Medicaid Eligibility: Crisis Planning and Long-Term Care Medicaid Overview

Ellen LaPlante, Unsworth LaPlante, PLLC

I. CHOICES FOR CARE SETTINGS

In Vermont, Long-Term Care (LTC) Medicaid is also called "Choices for Care." Once an applicant qualifies for LTC Medicaid, they have a variety of choices as to where they can receive care and have Medicaid financially contribute to that care. There are four main categories of where care can be received under Choices for Care:

A. In the Home

Most people, when asked, say that their preference is to remain at home and receive care in place. More and more people are in need of long-term care at some point. In fact, almost half of all people over the age of 65 need long term care before they die. As people are living longer and the percentage of people who need long-term care increases, the number of people who want to receive care at home increases as well.

When a Vermonter received LTC Medicaid for in-home care, that care can be provided through an agency that contracts with Medicaid like Home Health (previously Visiting Nurses Association) or Bayada. The biggest hurdle for people receiving care from an agency caregiver is that often there are not enough caregivers available to provide the care the applicant may need. Additionally, the Department of Aging and Independent Living, which does the evaluation for how much care is needed, typically does not recommend more than about 36 hours of care per week.

In addition to receiving care from an agency caregiver, Vermonters have the option to receive care from a family member or friend that can be paid through a third-party vendor by Medicaid. This allows for caregivers to be trusted individuals for in-home care.

B. Adult Day Care

Adult day care allows a Vermonter who may need some assistance to also maintain some independence. It is ideal for someone who is, for instance, living at a residence with a child, but that child goes to work every day. The child can drop

their parent off at Adult Day Care to ensure that they are being cared for during the day, and then pick them up after work. This may give a child the peace of mind that their parent is receiving safe and supervised care while away from the home.

C. Assisted Living (Enhanced Residential Care)

Enhanced Residential Care facilities can provide a variety of options and there is a large spectrum as to what type of care or support is provided based on need. In Vermont, there is a tiered system for levels of care provided at facilities in the state, where Level IV is the lowest level of care provided as part of a Residential Care facility. This will typically include help with personal needs like mobility and providing meals.

Level III, which is a step higher, is typically provided through Assisted Living. The amount of care a resident receives in Assisted Living will be tailored to the individual, but can include assistance with medical needs, along with personal care.

In Vermont, the range for cost of Level III or IV care is between about $2,000 and $6,000 per month, with Chittenden County being traditionally higher than other counties. The state of Vermont maintains an ongoing list of all Assisted Living Facilities and their licensing through the Agency of Human Services. Many of these facilities are places that an applicant can choose to receive LTC Medicaid but maintain some independence if their needs aren't that of full nursing care.

D. Nursing Home

The level of care provided at Nursing Home falls in either Level I or Level II care under Vermont's system. For licensing purposes, Nursing Homes are also call "skilled nursing facilities." Nursing Home residents will typically receive full Medical attention and care, in addition to their personal care needs. Many residents will need help with some or all of their Activities of Daily Living.

In Vermont, the average cost of a Nursing Home is well over $120,000 per year, with the highest cost facilities again being in Chittenden County. For many residents of Nursing Facilities, doing more advanced planning to qualify for

Long-Term Care Medicaid can be advantageous for savings assets for their family and still receiving the level of care they need. (See the Trust discussion below).

II. ELIGIBILITY STANDARDS

A. The Needs Assessment

Also called a clinical evaluation, this assessment occurs when a nurse employed by the Vermont Department of Aging and Independent Living (DAIL) evaluates each applicant to determine whether they need Long-Term Care. This is a medical evaluation, and the biggest determining factor in most cases is whether the applicant can complete Activities of Daily Living (ADLs) on their own. While the evaluation can vary depending on the nurse, most applicants who are unable to complete at least two ADLs on their own are able to pass the clinical evaluation. ADLs typically include: Walking, feeding oneself, transferring (ex: from sitting to standing or laying to sitting), toileting, personal hygiene, and dressing.

Additionally, those applicants who suffer from cognitive diseases such as Alzheimer's or Dementia can be evaluated based on their mental and intellectual function, not just their physical abilities.

B. Asset Eligibility

The threshold amount of assets or "Available Resources" that a Medicaid applicant is permitted to have and still be able to qualify for Medicaid is $2,000 if they are a single person. If the applicant is married, their spouse is also allowed to have $128,640 in Available Resources (a total of $130,640 in resources). Available Resources generally include all cash, real estate that is not the applicant's primary residence, and any other assets.

The Medicaid Department typically releases new standards for allowed resources and average daily and monthly costs of care each October 10. However, because of COVID-19, no new standards have been released in 2020. The next date for an expected change is every January 1. It is unclear whether the Medicaid Department plans to release standards changes for January 1, 2021.

Valuation of assets is an important piece in determining correct calculations and techniques at both the Medicaid Pre-Planning and Crisis Planning stages. The Deficit Reduction Act of 2005 set parameters for calculating the value of assets because prior to that time, many Medicaid applicants were transferring assets out of their name in hopes of qualifying for Medicaid or were selling assets for less than fair market value.

Now, applicants must disclose any assets that have been are sold or transferred within the five years prior to Medicaid Application. Those that were done so for less than fair market value or as a gift generate penalties by the Medicaid Department. That penalty is calculated by determining how much was given away and assigning a period of time based on the average cost of care. (See the Trust discussion below for more information on penalty periods).

C. Income Eligibility

Most people who apply for Medicaid have more difficulty meeting the Asset standard than the Income Eligibility Standard. That is because, when the Medicaid office reviews an application for income, they look at the applicant's monthly income and determine whether there is more income than the applicant's monthly cost of long-term care. To oversimply this, if the monthly income is less than the cost of care, they meet the income test. However, it is important for an applicant to understand that a significant portion of the income they are receiving will likely be used toward care. The portion is call a "Patient Share." To calculate the patient share, the case worker evaluating the application first takes into consideration Gross Monthly Income and then deducts from that exempt expenses such as health insurance or regular medical costs. She then deducts the "Personal Needs Allowance" which under current Medicaid Rules is $72.66.

For example, take the income and expenses of this applicant into consideration:

INCOME

Gross Social Security Income	$1,289
IRA Distribution	$107
Pension Distribution	$490

TOTAL MONTHLY INCOME:	**$1,886**

EXPENSES

Medicare Part B Premium	$134
Private Health Insurance Premium (Supplement)	$206
TOTAL MONTHLY HEALTH EXPENSES	**$340**

Patient Share Calculation:
$1,886 (Income)
- $340 (Health Costs)
- $72.66 (Personal needs Allowance)
$1,473.34

The applicant would be responsible for $1,473.34 each month toward the cost of their care. Medicaid would pay for the remainder, once the applicant is approved. It is important to note that the Personal Needs Allowance is applicable when someone is receiving care in a Nursing facility. If the applicant were applying to receive Enhanced Residential Care or Care in the Home, the calculation would take into consideration the costs for Home Upkeep. See also the discussion below regarding the MMMNA for evaluating income for the spouse of an institutionalized applicant.

