

Introduction

The prospect of entering a long term care facility or nursing home is great. With increasing life expectancies and better health care, more and more people have found it necessary to enter nursing homes. More than half of women and nearly one-third of men will go to a nursing home in their lifetimes.

Although some individuals have sufficient assets to pay the costs of long term care, others do not. Where assets are not sufficient, Medicaid may be available to pay for nursing home care for those over age 65, as well as those who are blind or disabled. Medicaid is a form of public assistance. Medicaid is a jointly financed federal-state program but a program administered by the states.

A number of requirements exist in order to be eligible for Medicaid. Among these requirements is that an applicant may have very few assets. A spouse who remains in the community – a community spouse – may retain somewhat more in assets but these are restricted as well.

Some planning may allow families to retain greater amounts of assets. This information is intended to provide a general introduction to the rules applicable to Medicaid planning where a family member may require long term care.

It should be kept in mind that the laws and rules applicable to Medicaid change. Our system is financially unstable and changes are likely. As significant, the interpretations of these laws and rules are periodically revised. Therefore, there is no assurance whether planning will ultimately prove successful or even if public assistance will be available. This is especially the case where any interest is retained in assets.

The Schmiedeskamp Estate Planning and Administration Group

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Caution: Informational Purposes Only

This material is being provided for informational and background purposes only. Legal advice is not given or intended to be given by virtue of this material. Further, this information should not be considered as suggesting or encouraging that Medicaid planning be undertaken. Each situation is different. Accordingly, the facts and circumstances of each situation must be considered to determine what Medicaid planning, if any, should be undertaken. This material is believed to be accurate but any planning is subject to current laws, rules, regulations, and policies as in force and effect.

The rules applicable to Medicaid planning are subject to frequent changes. Indeed, it is anticipated that “asset-shifting” will be given great attention over the next several years. Many suggested changes are under consideration. Proposals are considered to tighten the program. What is clear is that Medicaid planning will no doubt change and become far more difficult – even impossible – in years to come.

Appropriateness of Obtaining Assistance

There are considerations, both personal and legal, that relate to whether obtaining Medicaid assistance or engaging in Medicaid planning is appropriate. The traditional view of many elderly people and their families is that they should be financially independent. Care should be provided using their own funds supplemented, if at all, with help from family members. Public policy, as this information confirms, also discourages Medicaid planning. Taxpayers simply no longer can afford to allow families to retain or shift assets and become eligible for assistance. Some states have even moved to make adult children responsible for the nursing home expenses of their indigent parents. The demands on Medicaid funding have become so great that payments to nursing homes have been reduced and services curtailed. With this said, the cost of nursing home care is substantial and families are not able to pay the costs of care. A spouse remaining at home, especially, runs a serious risk of not being able to provide for his or her care.

This information is not intended to take a position of whether a person should or should not undertake Medicaid planning. The goal is simply to better inform the reader of the rules that apply to Medicaid eligibility.

Initial Considerations

Are There Sufficient Assets to Pay Nursing Home Expenses?

Determine whether there are sufficient assets to pay for nursing home care without special planning. Check out the costs of nursing homes considered. Are the applicant's income, social security, and retirement plan benefits, sufficient to pay for monthly care? If not, are there investments that may be liquidated and be sufficient to supplement income? Is there nursing home insurance coverage? Take a realistic look at where the applicant and spouse, if any, would be financially if long term care is required.

When determining whether there are sufficient assets to pay for nursing home care, take into account expenses that will be reduced or eliminated. Where a spouse remains at home, these "savings" may be more limited. But where one person is involved, there may well be reductions in expenses – food, transportation, household expenses, etc. The ability to pay for nursing home care should take into account funds that will no longer be required to be devoted to other expenses.

Alternatives to a nursing home may be appropriate in some circumstances. Home care with a family member may be available. A military veteran may have the option to consider a veteran's home which considers income rather than assets.

It is important to recognize that there is no right to be admitted to a specific nursing home. Most nursing homes have only a limited number of Medicaid beds or rooms. Many homes utilize these beds or rooms for residents who initially paid for their care and were transferred to Medicaid. Not all nursing home will initially accept residents who are on Medicaid day one. Thus, reliance on Medicaid may limit one's choice of nursing homes.

Doesn't Medicare Take Care of Nursing Home Expenses?

