husband. Income from investments solely in the wife's name is considered available solely to the wife. This includes all income from pensions and other government programs including Social Security as well as income from investments. All income considered available to the spouse in the nursing home

must be used to help pay for the cost of nursing home care even after the person qualifies for Medicaid.

- b. Income from assets which are held jointly by the husband and wife is deemed to be divided 50/50 between the spouses. Therefore, if the husband and wife receive income from investments held jointly, the community spouse may keep half of the income from these investments. The other half must be used to help pay for the nursing home care of the other spouse.
- c. “Minimum monthly needs allowance.”
 - i. The community spouse is entitled to a “minimum monthly needs allowance” of \$1,750 of the income of both spouses. This amount may be increased if the community spouse does not have sufficient income to cover his or her housing costs
 - ii. If the community spouse has an income of less than the income allowance, he or she will be entitled to the portion of the institutionalized spouse’s income necessary for the community spouse to receive the income allowance. The institutionalized spouse’s remaining income, reduced by income taxes and medical insurance premiums will be applied to the cost of nursing home care before Medicaid becomes available.
 - iii. In the event of severe hardship to the community spouse, the law provides for the possibility of a fair hearing or a court order exempting the Medicaid applicant from the rules described above. You might be able to get a court order changing the rules.

F. **Medicaid Qualifying Trusts.** Generally, transferring your assets to a trust does not provide any shelter from Medicaid consideration. In the case of an irrevocable trust, if there are any circumstances under which payments of income or principal from the trust could be made to benefit the individual, the corpus is considered an available resource. This is true without regard to the purpose for which the trust is established, the trustee’s discretion, and trust terms limiting or restricting distributions.

G. **Estate Recovery.**

1. In OBRA '93, Congress required every state to set up estate recovery programs for Medicaid recipients who use nursing homes or who participate in Medicaid community based waiver programs. States may choose to impose estate recovery on all the people who use Medicaid. The state is also given total discretion to determine what property can be seized upon the death of a Medicaid recipient.
2. The Federal government rejected Michigan's proposed Estate Recovery program. It is, therefore, difficult to predict what Michigan's eventual Estate Recovery program will be.
3. **Possible Exceptions:**
 - * The homestead is exempt from estate recovery if the spouse or a minor or disabled child lives in the homestead.
 - * An amount equal to 50% of the average price of a home in the county where the home is located is exempt from estate recovery.
 - * Ladybird deeds and other probate avoidance techniques may shelter assets from estate recovery.
 - * Current Department of Human Services Policy Bulletins indicate that estate recovery will not apply to Medicaid recipients who entered nursing homes or the MI Choice Waiver on or before September 30, 2007.
4. **What should you do about Estate Recovery.**
 - * Review your estate plan to make sure the assets are set up in such a way so as to avoid being subject to estate recovery.
 - * Watch out for scams. Unscrupulous individuals will use this news to try to scare people into purchasing products that are not in their best interests. Watch out for high pressure scare tactics, and consult with an expert advisor before signing anything.

H. **Medicaid Planning with Annuities**

1. **What Types of Annuities Qualify?**
 - a. The annuity must be irrevocable. In other words, a deferred annuity does not qualify because the assets in it can be withdrawn. An annuity that has been irrevocably annuitized may qualify.
 - b. The annuity payout must be actuarially sound. Under the new law, purchase of an annuity is not considered a divestment if the annuity is actuarially sound that is, if it is paid out over the person's actuarial life expectancy according to Medicaid's tables.

- c. The annuity must be non-assignable, and nontransferable. The annuitant cannot retain the right to borrow against the annuity or receive a cash distribution in addition to the normal annuity payment.
- d. The annuity must be commercially issued by a company licensed in the United States and issued by a licensed producer.
- e. The annuity must be purchased by the Medicaid Applicant/recipient or his/her spouse and solely for the benefit of the applicant / recipient or spouse.
- f. The annuity payments must be substantially equal monthly payments.
- g. State as Beneficiary. New rules under the Deficit Reduction Act provide that any annuity must name the State of Michigan as primary beneficiary. If the Medicaid recipient has a surviving spouse or disabled child, the spouse or disabled child may be named as primary beneficiary, but the State of Michigan must be named as secondary beneficiary. These rules also apply to annuities owned by the community spouse. If the community spouse dies before the nursing home spouse, the State of Michigan will place a lien against the amount they paid on behalf of the nursing home spouse. Any remaining funds from the annuity will go to the other named beneficiaries after the State's claim is satisfied.