III. COUNTABLE AND EXEMPT RESOURCES

A. Exempt Assets:

There are some assets that the state automatically "exempts" for purposes of qualification. This means that certain assets don't count toward an applicant's assets when they apply. Some of the most common exempt assets are:

a. Primary Residence: An applicant's home (with equity up to $595,000) cannot be held against them for qualification. However, Medicaid is permitted to lien the home after the applicant's death (and the death of the applicant's spouse if they are married). That being said, an Enhanced Life Estate Deed can offer a lot of protection for the home. See below for more information on deeds.

b. Vehicle: Each applicant is permitted to have one vehicle titled in their name (as is their spouse if they are married). There is no standard amount of value for the vehicle. While a vehicle will not preclude qualification, it should be noted that it should also be protected from probate if the applicant wants to avoid recovery of the vehicle as well. Interestingly, under Vermont's rules, a "truck" is not included in the list of exempt vehicles so technically even if the applicant's primary vehicle is a pick-up truck, it is not exempt. However, there have been many applications approved even when the pick-up is listed as the primary vehicle.

c. Burial/Funeral Accounts: Each applicant and their spouse is permitted to designate $10,000 for burial and funeral expenses. It is typically best to put this money in a separate account designated for burial expenses. The account can be opened jointly with a trusted friend or family member so that it can be accessed immediately after death to pay for expenses. It is important to note that the amount in the account at time of application cannot be more than $10,000 so if an account is opened months or years in anticipation of application as a savings or money market that grows even slightly by application time, it could pose an issue.

d. Home Improvements and Other Exempt Expenses: If a Medicaid Applicant knows that their house needs a new roof, or that making the home more handicapped accessible would allow them to receive care in the home longer, they should do that work ahead of the application. Any money spent on home improvement is an investment in an asset in which they can protect 100% of the equity. Other things to consider spending money on would be new medical equipment such as wheelchairs or ramps, a vehicle upgrade, or paying friends and family for care if they are currently providing it for free (note that a formal care agreement should be signed in this case).

B. Countable Assets:

Any asset not exempt by Medicaid is a countable asset. As noted above, the threshold amount of assets or "Available Resources" that a Medicaid applicant is

permitted to have and be able to qualify for Medicaid is $2,000 if they are a single person. If the applicant is married, their spouse is also allowed to have $128,640 in Available Resources (a total of $130,640 in resources).

C. Special Asset Rules:

IRAs and Qualified Annuities:

Individual Retirement Accounts, commonly known as IRAs, are treated differently than all other assets from a Medicaid perspective. The rule in Vermont regarding IRAs (and other tax-deferred accounts), is that if you take distributions from the account based on the Social Security Table for life expectancy, you do not have to count the principle of the account as an available asset.
For example, if a 70-year-old woman owns an IRA worth $100,000, her life expectancy according to Social Security is 16.33 years, or 195.96 months. That means that if she takes $510.31 each month from the IRA (195.96th of the principle balance), she is allowed to exempt the remaining principle from counting as an available resource and it cannot keep her from qualifying for Medicaid.

The only catch to this rule is that the income taken each month from the Medicaid recipient must be treated as all income, and used to pay toward care. So if the woman were to actually live to be 87, she would see her IRA completely depleted and spent on care. However, because most people who apply for Long-Term Care Medicaid do not make it the full life expectancy, using this rule to protect at least part of the IRA is typically advantageous.

Three additional things are important to note here:

i. If the applicant is married, the spouse must take this distribution but does not have to use their forced distribution to pay for the Institutionalized Spouse's care. The only thing the Community Spouse has to use this money for is their own expenses. That means that the spousal allowance may be affected, but the Community Spouse will always get to keep at least their own income.

ii. The SSA life expectancy tables are different than the IRS tables for life expectancy. Just because an applicant is taking forced RMDs (after the age of 72) doesn't mean they are complying with this requirement. The distributions must be on the SSA table to qualify for Medicaid.

iii. This is the current rule in Vermont, but other states treat IRAs just like other cash accounts and do not allow special exemptions for them to be exempt assets. This is one more reason that planning for Medicaid should only be done in the state that the person plans to receive long-term care.

Non-Qualified Annuities:

If the annuity is funded with an IRA or other tax-deferred account, it is treated as a Retirement Account. However, if the annuity is funded with post-tax money, Vermont Medicaid has some very specific rules for how the account must be set up to qualify for Medicaid. The two main things to know:

i. The primary beneficiary (or secondary if the applicant is married) must be the Medicaid Department up to the amount they contributed toward care.

ii. Monthly distributions must be taken from the annuity in the same manner as retirement accounts if the applicant wants to preserve the principal.

One issue that occurs with annuities is that they often have a fee associated with cashing them out or changing this distribution. In some cases, annuities are restricted from ever changing the distribution. This can pose a large burden on the applicant because of high fees. Additionally, if the annuity distribution cannot be changed at all, the applicant must count the monthly set distributions as available income and then must still change the beneficiary so that the state is primary.

IV. IRREVOCABLE TRUSTS

A. What type of Trust?

Most Trusts used for Medicaid qualification are self-settled. Unlike a First Party (Self-Settled) Special Needs Trust, Irrevocable Medicaid Trusts (also called Intentionally Defective Grantor Trusts) are not required to have a payback provision. This is because they are subject to the Five-Year Lookback period under Medicaid Law,

and therefore may generate a penalty. The chart below gives a good demonstration of the similarities and differences of a First-Party Special Needs Trust as compared to an Irrevocable Medicaid Trust.

	First-Party Special Needs Trust	Irrevocable Medicaid Trust
Self-Settled	Yes	Yes
Payback Provision Reqd.	Yes	No
Generates a Penalty Period	No	Yes
Grantor can be Trustee	No	No
Grantor can be Beneficiary	Yes	Income-only

Trusts set up for purposes for qualifying for Long-Term Care Medicaid have a lot of very specific requirements, but the status of the Grantor/Settlor is not an issue. The Settlor of an Irrevocable Medicaid Trust (or their spouse) is the most likely person to also be the Medicaid applicant. The reason this does not pose a concern is because the Grantor also recognizes the chance to be penalized for the transfer to the Trust. If the Grantor transfers assets into the Irrevocable Medicaid Trust (whether or not they retain the right to income), and five years passes before a Medicaid application is filed, the Grantor Trust does not need to be reported to Medicaid. However, if the five years does not lapse, a penalty period will be assigned based on the assets transferred into Trust.