Medicare does provide for some nursing home expenses. But, the benefits are quite limited. Unlike Medicaid, which is a needs based program, Medicare extends to those who are 65 or older regardless of need, as well as those with certain disabilities.

If certain eligibility requirements are met, Medicare will pay for approved nursing home care for a period of 20 days. For an additional 80 days, Medicare will pay for approved nursing home care to the extent the cost exceeds a substantial per day co-payment which may or may not be paid by the individual or the individual's health insurer. Most Medicare supplements pick up only deductibles and co-payments.

The Medicare benefit is not automatic. Restrictive requirements are established. To be eligible, a person must have first been hospitalized for at least three consecutive days and must go to a nursing facility that participates in the Medicare program within 30 days of discharge from the hospital. The stay must be for a condition treated in the hospital and must be rehabilitative (which means that it is expected that the person will improve significantly within a reasonable period of time). Other requirements also exist.

What should be clear is that Medicare provides only a limited benefit. Medicare provides no assurance that nursing care will be paid.

Should Long Term Care Insurance or Other Provisions Be Made to Pay for Care?

This information assumes that Medicaid may be required for a person's care. Where circumstances warrant, of course, other means should be considered to pay the costs of long term care. Long term care or nursing home insurance is one possibility, among others. Typically, though, when Medicaid is considered nursing home insurance is likely unavailable due to one's health.

Medicaid Eligibility and Exemptions

Will Medicaid Take Care of Nursing Home Care?

Medicaid is a form of public assistance. It is a needs based program. Where nursing home care is required, Medicaid will pay for that care ... but only if the person fails to have sufficient available assets to pay for that care. If there are available assets to pay for long term care, Medicaid will not apply.

Medicaid is administered by the State of Illinois. Actually, however, it is a federal program governed by provisions of the Social Security Act. 42 U.S.C. §§ 1396-1396v. In Illinois, the Illinois Department of Healthcare and Family Services (formerly the Illinois Department of Public Aid) administers the Medicaid program. However, it is actually the Illinois Department of Human Services that determines eligibility for assistance.

To be eligible for Medicaid, a person must be a resident of Illinois. The person usually must be aged, blind, or disabled. Finally, the person must meet financial requirements. The requirements governing Medicaid are subject to the Illinois Public Aid Code (305 ILCS 5/1-1 *et seq.*) and various state regulations (89 Ill. Admin. Code, Part 120 *et seq.*). The Department of Human Services has a detailed Policy Manual covering the requirements. This manual is available on the Department's web site <<http://www.state.il.us/agency/dhs>>. Some references are made in this information to the Policy Manual (PM) <<http://www.dhs.state.il.us/page.aspx?Item=13473>>. Because the specific site changes periodically, one may need to search from the Illinois Department of Healthcare and Family Services' Home Page which is at: <<http://www.hfs.illinois.gov/>>.

What Assets are Exempt or Not Considered in Determining Medicaid Eligibility?

In determining eligibility, certain assets are exempt. This means that these assets are not considered or counted in deciding whether a person is eligible to participate in the Medicaid program. Stated otherwise, these are the only assets that may be retained and still be covered under the Medicaid program.

For a Medicaid recipient, here are the exempt assets:

- ***Cash and Equivalent:*** The sum of \$2,000 of cash or its equivalent is exempt. The equivalent of cash would be any asset readily convertible to cash, such as bank accounts, investments, stocks, bonds, retirement accounts, and the like. If there is a married couple in the nursing home, the exemption is raised to \$3,000. PM 07-02-01.
- ***Homestead Property:*** An applicant's home or dwelling and the land on which it is located are exempt. This includes any surrounding property that is not separated from the home by someone else's property. Accordingly, it may be a farm on which one's house is located. The person must live in the home to be exempt or intend to return to the home. A person may happen to own a home and actually live elsewhere, such as with a child. The exemption also applies even if the applicant does not intend to return to the property, but the property must be occupied by the applicant's spouse, brother or sister, or a minor or disabled child. PM 07-02-04-a. Where these conditions are not met, the exemption is lost. After the requirements have not been met for 120 days, a presumption arises that the home is abandoned and a lien is then filed against the home for Medicaid payments.
- ***Personal Effects and Household Goods:*** Personal effects and household goods are exempt to the extent they do not exceed the value of \$2,000. Wedding and engagement rings are exempt, as are items needed because of a person's medical or physical condition, regardless of value. PM 07-02-06-b. Federal law actually exempts all personal effects, but Illinois law is more restrictive.
- ***Motor Vehicle:*** A vehicle is exempt to the extent of a value of \$4,500. The exemption is unlimited where the vehicle is required for employment, transportation for medical treatment of a specific or regular medical problem, has been modified for operation by or transportation of a disabled person, or is necessary because of climate, terrain, remoteness, or similar factors to provide necessary transportation to perform essential daily activities. PM 07-02-05. Federal law, unlike Illinois law, exempts one motor vehicle regardless of value.
- ***Life Insurance:*** Life insurance policies with a cash surrender value of up to \$1,500 are exempt. Some other policies are also exempt. These generally include term policies with no cash value, group policies provided by an employer, group policies required for employment, policies on the life of an ineligible family member who is not the Medicaid applicant's responsible relative (*i.e.*, spouse), and policies on the life of the applicant owned by someone else. PM 07-02-07.
- ***Burial Funds and Spaces:*** Burial funds are exempt, but the amount varies. Up to \$1,500 may be set aside in a bank account, made payable on death for funeral and burial expenses, or otherwise specifically identified as a burial fund. PM 07-02-08-a. This amount, alternatively, may be placed in a revocable prepaid burial contract.

PM 07-02-08-b. These exemptions apply to *revocable* arrangements. Where there is an *irrevocable* prepaid burial contract, the exemption currently is increased to \$6,220. PM 07-02-08-c. Again, this arrangement must be irrevocable. If the burial contract is funded by life insurance and the policy is assigned to the funeral home, the policy is exempt. PM 07-02-08-d. Federal law is more liberal and exempts an unlimited amount of money for funeral or burial purposes. Burial spaces intended for the use of a Medicaid applicant, the applicant's spouse, or any other member of their immediate family, are also exempt. PM 07-02-09. Interest on burial funds or appreciation in value of burial spaces arising after eligibility for Medicaid is also exempt. PM 07-02-10.

- **Self-Support:** Property related to a person's trade or business and necessary for that person's self-support is exempt. PM 07-02-11. Examples might include farm equipment and livestock.
- **Income:** A Medicaid recipient is entitled to little income. A personal needs allowance of \$30 per month and a \$90 per month veteran's benefit is not considered. PM 15-05-04. A number of other exemptions are allowed, including amounts to cover Medicare and other health insurance premiums, amounts to cover over-the-counter drugs or other medically necessary items ordered by a physician but not paid for by Medicaid, amounts necessary to cover medical transportation, and amounts to maintain a home where there is not a community spouse and the person is expected to return home within six months.

There are some assets that require separate mention. These include joint accounts and life estates.

Joint accounts are co-owned by two or more persons. Upon the death of a joint tenant, that joint tenant's interest passes to the surviving joint tenants. For some purposes, the joint tenants are treated as holding equal interests in the property. Medicaid rules presume that the applicant for Medicaid owned the entire account unless it is shown that the funds came from some other person or access to the funds is somehow restricted. Where the joint asset is real estate, the Medicaid applicant is deemed to own a proportionate share based on the number of joint owners. PM 07-02-02.

A **life estate** is the right to the use of property during one's lifetime. It usually involves the transfer of a home with the right to continue to reside in the home or a farm with the right to income retained. *A life estate is not considered an asset for Medicaid purposes.* PM 07-02-14. Where a Medicaid recipient holds a life estate, a lien still may be filed against that interest. Upon the death of the recipient, however, the lien effectively ends, as does the life estate. Under current practice, the lien is not enforced during the recipient's lifetime. If it were enforced, the life estate could be acquired and even the real estate partitioned. This practice is always subject to change. Still, at present, life estates are frequently used in Medicaid planning.

As should be quickly apparent, the exemptions are very limited. A person who will receive Medicaid must exhaust nearly all assets in order to be eligible. A Medicaid applicant with assets over the exemptions will be required to spend the excess before becoming eligible for benefits.

It is important to recognize that the fact particular assets are not considered for determining eligibility does not mean that the assets may not be subject to a claim by the Illinois Department of Healthcare and Family Services to recover payments made for the care of a Medicaid recipient. Where a homestead is retained, for example, the Department will file a lien against the real estate. This lien may be enforced when the homestead exemption no longer applies, such as on the death of the Medicaid recipient.