2. **Medicaid Planning Strategies.** Under limited circumstances, the purchase of annuity can shelter assets from Medicaid for the benefit of a spouse. The annuity converts countable assets (the assets used to purchase the annuity), into a stream of income.

- a. Single Person In Nursing Home. Generally, the new Medicaid rules make annuities for single people almost useless. Over time, more complex strategies may evolve which employ annuities. Until these strategies are tested or regulations are issues, annuities will have substantial risks.
- b. Married Couple with One Spouse in Nursing Home. The use of annuities for married couples must be carefully coordinated with the special Medicaid rules for married couples described above. For example, assume a married couple, Joe and Martha, both age 65, have \$160,000 in non-exempt assets at the time Martha enters nursing home care. After spending \$30,000 paying off debts, buying prepaid burial arrangements, replacing their car, fixing up their home, etc., they still have \$48,000 to spend-down before Martha can qualify for Medicaid. Joe might use the \$48,000 to

purchase an irrevocable immediate annuity providing him with monthly payments for the next 14 years. Since his life expectancy (according to the Medicaid tables) is 14.96 years, this is actuarially sound. Martha can qualify for Medicaid as soon as the annuity is purchased. Joe gets additional money that he can either use for his own needs, or save in his own name for future needs. If Joe dies before the end of 14 years, the state will get the remaining annuity payments.

3. **Annuities and the Married Person Income Protection Rules.** The income protection rules described above allow the at-home spouse to keep all of his or her own income, plus enough of their spouse's income to bring them to a minimum monthly needs allowance level of \$1,750 (or higher if the at-home spouse has excess housing costs).
 - a. If the at-home spouse has income in their own name (from social security, pension, etc.) in excess of \$1,750, the at home spouse can retain all the benefits of the income stream from the annuity. Since their income exceeds the \$1,750 minimum income limit, they are not getting any of their spouse's income anyway.
 - b. Annuities may be less useful when the at-home spouse is receiving some of the nursing home spouse's income to bring them up to the \$1,750 limit. For example, assume that Martha is the at-home spouse, and that she has income from social security of \$400 per month. Joe is in the nursing home, and has income of \$2,000 a month. The income protection rules allow Martha to keep \$1,350 of Joe's income each month. She may also keep enough to pay health insurance premiums, his \$60 personal needs allowance, and, if there is a court-appointed guardian, an additional \$60 for guardianship fees. The rest of Joe's income goes to the nursing home. If Martha purchases an immediate annuity that pays her \$700 per month over her life expectancy (18.96 years), with a minimum guarantee of 15 years, she gets no real benefit. Each dollar she receives from the annuity offsets a dollar that she would have been able to use from Joe's income. Under the new DRA rules, after Martha's death, the state would get any remaining annuity payments.
4. **There is never a reason to buy a "Medicaid qualified annuity" before a person enters nursing home care.**

I. **Other Considerations.**

1. People have varying degrees of comfort with regard to planning for and receiving government benefits. These are legitimate concerns which should be addressed by the person who assists you with Medicaid planning.
2. Medicaid generally only pays for nursing home care. Accelerating Medicaid eligibility may foreclose the option of living in a less restrictive setting, like assisted living.
3. Many nursing homes discriminate against Medicaid recipients. Many nursing homes do not accept Medicaid or have only a limited number of Medicaid beds. Also, some doctors do not accept Medicaid. Some nursing homes will allow a person to enter as a private pay patient and then convert to Medicaid after a certain amount of time. This may make it more difficult to get into a nursing home.
4. Many nursing homes contractually prohibit gifting.
5. It is essential to coordinate any Medicaid planning you do with your existing estate plan, and for the community spouse to review his or her plan after eligibility is granted.
6. It is also important that you contact someone with expertise in the Medicaid, estate planning and tax areas for assistance in Medicaid planning since any transfers of assets may have estate tax, income tax, gift tax or other consequences which should be considered before such action is taken.
7. The Medicaid rules are very complex. Documentation requirements can be extremely strict. Mistakes or misinterpretations can be costly and frustrating. It pays to get expert help.
8. “If it should work, it doesn’t work. If it shouldn’t work, it does work. If it makes sense, you’ve got it wrong.”
9. Continuing Uncertainty. Medicare D and the new Medicaid rules are both too new to know all the complications, changes and problems which may come up. Consumers need to check and re-check information to make sure that they are acting on the most current facts.