B. How an Irrevocable Medicaid Trust Works

i. <u>Transfer creates penalty period:</u>

The Five-Year Lookback Rule comes into play when you consider transferring assets to qualify for Medicaid. What the rule actually means is that if an applicant has given away, transferred away, or sold something for less than fair market value in the last 60 months, Medicaid is allowed to "penalize" them by forcing them to either have the asset returned or by paying for a portion of their care out of pocket before Medicaid will kick in. The portion of care is called the "Penalty Period."

The Penalty Period is the amount of time for which the applicant must pay for

their own care because of a previous transfer. This amount is calculated by taking the amount of money transferred away and dividing it by the average monthly cost of care, a number called the Regional Divisor, which in Vermont is currently $9,595.61. For instance, if someone transferred $100,000, they would divide that transferred amount by the Regional Divisor and have a Penalty Period of about 10 months. They would have to pay out of pocket for that amount of time before Medicaid would allow them to be qualified. It is important to note that if an applicant knows they will have a Penalty Period assigned, they should still apply as soon as possible because the Penalty Period clock does not actually begin ticking until an application is filed and Medicaid assigns the Penalty Period.

ii. Transfer creates gift:

The transfer of assets into an Irrevocable Trust is treated by the Medicaid Department the same way that they would treat a gift or transfer for lesser than Fair Market Value. This means that if the Trust were created and funded in fewer than five years (60 months), the Medicaid Department can penalize the applicant for the transfer. However, transferring assets to the Trust is often preferable to an outright gift. With a transfer into the Irrevocable Trust, the grantor still maintains a step-up-in basis (see tax discussion below), can retain all income from the Trust assets, and can retain the right to change Trust beneficiaries through a power of appointment. Additionally, the grantor can dictate how Trust assets are distributed, just as they would in a Trust created for any other purpose.

iii. Transfer is non-taxable:

Because the Irrevocable Medicaid Trust is a grantor Trust, the transfer into Trust is not a taxable event and doesn't create any negative tax ramifications. Additionally, it does not require a separate tax return be filed for the Trust.

C. Taxation of Medicaid Qualifying Trusts

An important element of an Irrevocable Medicaid Trust is for the Trust to retain Grantor Status. Unlike an Irrevocable Trust that a client would use for asset protection or tax-avoidance, most clients want the assets in their Irrevocable Medicaid Trust to remain in their "estate" for purposes of taxes. There are a few important things to note to make sure the Trust serves its purpose:

i. Income is Taxable:

When an Irrevocable Medicaid Trust is established, the client has a choice to make: either reserve all income for themselves from Trust assets, or allow that income to accumulate in the Trust. If the client chooses to allow the income to accumulate in the Trust, it is important that they reserve a Power of Appointment over Beneficiaries to ensure that the Trust is legally deemed a Grantor Trust. But, whether or not the client chooses for the income to be distributed to them personally, or for the income to accumulate in the Trust, any income generated by the Trust is taxed to the Grantor. This means that even if the Trustor doesn't receive the income from the Trust, he or she is still responsible for paying the taxes on that income. Importantly, neither the Trustee nor Beneficiary bears any personal liability for the taxes on income generated by the Trust during the Trustor's lifetime.

ii. Income is Countable:

If the client does choose to keep income generated from the Trust (have the income pay out to the Trustor rather than accumulate in the Trust), the client must claim that income on the Medicaid Application if and when the client applies. This means that when the Medicaid Department calculates the patient share (the monthly amount the applicant is responsible for), income from Trust assets becomes part of the calculation.

iii. Step-up in Basis

Because the Trust used for Long-Term Care Medicaid Planning is a Grantor Trust, the client gets the benefit of a Step-up in Basis. This means that any assets transferred to the Trust during the Grantor's lifetime get a new basis at the time of the Grantor's death. Therefore, assets like a family camp or investment account that has appreciated over time can be distributed to the beneficiaries without the Grantor (or Beneficiary) having to worry about paying a Capital Gains Tax on the growth of that asset. This aspect of the Trust is one of the best arguments for the Trust versus an outright "gift" to the beneficiary. For instance, Clients John and Jane

Smith own a family camp that Jane inherited from her grandparents 40 years ago. The camp was worth $50,000 at that time. Today, it's worth $250,000. If John and Jane give the camp to their kids (in hopes of making it through the five-year lookback period), and then die seven years later, the kids will pay a capital gains tax on the $200,000 growth when they sell the camp. If instead, John and Jane transfer the camp to their Intentionally Defective Grantor Trust and die seven years later, and then kids sell the camp for $250,000, no capital gains taxes are due. This is because there was a Step-up in basis for Trust assets.

D. Choosing the Assets for Funding the Trusts

The Funding of a Medicaid Trust is arguably the most important step, albeit the last, especially in a pre-planning scenario. Before the Trust can be funded, it is important to keep in mind the signature requirements of the Trust. Oftentimes, the logistics of signing can be what holds up the funding of a Trust. Practically speaking, if the client (Grantor) lives here in Vermont, his or her child (serving as Trustee) may live out of state. It will be important to ensure that the Trustee signs in front of witnesses and a notary just like the Grantor before the Trust is deemed to be in effect.

Once the Trust has been signed and established, it should be funded immediately. Just as with funding any Trust, the mechanism for funding will be dependent on the type of asset being transferred into the Trust. However, it is important to make sure the Certificate of Trust is as fool-proof as possible so that third parties (banks, financial institutions, etc.) are clear regarding the Trust's provisions. The most important provisions to include in the Certificate of Trust are:

1. Name of the Trust
2. Date of the Trust
3. Trustor Name(s)
4. Trustee Name(s)
5. Tax ID (Grantor Social Security Number)

6. The fact that the Trust can be continually funded after it has been established.

The Certificate of Trust should be signed, witnessed, and notarized with the same formalities as the Trust Instrument itself.

The reason Trust funding timing is so important when doing Medicaid Pre-Planning is because the transfer into Trust is what starts the Look-Back Period clock ticking. Ideally, the Irrevocable Medicaid Trust will be established and fully funded at least five years prior to the Trustor (or her spouse) needing Long-Term Care.

Unlike a Revocable Trust, whose funding issues could be "solved" at any point during the Trustor's life, it is strongly advisable to give clear instructions to the client for Irrevocable Trust funding, personally assist with all funding letters to banks and financial institutions, and then double check to ensure that all statements reflect the Trust's name once the process is complete. This ensures that the attorney has done their due diligence to get the five-year look-back period underway.