What Exemptions Apply When a Spouse Remains in the Community?

Spouses are generally responsible for the nursing home care of each other. Therefore, the assets of a spouse who remains in the community are considered available to provide for the long term care of the other spouse. Some additional exemptions apply to a community spouse.

These are the additional exemptions for the community spouse:

- ***Personal Effects and Household Goods:*** The personal effects and household goods of a community spouse are fully exempt. A person in a nursing home, moreover, may transfer an unlimited amount of personal effects and household goods to the community spouse.
- ***Community Spouse Asset Allowance:*** A community spouse is entitled to a Community Spouse Asset Allowance. As of 2016, this amount is \$109,560, and is adjusted annually. PM 07-02-22. The Community Spouse Asset Allowance may be the community spouse's own assets or those transferred from the spouse who will or receives Medicaid. Assets transferred to the community spouse must be transferred within 90 days after Medicaid approval. PM 07-02-22-a.
- ***Motor Vehicle:*** The usual motor vehicle exemption is expanded for a community spouse. The community spouse is entitled to a vehicle regardless of the vehicle's value. PM 07-02-05, 07-02-22.
- ***Court Ordered Increased Allowance:*** Although not common, the Community Spouse Asset Allowance may be increased by court order. This requires a petition to a court supported by information supporting the claim.
- ***Community Spouse Maintenance Needs Allowance:*** A community spouse is entitled to a maintenance needs allowance. This is a monthly allowance of income that may be retained. This amount is \$2,739 (as of 2016) each month, adjusted annually, less the community spouse's own income. PM 15-04-04-a.

- ***Dependent Family Member Allowance:*** Where a nursing home resident has a dependent family member, the community spouse also is entitled to a further needs or income allowance. The allowance is around \$1,966.25 (as of 2016) adjusted annually for each dependent family member less the family member's own income. PM 15-04-04-b. It is reduced by the dependent's income. A dependent family member includes dependent children under age 21, dependent adult children, dependent parents or dependent brothers or sisters of either the nursing home resident or the resident's spouse.

It is important to keep in mind that the exemptions of the spouse in the nursing home are those previously mentioned. The additional exemptions only apply with regard to the community spouse. If there is no community spouse, the community spouse provisions do not apply.

Are There Caretaker Rules?

Notwithstanding the general rule that transfers of assets will create a penalty period, there are certain transfers of assets to caretakers that can be made without affecting an individual's eligibility for Medicaid.

Transfer of Residence to Caregiver Child. One permissible transfer that will not affect eligibility for Medicaid is the transfer of the applicant's residence to their child who provided care to applicant in the home for two (2) years prior to the date the applicant became institutionalized. The services provided by the child must have been the type that would have otherwise required institutionalization.

The Department of Human Services requires evidence to support the claim that services provided were of the nature and type noted above. That evidence can be in the form of a physician's statement or an evaluation conducted by a medical professional showing the need for the services. A diagnosis of Alzheimer's or dementia related illness is prima facie evidence that the services were of the appropriate nature.

The child must have resided with the applicant in the residence for the two years immediately preceding the applicant's institutionalization. The Department will require that the child provide evidence to support the claim of residence with the applicant. That can take the form of a driver's license, cancelled checks, tax returns, etc.

Finally, the child will be required to provide evidence that he or she provided care that prevented institutionalization of the applicant. A sworn affidavit of the child can be provided.

Caregiver Agreement. A caregiver agreement can be entered into with anyone, including a child. In fact, many people enter into caregiver agreements with companies that provide both personal and medical care to applicants in their homes. The difference between a caregiver agreement with a child or with a third party is that the Department of Human Services will presume that payments made to a family member of the applicant are transfers for less than fair value (i.e. a gift).

A contract for personal care will be treated as a transfer for less than fair market value as a general rule. In order to overcome that presumption, the applicant will need to clearly identify the services to be provided. The payment for services must be in an amount that is consistent with the prevailing cost for such services in the area.

Transfers to Qualify for Medicaid Eligibility

May Assets Be Transferred in Order to Qualify for Public Aid?