The assets that should be transferred to the Irrevocable Trust include any assets that cannot be immediately protected from Medicaid and whose values are over and above the Allowable Resources thresholds. These assets typically include any secondary real estate (outside of the primary residence), non-retirement investment or cash accounts, and vehicles that are not the primary automobile driven by the applicant or their spouse.

ADVANCED MEDICAID PLANNING AND ASSET PRESERVATION

Michael D. Caccavo, Esq

The rules for Countable and Excluded or Excludable assets are found in Section 29.07 - dealing with assets in general, including definitions and general principles; and 29.08 - dealing with exclusion of assets.

A. Community Spouse Resource Allowance

The Community Spouse Resource Allowance is adjusted annually. The current amount for 2020 is $128,640.00. This is the total value of **countable** assets that the community spouse may keep and still have the Institutional Spouse qualify for Medicaid.

Any assets that are otherwise countable can be used towards this amount. So, if there is excess cash value in life insurance, or annuities, stock portfolios or CD's , those assets can be allocated to the CSRA and disregarded for purposes of qualification. Section 29.09 discusses how various assets are valued for purposes of the CSRA.

The assets for the CSRA can be in either spouse's name at the time of application But be sure that the client understands that they must be transferred to the Community Spouse prior to the first annual review, so they should start making the transfers as soon as possible.

B. Annuities

The changes to the Medicaid Rules, as a result of the DRA 2005 have drastically changed the effective use of Annuities in Medicaid planning. Under the current rules an annuity is treated in one of three ways, depending on the status and terms of the annuity. Annuities are defined and discussed generally in the rules at Section 29.07(b)(2)(iii). The excludability rules are at Sec. 29.08(d)(1).

An annuity is countable as a resource if it is in its accumulation phase and can be liquidated or sold. Previously, all that needed to be done in such a situation was to annuitize the investment, but that no longer works. Any annuity in payment status is evaluated under one of the other two rules.

Second, under Sec. 29.08 (d)(1) an annuity is not counted as an available asset if meets the following criteria:

(i) Has only the applicant and spouse as beneficiaries, and;

(ii) provides payment to the applicant and or spouse in equal intervals and equal amounts, and;

(iii) the payments are based on their life expectancies, according to the DCF/Social Security tables, and;

(iv) does not contain a death benefit or any payment to anyone else if applicant and spouse die before full payment period, and;

(v) the contract is calculated to return at least the amount used to establish it plus earnings.

For annuities purchased after Feb. 8, 2006, or annuities purchased prior to that date that do not meet the above requirement (iv), if the annuity designates Vermont Medicaid as the first remainder beneficiary up to the amount of long-term care assistance and community service Medicaid payments made by the state for the institutionalized individual, except that a community spouse, minor or disabled child may be named ahead of the State, provided the State is named as secondary beneficiary, then it may also be considered as a non-countable asset. (Note that there are different rules for applications filed before 10/7/05, but since we aren't likely to be dealing with any of those now, I won't bother covering them.)

It should be borne in mind that any payments by the annuity, if payable to the institutional spouse, will be included in calculating the patient share under Medicaid. Thus, while the annuity may provide assistance for the community spouse if other income is below the spousal support figure, any excess will be used for the cost of nursing home

care. On the other hand, if the annuity is owned by or paying to the community spouse, the income is not countable, but the spousal share may be reduced.

NOTE that the rules require the use of the SSA actuarial tables in determining life expectancy, not the IRS tables. It also provides that DCF may develop its own alternate tables which will be adopted by rule. This rule applies to all situations involving the deferred receipt of full fair market value (FMV), such as **promissory notes, annuities, retirement accounts,** and other such arrangements.

Thus under the new regulations the use of annuities has changed substantially and new annuity products are developing for the changing Medicaid planning landscape. The most useful type of annuity these days is the Single Premium Immediate Annuity, see later discussion of SPIA's.

NOTES: a. Many Annuity salespeople are not aware of the new regulations and are still selling standard annuities claiming that they are an effective means of protecting assets for long term care. Also, nationally there have been numerous abusive sales schemes involving annuities and the elderly. Be sure to warn your clients.

b. Annuities have a built in trap if the client is using them as an investment and wealth accumulation vehicle, especially later in life. Annuities grow on a tax deferred basis. However, at death, there is income tax due on the earnings as "income in respect of a decedent". This can complicate the estate plan and the duties of an executor and substantially reduce, unexpectedly, the property passing to the named beneficiaries.

c. Many regular annuities (not SPIAs) have large penalties for early cancellation or payment. Be sure to consider these carefully in the context of your client's age and health. Also advise your clients to be aware of these issues. I have heard of some instances where an inappropriate annuity was sold, and it was possible to get the transaction reversed, but it is always better, and less expensive, to avoid the problem rather than having to correct it.

SINGLE PREMIUM IMMEDIATE ANNUITIES

With the drastic changes in the Medicaid look-back and the application of the penalties, this type of annuity has become a very useful planning tool for 'emergency' planning situations. With such a policy a couple can take a large amount of countable assets (cash, investments, other annuities) and convert the asset into an income stream for the Community Spouse.

For example a client can take a disqualifying $125, 000.00 regular annuity and use it to purchase an immediate annuity for the community spouse. The purchase is a 'purchase for value' so not penalized, the annuity meets the Medicaid criteria and the CS receives payments/income for whatever time period is contracted for so long as it is not longer than the CS actuarial life. The asset no longer counts; the income to the CS has no effect on qualification. Once the IS is qualified, gifts by the CS will not affect qualification so gifting is still viable (although it will affect the CS if later institutionalization is required). However, the income from the annuity will increase the CS's income and may reduce or even eliminate the Community Maintenance Allowance. There are immediate annuities available that meet the Medicaid criteria that will pay for as short a period as 1 year.

When using SPIAs for an individual, you will have to be careful to do some computation as to whether the payback requirement will actually preserve any assets for family members. This is also important when choosing a payback term. Remember, the term cannot be longer than the annuitant's life expectancy, but it may be shorter.

Existing annuities can be converted to SPIA's without tax consequences by doing a Sec. 1035 exchange. This avoids the immediate recognition of taxable income or gain as would be the case with a regular liquidation.

SPIA's can be used in situations such as the one described above to immediately qualify someone with a disqualifying annuity or other cash or investments. They can also be used as part of a more complicated gifting strategy to assist in a 'reverse half a loaf' plan.

Reverse Half a Loaf Gifting

In pre-DRA days we used what was called a “half a loaf” gifting plan to transfer assets and qualify a person for Medicaid. Basically it was a gift of some funds where the retained funds would cover the gifting penalty. With the DRA this planning is no longer possible because the penalty doesn’t start to run until the applicant is “otherwise qualified for Medicaid”, meaning they can’t have any funds.