Medicaid law discourages and, in some situations, bars transfers of assets in order to qualify for benefits. Indeed, in 1996 a federal law added criminal penalties for certain asset transfers made to qualify for Medicaid. *See* Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320a-7b. Although efforts were made to repeal the law, it was instead amended in 1997 to limit criminal liability to persons who, for a fee, counsel or assist a Medicaid applicant in making a transfer for the purpose of becoming eligible for Medicaid. The law was promptly challenged and in 1998 a New York federal court found the statute unconstitutional.

As the law has developed, transfers are technically prohibited but allowed provided that Medicaid is not sought during an applicable penalty period (which, except for certain trusts, will not exceed 60 months). Transfers may not be made on the eve of entering a nursing home. Because very few individuals are inclined to transfer assets many months before requiring Medicaid, the establishment of the penalty period has greatly limited Medicaid planning.

How Are Outright Transfers Treated to Qualify for Medicaid?

Where non-exempt assets are transferred by a Medicaid applicant or the applicant's spouse for less than fair market value during the 60-month period immediately before or any time after applying for benefits (commonly referred to as the "look-back period"), a penalty is imposed. What this means is that any bargain or gift transfers within that 60-month period are held against the Medicaid applicant.

The ineligibility period is dependent upon the amount of the gift and the nursing home monthly charge for care. PM 07-02-20-d. The actual number of months a person is ineligible is determined by dividing the uncompensated value of the property transferred by the monthly private-pay cost of the nursing home in which the Medicaid applicant is residing. As an example, if a person transfers property at a bargain or as a gift of \$60,000 and the average private-pay cost is \$3,000, the penalty period would be 20 months (that is, 60,000 divided by 3,000). The applicant would have to delay applying for Medicaid for 20 months.

Because of the penalty provision, an individual who may be required to apply for Medicaid must recognize that any gifts will delay the time when eligible for benefits. If long term care is required within a short time frame, outright gifts are not practical.

How Are Trusts Treated for Medicaid Purposes?

The treatment of trusts for Medicaid purposes is quite complicated. Transfers in trust are not especially common because, among other requirements, it must be established more than 60 months before entry into a long term care facility. Seldom are trusts planned that far in advance.

There are quite a number of types of trusts. Among the types of trusts and some of the issues that arise from their use are:

- ***Revocable Trusts:*** A revocable trust is a trust that may be changed. Where a revocable trust is established by a Medicaid applicant, a spouse, or another person authorized to do so by the applicant or the applicant's spouse, the trust principal is an asset of the applicant, any income made to or for the benefit of the applicant is income, and any other payments are a transfer of assets. As such, these trusts provide little benefit when applying for Medicaid. PM 07-02-15-a.
- ***Irrevocable Trusts:*** An irrevocable trust is a trust that cannot be changed. Where an irrevocable trust is established by a Medicaid applicant, a spouse, or another person authorized to do so by the applicant or the applicant's spouse, that part of the principal from which payments to or for the benefit of the applicant may be made is an asset. Income and other payments are treated substantially the same as revocable trusts. PM 07-02-15-a. Although irrevocable trusts established by a Medicaid applicant or spouse are frequently mentioned, they are seldom used because of the 60-month look back, the possibility the rules on what to consider an asset may change, the fact that they are irrevocable, and because of the close scrutiny they are given. One isn't certain they will work until after Medicaid is sought.
- ***Self-Sufficiency Trust:*** Principal and payments from a Self-Sufficiency Trust Fund established in accordance with Illinois law are exempt. 20 ILCS 1705/21.1. PM 07-02-15-b. These trusts are managed by the State of Illinois and used for the benefit of a designated beneficiary. Funds not used remain with the trust.
- ***Pay Back Trust:*** A Pay Back Trust is exempt. This trust is an irrevocable trust containing assets of a disabled person under age 65 that is established by a parent, grandparent, legal guardian or court for the benefit of the disabled person. The trust must provide that any amount remaining in the trust up to the amount expended for the person's care must be paid to the Illinois Department of Healthcare and Family Services upon the death of the person. PM 07-02-15-b.
- ***Pooled Trust:*** A Pooled Trust is similar to the Pay Back Trust except that it is managed by a non-profit association. PM 07-02-15-b.
- ***Non-Spouse Third-Party Trusts:*** A third party, such as a parent or grandparent, may establish a trust for the benefit of a person. Whether these trusts will be considered for Medicaid purposes depends on the terms of the trust. Broadly stated,

a trust intended to support a person will be considered for Medicaid purposes, but a trust merely making payment discretionary and supplementary is not considered. Illinois law provides that a discretionary trust is not considered for Medicaid purposes or subject to an obligation to repay for Medicaid benefits. 760 ILCS 5/15.1. These rules apply whether a trust is established by a third party during his or her lifetime or upon death. Except where a spouse is involved, the trust may be established during one's lifetime or by will. These trusts are frequently referred to as "special needs" trusts.

- ***Spouse Established Trust in General:*** A trust created by a spouse is not treated the same as a third-party trust unless it is created by will. Therefore, if a spouse wishes to establish such a trust for the benefit of a spouse who is in or likely to enter a nursing home, it should be created upon death and by will. If, instead, a trust is created during one's lifetime (which is usually called a living or inter-vivos trust), the transfer penalty period will be applied against the spouse seeking Medicaid. It has been recognized that a spouse may be disinherited by will and this is not a transfer of assets that will disqualify a spouse for Medicaid. *Bezzini v. Department of Social Services*, 49 Conn. App. 432, 715 A.2d 79 (1998). It is often suggested to also leave to the spouse who is in or may enter a nursing home the statutory share the spouse would have received if the spouse renounced a will (which in both Illinois and Missouri is one-half if there are no descendants and one-third if there are). Where a trust is used, an application for Medicaid would need to be delayed until the penalty period has elapsed.
- ***Spouse Established Trust of Community Spouse Assets:*** Where a spouse's assets are within the community spouse limits discussed earlier, somewhat greater flexibility exists. This is because no resources of the community spouses are deemed available to the institutionalized spouse. The community spouse, for example, may place the assets in a special needs trust. Although, perhaps, a living or inter-vivos trust may be used, a trust under will is ordinarily the preferred approach to avoid any argument that the assets should be considered assets of the spouse in the nursing home. Also, because the assets are not considered as belonging to the institutionalized spouse, disinheriting the spouse by a living or inter-vivos trust, using non-probate forms of transfer (*e.g.*, joint tenancy, POD or TOD), or gifting the assets might be appropriate. This helps prevent any of the community spouse's assets from being recovered for the institutionalized spouse's obligations.

Except for trusts established by third parties, trusts are not commonly used for Medicaid Planning. If trusts are used at all by a couple where a spouse is or may enter a nursing home and seek Medicaid, trusts will ordinarily be established only under a will (that is, a testamentary trust).

May Annuities Be Purchased?

A Medicaid applicant may purchase an annuity. An annuity is a contract to receive fixed, periodic payments, either for life or for a specified number of years. When an annuity is purchased, the

person usually pays a lump sum premium in exchange for the guaranteed payments. An annuity is subject to special rules. Purchase of an annuity may be appropriate to consider if it is necessary to enter a nursing home within the 60-month look back period.

If periodic payments have not yet started and access to the principal is allowed, then the principal is considered an available asset. If the terms of the annuity do not permit access to the principal, the principal is not an available asset, but any payments made to or for the benefit of the applicant are income. PM 07-02-17.

The purchase of an annuity is a transfer of assets that is subject to the transfer of asset policy. In other words, where an annuity is purchased, fair value must have been received. Whether fair value has been received is determined based on the expected return from the annuity. If an annuity pays for one's life, the yearly amount of benefits is multiplied times the Medicaid applicant's life expectancy. For example, the life expectancy for a 75 year old male is 9.24 years and an 80 year 6.98 years and 12.05 years and 9.11 years, respectively, for a female. Where the annuity pays for a fixed number of years, the yearly amount of benefits is multiplied times the appropriate number of years or, if less, the applicant's life expectancy. If the expected return as calculated is above the amount paid for the annuity, fair value is received. If less, the shortfall or difference is a non-allowable transfer.

To clarify this further, consider some examples: If a male at age 65 purchases a \$10,000 annuity to be paid over the course of 10 years, his life expectancy according to the required table is 14.96 years. Thus, the annuity is actuarially sound. However, if a male at age 80 purchases the same annuity for \$10,000 to be paid over the course of 10 years, his life expectancy is only 6.98 years. Thus, a payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and that amount is subject to penalty. *See Centers for Medicare and Medicaid Services State Medicaid Manual Transmittal 64.* It is also necessary that the payments be made in "approximately equal periodic payments." An annuity providing for small payments with a large balloon the last month is not a qualifying annuity. *Gillmore v. Illinois Dept. of Human Services*, 354 Ill. App. 3d 497, 822 N.E.2d 882 (2004) (annuity did not qualify under Medicaid providing for payments of \$188.94 for 115 months and a final payment in month 116 of \$72,741.94 where life expectancy was 116 months).