Under the new penalty rules imposed by the DRA, in order to start the gift penalty clock running, the applicant must be otherwise eligible for Medicaid, meaning he has no more than $2000 in countable resources. Thus all funds must be transferred before applying. The simplest method is to transfer all applicant’s money, then apply. When they are approved and the penalty is imposed, the transferee of the funds can pay the monthly expenses. Then each monthly payment covers one month of the penalty AND constitutes a partial return of the gift, reducing the total penalty as well. This method will require the applicant to recalculate the penalty in light of the partial return, and to reapply when it appears the proper penalty has been ‘served’.

A SPIA (Single Premium Immediate Annuity) or a Promissory Note, can be used in the same scenario. The transfer calculation is made, a portion of the funds are gifted (approximately one half) and the balance of the funds are used to purchase a SPIA or loaned, with a Medicaid qualified promissory note, to a trusted individual. Then application is made. The purchase of the SPIA, or the loan/note is not penalized nor is it a countable resource. The monthly proceeds will pay for the nursing home during the penalty period. When the payments are done the penalty should be over and the applicant immediately qualified for Medicaid. While using the SPIA in this manner does entail a modest fee, it has the advantage of being easier to calculate, and avoiding the requirement of re-applying. It also avoids the risks of having the funds to pay through the penalty period in one individual’s name (death, creditors, etc.).

Private mortgages, which will be discussed in more detail later, could also be used as a funding source to pay during a ‘reverse half a loaf’ penalty.

Two things to be careful of when using SPIAs :

1. Be sure that the payment computation uses the SSA life expectancy tables and NOT the IRS tables, http://www.ssa.gov/OACT/STATS/table4c6.html ,and;

2. Be sure the beneficiary designations meet the Medicaid criteria for Medicaid payback.

I have worked with only a very few local financial advisors who really understood SPIA's and could find the right product. There is an attorney, Dale Krause, at dalekrause@medicaidannuity.com (www.medicaidannuity.com) who is licensed to sell these products in Vermont and is extremely knowledgeable about the products and planning techniques and very helpful in making calculations and obtaining the product.

C. Bank Accounts

Bank accounts are dealt with generally in Sec. 2908(b)(2)(i). Bank accounts are countable resources. Even joint bank accounts are countable as an asset of the applicant or spouse unless the joint owner can demonstrate that they have deposited funds in the account, in which case those funds would be excluded. Adding someone else's name to a bank account is not a penalized transfer, so long as that person does not withdraw funds for their own benefit. This does bring up a danger with joint accounts. A creditor of a joint owner may levy on the entire account (except for Social Security benefits in such account), regardless of whose funds actually created the account. So if Mom puts Son on her account, and Son has a judgement against him, his creditor may garnish the entire account, even if it was all Mom's money.

Joint Accounts created before 1993 receive different treatment. Prior to OBRA '93, joint accounts were exempt. After OBRA, they were deemed to belong to the applicant unless and to the extent that the joint owner could show they had contributed to the account. Occasionally we still run across accounts that were made joint prior to 1993. The joint owner can withdraw the funds, without penalty. Be sure you have good documentation of the establishment and continuation of the account.

D. Burial Contracts/Funeral Trusts/Assets used for Funerals

Commented [MSOffice1]: Get the link or reference for the SSA tables

Burial Funds are discussed generally in Sec. 29.07(b)(1)(iv) of the rules and the excludability rules are at Sec. 29.08(e). The applicant, and spouse can each have up to $10,000.00 set aside for burial. This can be in a pre-paid burial plan, or a cash value life insurance policy, or just a designated bank account, or a combination of the above. The account cannot exceed $10,000.00 when established, but interest that has accrued will not disqualify it. Be aware, however, that the value of a burial plot and marker are included in the computation, so if the client has a cemetery plot and stone already, the value of those must be deducted from $10,000.00 when you determine how much to put into the account. Burial accounts can be a great last minute planning technique.

E. Disaster Relief Act and Other Excluded Government Payment Programs (Reparation Payments, Alaskan Native Claims, Nazi Persecution Payments, etc.)

I have never really run into any of these particular items and an asset or income source for any of my clients. The Vermont rules do deal with them specifically, and list all government excluded assets in Sec. 29.08(i)(9) .

F. Income-Producing Property

Income producing property is discussed in Sec 29.08(a)(7). Commercial real estate and rental real estate that produces at least 6% of FMV per year in income is exempt as an asset. However, the department has an unusual interpretation of 'income', which income has to be included in calculating the patient share. The department says 'income' is the gross amount received for the property, not the net after expenses. So if a client has property such as this, the lease should be a net lease, or the client will not be able to use the rental income to pay the property taxes, etc.

G. Life Estates

Life Estates are defined in general in Sec. 29.07(b)(1)(ii). The specific rules dealing with the various forms of life estates and how they are treated or excluded are found in Sec. 29.08(a)(6), with subsection (A) dealing with 'bare' life estates; subsection

(B) dealing with Enhanced Life Estates in general, and: subsection (C) dealing with the ELED for the primary residence. This section will only deal with a 'Bare' life estate, for discussion about Enhanced Life Estates (Ladybird Deeds) see the section on The Home.

Reserved Life Estate without Power of Sale: The Reserved Life Estate without Power of Sale is an excluded resource, 29.08(a)(6)(A). The "Look Back" period will apply and a penalty will be assessed on the value of the remainder interest in the land.

At the present time the main benefit of using a Deed with a Retained Life Estate without Power of Sale is Probate avoidance. This can be an added benefit by avoiding not only the expense and delay of probate but also the possibility of a Medicaid reimbursement claim against the Probate Estate. Another use of the Life Estate is to obtain a discount on the value of a gift.

This type of transfer does not allow retention of control, because the remaindermen do have an interest and therefore would have to sign any documents affecting the property. There is also less creditor protection, as the interest of the remaindermen may be subject to attachment and divestment, subject to the life estate, of course. On the other hand, if the property were to be sold during the elder's lifetime, it does offer some protection of asset because the remaindermen are entitled to a portion of the sale proceeds.

This type of ownership does not provide all of the tax benefits of the Power of Sale Life Estate. For capital gains tax, if the property is sold during the life tenant's lifetime the remaindermen will share in any sale proceeds and will have to pay capital gains tax on their share (with carry over basis), thus losing some of the capital gains tax exclusion. The capital gains step-up on death, however, is preserved by the retention of the life estate.

H. Loans and Promissory Notes

Private loans, promissory notes are discussed generally in Sec 29.07(b)(2)(v), and mortgages at Sec. 29.07(b)(2)(iv). These arrangements are essentially treated the same as annuities. The requirements for excludability are found at Sec. 29.08(d)(2). These arrangements have to meet all the requirements regarding no payees besides the applicant

or spouse, payback no longer than life expectancy, regular equal payments at least annually with no balloon provisions, reasonable interest, etc.

While the current Vermont rule does not specifically say that the note must be unassignable and non-cancellable, it is wise to include that language in the document. If you do not, the applicant may have to prove that the note cannot be sold, or have the Fair Market Value counted as an asset or penalized as a transfer. The department requires 3 independent valuations of such notes, which could be difficult to get. It is much simpler to include the language making the note non-transferable and unassignable. Likewise, Medicaid payback language in the event of the death of the note holder is not specifically required but it may be useful to include it anyway.

Be aware that while non-conforming annuities can be made complying but adding the Medicaid payback language, the promissory note section has no such provision. So if you are faced with clients who have a note that is countable it can be difficult to remedy the situation and selling the note may be the best alternative.

The only real difference between a private mortgage and a private unsecured note and a private SPIA would be whether there is a mortgage or security for the instrument. **Note:** With private notes and mortgages you should be sure to NOT include language allowing for prepayment without penalty. While this is provided for in the Vermont statutes, DCF has raised questions and claimed such a provision made the note a countable resource.

I. Life Insurance

Life Insurance comes in two basic varieties, Term Insurance and Cash Value (or Whole Life, Universal Life) life insurance. The general discussion and definition of Life Insurance is found in Sec. 29.07(b)(1)(iii).

A. Term Insurance: Term insurance is pure insurance, offering a death benefit, but accruing no lifetime value with the premiums. Term insurance, no matter what its face value is excluded as a resource under Sec. 29.08(b)(1)(ii).

This exclusion does present a planning opportunity, if the client's goal is to ensure assets pass to beneficiaries but are not needed for current support. By purchasing a term policy, provided the premiums can be paid or if a single premium policy is available, the client can insure his beneficiaries receive a death benefit, free of any Medicaid claim. The purchase of the policy is not a prohibited transfer because it is purchase for value. The policy itself is not a countable resource because it has no present value.

B. Cash Value Insurance: Cash value life insurance includes the traditional Whole Life policies, as well as the numerous Variable life and Universal life type policies. Under 29.08(b)(1)(i)(A) if the combined FACE VALUE of all policies owned by any one member of the financial responsibility group does not exceed $1500.00, the total CASH VALUE is excluded as a resource.

Under 20.08(b)(1)(i)(B) if the FACE VALUE of all policies owned by any one member of the financial responsibility group exceeds $1500.00, then $1500.00 of the CASH VALUE is excluded and all amounts in excess of $1500.00, including any dividends, is considered a countable resource.

NOTE: Be sure to note the distinctions here, the test is not the current Cash Value, but the Face Value. Under the rule, it seems that a policy with a Face Value of $1500.00 but a Cash Value in excess of that amount would NOT be countable.

Often you will encounter clients with one or more small whole life policies. Frequently they are paid up insurance and the cash value is very close to the death benefit. You may cash these policies out and then deal with them as any other cash asset, or you can allocate the policy to be a part of the "Burial Account" in your planning.

J. Vehicles

Vehicles are dealt with in Sec 29.08(i)(2). A person is allowed to own an automobile (yes, even if they can no longer drive). In fact, **all** automobiles are excluded

resources, see 29.08(i)(2)(i).There is no limit on the value of the car, but it should be used for the person's transportation. **Note**: a truck is not a car, trucks, even pickup trucks, may not be excluded the same way cars are. Classic or collectible vehicles are countable resources, unless they are used for transportation. If you are going to have a client invest in a new car for planning purposes, my suggestion is to be cautious; purchase a modest vehicle (think Buick not Bentley), get one the elder can actually ride in (sedan not full size SUV), and have the elder actually ride in it occasionally.

Collectible automobiles, unless used for general transportation, are treated as countable resources and not an excluded vehicle, see Sec. 29.08(i)(2)(ii).

Also, be cautious when the new vehicle is titled. I know of one client who titled a new car jointly with her son, and DCF took the position that there was a transfer of one half the value of the car. A better alternative would be to use a Beneficiary Title which the Department of Motor Vehicles will now issue. Also, you might check with the auto insurance company to see if they will insure the vehicle without a licensed driver on the title; if they won't, be sure to document their position before titling jointly.

K. Stocks, Bonds, and Mutual Fund Shares

Stocks, bonds and mutual funds are generally countable resources. They are discussed and defined in Sec.29.07(b)(2)(ii). If they are held in a retirement type account – IRA, 401k, 403b, etc, then they will fall under the Retirement Account rules discussed below. If they are held in a regular investment account, or bank account, they are countable, except as below.

Certain bonds, primarily some U.S. Treasury bonds, have a minimum retention period before they can be cashed in. DCF issued rule 29.08(i)(11) to deal with this planning technique. Under this regulation bonds fall into 3 categories:

1. Bonds purchased prior to June 15, 2004 which are not in their minimum retention period are treated as available resources.

2. Bonds owned at the date of the regulation, and in the minimum retention period at the date of the regulation will continue to be excluded, forever.

For bonds purchased after the effective date of the regulation to not be considered as countable assets, they must be in the minimum retention period and the owner must request a hardship waiver from the Treasury Dept. to allow cashing the bonds early AND the waiver must be denied. In that circumstance, the bonds will not be countable until the minimum retention period ends. At the end of the retention period, they will be countable.

Therefore, if your clients have bonds that were purchased between June 15, 2003 and June 15, 2004 (be sure to verify the end date of the minimum retention period is AFTER the effective date of the regulation) those bonds are EXEMPT assets, forever. For bonds purchased after the effective date this technique might remain effective in situations of reduced lifespan. If the elder is not expected to survive longer than the minimum retention period, the technique could work, depending on the Treasury Department's criteria for 'hardship waivers.' I have no knowledge of those criteria at the present time. If however, the elder outlives the minimum retention period, the bonds become countable resources and will or may disqualify the elder from Medicaid LTC coverage.

L. Trusts

Trusts have several basic categories : Revocable, Irrevocable, Self-settled, and Third Party. The Medicaid rules discuss trusts in general and give definitions in 29.07(c)(1)(iv). The rules regarding the excludability of various trusts are in 29.08(e)(1).

Trusts will be covered more extensively in other sections of the Seminar today, particularly SNT's and Irrevocable Trusts. I will not cover them here. I do wish to lightly touch on several Trust issues.

Revocable Trusts

Assets in Revocable Trusts owned by the applicant (or spouse) are considered countable resources. Transfers to a Revocable Living Trust are not subject to the lookback because they remain countable assets. This means that for assets in such trusts there is also no Medicaid protection except Probate avoidance.