Annuities provide a number of benefits in some circumstances. It allows eligibility for Medicaid and, thus, the monthly nursing rate will be charged according to Medicaid prices rather than a nursing home's usual charges. If the annuity is not exhausted at the death of the applicant, some benefit may be available for one's family after reimbursement to the Department. Keep in mind, though, that there are costs associated with the purchase of annuities. They are not frequently utilized but may be worthy of consideration in some circumstances.

How Are Transfers With Life Estates Reserved Treated?

Real estate may be transferred to others, usually children, with a life estate reserved to the owner. The owner is the life tenant; those to whom the real estate is transferred and will receive the real estate upon the life tenant's death are the remaindermen.

If a transfer is made without payment, the difference between the value of the real estate and the value of the life estate is the amount of the gift. To determine the value of the life estate reserved, the Illinois Department of Healthcare and Family Services uses a table. *See* WAG 25-03-11. However, the life estate itself is not considered an available asset. Because of this, life estates are frequently used in Medicaid planning. However, keep in mind that the creation of a life estate is subject to the 60-month look back period.

What Transfers Are Permitted?

What transfers are permitted to still qualify for Medicaid? Among some others, these are the sorts of transfers that may be made before applying for Medicaid:

- Transfers made outright more than 60 months before entry into a nursing home or before applying for Medicaid. PM 07-02-20-b.
- Transfers made for fair market value.
- Transfers to a community spouse within the allowances available to a community spouse.
- Transfers of a homestead to a spouse.
- Transfers made to or from certain trusts.
- Transfers to, for the benefit of, or in trust for, any child who is blind or disabled.
- Transfers made exclusively for a reason other than to qualify for Medicaid.
- Transfers for less than fair market value that are returned to the person.
- Transfers where it is decided that denial of payment would create an undue hardship, such as where the person is mentally unable to explain how the assets were transferred, forcing the person to move from the nursing home, preventing the person from joining their spouse in a facility, or preventing the person from entering a facility near their family.
- Transfers of smaller amounts are permitted. The specific amounts allowed are one-half of the average monthly cost of nursing facility services. This amounts to about \$2,750 currently. This amount may be transferred each month.

In addition to these allowable transfers, transfers are permitted to a person's community spouse that are the result of a court order. This means, in effect, that a court may increase the amount that may be retained by a community spouse.

What Is a Spouse's Obligation to Pay Nursing Home Care?

A community spouse is obligated to provide for the long term care of a spouse. Because of this, the assets of the community spouse are considered and, ordinarily, expected to be disclosed when Medicaid is sought.

Because the support obligation of a spouse is actually independent of the determination for nursing home eligibility, a community spouse may decline to disclose assets other than those transferred from the nursing home spouses. Transfers from the community spouse must be disclosed. The spouse entering the nursing home may receive Medicaid where information is not disclosed. However, if a community spouse refuses to disclose assets, the case will be referred to the Field Recovery Unit to determine whether any contribution is required from the community spouses. In a recent opinion, the Illinois Supreme Court reaffirmed that while an eligibility determination takes into account only the income over which the spouse needing nursing home has actual control, the community spouse can be liable for certain long-term care costs incurred by the institutionalized spouse and may, in some situations, have to reimburse the State. *See Poindexter v. Dept. of Human Services*, 229 Ill.2d 194 (2008).

Are Liens Claimed?

Where a Medicaid recipient dies, an estate claim may be made. The claim is for all financial assistance paid to or on behalf of the recipient and, with some exceptions, all medical assistance paid out. A lien or claim is not made unless payments were made for at least 120 days.

A lien will not be filed against a home where it is occupied by a spouse, a minor, a disabled or blind child, or a sibling who has an equity interest in the property and has legally resided in the property for at least one year before the resident entered the nursing home. The lien may be enforced when there is a transfer of the home, in cases of fraud, or at the time of the death of the owner.