It also means **holding the house**, which would normally be an exempt asset, **in a Revocable Trust (RLT) renders it countable**. This issue needs to be addressed during the funding process if you are using RLT based planning for your clients. If you have Medicaid planning clients who already have an RLT based plan, you need to examine what assets were funded into the Trust. The major assets that can be troublesome here are the primary residence, and possibly vehicles, which are excluded if owned by the individuals but countable if owned by the Trust. In such situations be sure not to fund these items into the trust, or if already in, be sure to convey them back out. It is also helpful, if you have an RLT situation, to be sure the Trustee and successor Trustees have gifting and transfer powers, and that gifts directly from the Trust are deemed to be gifts to the Grantor first, then individually from the Grantor to the recipient. You should also be sure that the individual has a good Durable Power of Attorney as well, and not rely on the gifting authority of the Trustee.

Irrevocable Trusts

The treatment of an Irrevocable Trust for Medicaid purposes depends on how available the assets in the trust are to the applicant (or spouse). If the funds are available then the transfer is not penalized but the assets are countable. Under the DRA 2005 (Deficit Reduction Act of 2005, passed Feb. 8, 2006, Vermont implementing regulations effective Feb. 1, 2007) the there is no distinction between gifting to an Irrevocable Trust that is unavailable to the applicant (or spouse) and gifting outright. All gifts are subject to the 60 month lookback period.

The Irrevocable Trust has advantages over simple gifting in several ways. The terms of the Trust can place conditions on the current use of the funds thus preventing the wasting of assets or exposure to the claims of creditors of the beneficiaries. This can ensure that monies are available for specific purposes, as long as not generally available for the benefit of the applicant. It can provide for the preservation of real property and provide for its maintenance. The use of a Trust can avoid the Gift Tax issues that arise if a gift is made to one child for distribution to all children after the parent's death. It can also avoid the often overlooked problem of the complications if the gift recipient unexpectedly dies first. It can provide the usual Trust protections for the non-grantor beneficiaries, such as creditor avoidance, divorce protection, dynasty preservation, etc. The Trust, if drafted with appropriate reserved powers,

can remove appreciated assets from Medicaid countability but preserve the step up in basis at death. Ideally, the trust can preserve present funds so they may be funneled back for the grantor's benefit by the other beneficiaries (see below). The grantor may appoint a Trust Protector to ensure the basic goals of the trust continue to be honored and current requirements complied with and to amend the Trust to comply with future tax or Medicaid rule changes.

Often clients may choose the simplicity of straight gifting over the added complexity and expense of a Trust. This is not necessarily bad, but clients should be aware of the risks of gifting, both to the assets and the potential tax issues for the recipient as well as the benefits in the Medicaid plan. They should also be apprised of the potential benefits of a trust arrangement along with its attendant dangers.

One place I use Irrevocable Trusts more is in connection with Reserved Life Estate Deeds. I have created a Trust to be the grantee/remainderman in many situations. It has worked very well if there are some special circumstances such as; unequal distributions to beneficiaries; having grandchildren as beneficiaries; if there is to be a sale contract at a price certain or to a certain party, etc. In these situations one Trustee can be the named grantee, and execute any necessary documents. Any special distributions of the house or proceeds can be in the Trust and not cluttering the deed.

Special Needs or Supplementary Needs Trusts (SNT's)

The prior discussion has presumed that the Grantor of the trust is also the Medicaid applicant or a penalized transferor. However, similar considerations apply if a Medicaid applicant or recipient is the intended beneficiary of the Trust. This may be the situation with a Testamentary trust or a Trust established by someone else for the Elder's benefit. In such situations, care should be taken to insure that the trust would qualify as a Special Needs Trust, so that the trust income is not deemed income of the Elder, or worse yet the corpus is not deemed an available resource.

Special Needs Trusts do have a valuable role to play in Medicaid planning . Take note that 42 USC§1396p (d)(2)(A) (for the text see appendix 3) requires that the trust be created **BY WILL** for the spouse. Be aware that there is the possibility of a challenge if one spouse

leaves his or her entire estate to the surviving spouse in a Special Needs Trust. In some arrangements the spouse needs to disclaim a bequest to become the beneficiary of the SNT. In such a situation, the disclaimer could be deemed a penalized transfer. In estates where the spousal share is left to the spouse in an SNT there could be a claim that since the spouse does have the statutory right to elect against the will, to the extent of the spouse's statutory share, if not taken, there may be a penalized transfer.

M. The Home

The primary residence and ALL contiguous land is exempt up to an equity value of $595,000.00. The equity limit does not apply if the CS or other specifically enumerated person is residing in the home, see Sec. 29.09(d)(6)(ii)(B). The property does not all have to be held under one deed or be one parcel, all that is required is that the parcels be contiguous, meaning they touch each other, or would touch but for an intervening road or stream. There can be an issue with other structures, especially other residences, mobile homes, etc. on the property, but the home and land are exempt.

Life Estate Deed with Reserved Power of Sale: The Life Estate Deed with Reserved Power of Sale, a/k/a "**Enhanced Life Estate Deed**" (**ELED**), or the "LadyBird Deed" or "Medicaid Deed" as it is known nationally and the "Italian Deed" or "Granai Deed" as it is known in Central Vermont (named after the late C.O.Granai, Esq. of Barre, who used the form in numerous deeds and had the 'honor' of having the Vermont Supreme Court uphold the language in Aiken v. Clark, 117 Vt. 391, 1952), can be a powerful and important tool in the Elder Planning arsenal. The benefits are as follows:

A. **Exempt for Medicaid**. For the homeplace, at least, the property remains an exempt asset for Medicaid purposes, up to a maximum equity value of $595,000. Current Medicaid regulations promulgated by DCF particularly regulation 4241.6 have made clear that with a transfer, only the life estate with reserved power of sale is entitled to the full exemption. The exemption actually rests on the status of the property as the homeplace, and the Life Estate with power of sale retains sufficient control to avoid being a gift.

B. **Retain Control.** Because the Grantors reserve for themselves the full power to mortgage, sell, lease or convey the property during their lifetimes, they retain full control over the property. There is no loss of control or even veto power given to the remaindermen. This is a major concern for many elders, especially if they are doing more long term estate and Medicaid planning rather than immediate or emergency Medicaid planning. For these clients it is comforting to know that while they are ensuring the property will pass to their children, they could still sell it and buy a condo or that motor home to travel the country if they wanted, without the consent of the children.