Medicaid Planning

Is It Too Late For Medicaid Planning?

In a great number of cases, by the time Medicaid planning is considered ... it is simply too late. The 60 month penalty period, in particular, precludes much being done.

The limitations on transfers apply to nursing home or long-term care and community care programs. The limitations do not apply to hospitalization, drugs, or physician fees. Therefore, even where an individual is not eligible for long term care, hospitalization, drugs, or physician fees may be covered.

What Are Some General Planning Tips?

Some general planning tips:

- Be certain to review the assets and income of the prospective Medicaid applicant and, if married, the applicant's spouse before seeking Medicaid. What is the value of the assets? What salary, social security, retirement, interest, dividend, or other income is available? What is the value of assets in each spouse's name, together, or with others? What types of assets are involved?
- Determine whether there is in fact a need for Medicaid planning. For some, assets and income will be sufficient to pay the costs of nursing home care.
- Is it likely or not likely that Medicaid would be sought within 60 months?
- Should a gift program be considered? Is there a willingness to make gifts? Are there logical recipients, such as children, to whom gifts would be made? Will the gift program be able to be completed at least 60 months before applying for Medicaid? What are the income, gift or other tax consequences of a gift program?
- If a gift program is undertaken, what penalty period will be imposed based on the amount of the gifts? In general, this will be the number of months not exceeding 60 derived by dividing the amount of the gifts by the monthly private pay cost of the nursing home entered.
- What is the appropriate amount of gifts that may be made taking into account income and the possible need to enter a nursing home? A prospective Medicaid applicant often may make some gifts without affecting eligibility. The applicant should retain sufficient assets so that those assets and ongoing income will pay for care for at least 60 months. If, for example, nursing home care will cost \$3,000 each month (or \$180,000 for 60 months), and the applicant has \$1,000 of monthly income (or \$60,000 for 60 months), at least \$120,000 in assets (\$2,000 times 60) should be retained.
- Where transfers have been made, has the penalty period expired? It is usually advisable to allow the penalty period to expire before applying for Medicaid.
- If there is specific property that a child or other family member wishes to acquire, should a sale for fair market value be made? Transfers for fair market value are not prohibited.
- Are applicable exemptions being utilized?
- Are any special exemptions applicable, especially those not typically utilized? This may include transfers to disabled children.

What Are Some Planning Tips Where There Is A Community Spouse?

Some planning tips where there is a community spouse:

- Where one spouse will enter a nursing home, be certain to have exempt assets transferred to the community spouse to the extent permitted. Remember, this must be done within 90 days from the date of the application for benefits.
- Make certain a home is transferred to the community spouse. If a home is not owned, consider acquiring a home and then transfer it to the community spouse.
- If non-exempt assets that may be transferred to a community spouse exceed the applicable limits, consider whether any improvements, repairs, etc., should be made to a home to be transferred. These should be made before transferring the home to the community spouse. After the transfer of the home, further transfers related to the home may be limited and apply against the community spouse allowance.
- Consider whether funds should be used to prepay debt. Because a bona fide debt is adequate consideration, payment of debt is not an improper transfer. This is especially helpful when it increases equity in an exempt asset, such as a home.
- A community spouse is entitled to all household furnishings and personal effects. Although a purchase should not be made for investment purposes (*e.g.*, a Liz Taylor diamond ring), ordinary and appropriate household goods may be warranted.

What Are Some Disadvantages of Medicaid Planning?

Planning decisions may have a number of disadvantages. As such, caution should be used in Medicaid planning.

The most obvious disadvantage of an outright transfer is that control over assets is lost. There is no assurance that long term care will be required. Once a gift is made, it's made.

Where a home is transferred, income tax disadvantages may result. Those given the home will retain the donor's basis in the home. Where the home is retained, the gain on the home would be exempt from income tax if sold and, if not sold, would receive a step-up in basis upon death. If there is an outright gift of a home, the exemptions from real estate taxes are lost. These disadvantages may be avoided by retaining a life estate in the home which, at least currently, is not considered an available asset.

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Summary

The prospect of entering a nursing home is always troublesome. Apart from the emotional toll, there is the financial demand on family resources. In some cases, planning may result in some preservation of assets for family.

<p>Please note that this discussion provides general information. It is not intended to provide specific or personal legal advice.</p>
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