C. **Avoids Probate.** Many clients have a goal of Probate avoidance after their death. This deed accomplishes that goal. Avoiding probate is the second part of protecting the property from Medicaid. By having the property pass outside the probate estate, any possible Medicaid reimbursement claim will be avoided. If the property goes into the probate estate, it may have to be sold to generate cash to pay the Medicaid reimbursement claim. **Currently**, Vermont only employs estate recovery to obtain reimbursement of Medicaid expenses.

> **NOTE:** This may change. Several years ago the department was seeking rulemaking authority from the legislature and was looking at various methods to enable recovery against the primary residence. Many other states are employing 'expanded' estate recovery and asserting claims against remainder interests or treating the conveyance of a remainder interest as a transfer. It is still good planning, but clients should be warned that the rules may change in the future and the deed won't have the Medicaid planning benefits it currently does.

D. **Not Subject to Creditor Claims.** The Life Estate Deed does not subject the property to the claims of creditors of the remaindermen. It also protects against the claims of divorcing remaindermen and their spouses. And for the remaindermen, it does not qualify as an asset for scholarship applications or other such income or asset based programs. This is a major advantage over the simple joint tenancies often created in the past with the idea of avoiding probate. **Note:** The property is still subject to the claims of the Life Tenant's creditors, so this does not protect the property from claims of the Nursing Home or other creditors.

E. **Tax Rebate Preserved.** The Life Estate Deed can preserve the Home Owner's property tax prebate/rebate for the Grantors, at least while they are still living there.

> **Suggestions:** I recommend including specific language stating grantors are responsible for all taxes during their lifetime to avoid any issues with the tax department. Query if this is still necessary under the new ELED statute and the 'statutory form'. It is no longer necessary to have the clients execute a Homestead Termination and a new Homestead Declaration when you file the deed. It is also good practice to list the Grantor as the first Grantee on the Transfer Tax Return.

F. **No Medicaid Look-back.** The Life Estate Deed does not constitute a penalized transfer for Medicaid. Because the grantors retain full control during their lifetime, there is no present transfer. Therefore, there is no look-back or penalty period to be considered when using this conveyance.

G. **Step-up in Basis.** When the property does transfer to the remaindermen, upon the death of the Grantors, there is a step-up in basis of the property to the date of death value (26 USC §2036). This can be a significant benefit to the remaindermen, saving hundreds of dollars in capital gains taxes if they then sell the property.

> **Note:** This summer I have encountered problems with the Vermont Tax Department in claiming the sale price as the 'date of death value'. Until there is some policy from the tax department, I'm suggesting clients get a 'date of death appraisal' soon after the Life Estate holder dies.

H. **No Gift Tax Return Required.** There is no Gift Tax return required at the time of signing the deed because there is no present gift. There are contrary views on this issue.

I. **Disadvantages.** With all of these benefits it would seem that the Enhanced Life Estate Deed is almost a perfect planning technique. It is, almost. As with most things there are some disadvantages. The major disadvantage is in the Medicaid context. If only one spouse survives and receives Medicaid Long Term Care benefits, all their income must be spent for their care first. This leaves no funds available to pay for the ongoing expenses of the property. While the elder may not be living in the house there are still expenses for taxes, insurance and other maintenance. These cannot be paid for from the

elder's income. If the situation is not planned for, then the remaindermen will have to pay these costs to preserve the asset. It is a situation that can be planned for by gifting and having the remaindermen make an arrangement to pay these expenses from the gifted funds. Sometimes a Trust is established by the remaindermen for this purpose, or a memorandum of agreement may be used. Such formalized arrangements present a risk that the gifted assets may be included as available funds by Medicaid unless very careful drafting is done on the documents. I personally do not recommend such formal arrangements, preferring that my clients not risk the Medicaid plan with them.

The other disadvantage is if the house is sold while the elder is alive, all the proceeds belong to them. While this is advantageous if the elder is living independently, it can be a problem if they are in assisted living, not yet on Medicaid but with a nursing home on the horizon. Selling the house to pay for the assisted living, could leave a substantial amount of assets in the elder's name when it is time to move to the nursing home. Similarly, if the remaindermen cannot afford the expenses of the home and move to sell it, all the proceeds belong to the elder.

It should also be noted that if the home is a duplex or multifamily dwelling that is partly rented and partly occupied by the elder, the same rules apply. It still qualifies as a homestead and the Enhanced Life Estate Deed works. Any income can pose a problem however as the department is now taking a broad reading of the term 'income' to mean 'gross income' rather than 'net income' as used in the tax context. This means that the department will require all of the rent to be used for nursing home expenses (if owned by a single person, or allocated to the community spouse if there is one). Careful structuring of the lease, requiring tenants to pay things like taxes and utilities can avoid that department rule. Such a property is not subject to the 6% income test used for the commercial property exemption.

Currently, transfers using an Enhanced Life Estate Deed are subject to the Transfer Tax. Normally this is not a problem because the Grantees are usually the children. Since there is no consideration paid and it is a transfer between parent and child, it is exempt from the Transfer Tax. An issue does arise, though, when the transfer is not a between a parent and child or grandchild. A sibling or more remote relation or friend is

not exempt. The Tax Department has taken the position that the full tax has to be paid on transfer, even though no actual change in ownership is taking place. The Department also requires that the non-residential tax rate be used because the property will not be the **Grantee's** primary residence. You can, however, reduce the tax by using the mortality tables to calculate the value of the remainder interest and pay the tax only on that amount.

This summer, 2020, other attorneys have reported that the department may have eased it's position in this regard, and been willing to defer the tax until the death of the life tenant. I do not know how they will enforce collection at that time, as nothing needs to be filed in the land records. I do not know the procedure, but it is worth investigating if you have a situation involving such a transfer.

NEW ELED STATUTE

With the new ELED statute, 27 VSA Chapt. 6, we have some new, and prescribed language for an Enhanced Life Estate Deed, along with a set of definitions that help to avoid the complicated, and often extensive, drafting language of the past. Now, to create an effective Enhanced Life Estate Deed, all you need to do is state that the Grantors are reserving a "common law life estate" and specifically reserve "the right to convey the property during the Grantor's lifetime". I would include a specific reference to the statute as well.

The statute defines "convey" as including the right to "revoke" or "revise" the deed. The reservation of powers in the deed do not need to include any more than that term. (For now, I think I'll include the following terms, which are defined as included in 'Convey', just in an excess of caution.)

"Revoke" is defined in the statute as negating the transfer. It is accomplished by recording a new deed from the Grantor to her or himself. I would suggest including a statement in the deed that it was intended to 'revoke' the prior transfer.

"Revise" is defined as changing the Grantee on an ELED. A revision is accomplished by recording a new deed to a grantee other than or in addition to the grantee in the original ELED. The revised deed will supersede the original deed. A revised deed should name ALL the grantees, and not try to just add one more, piecemeal.

I believe that 'revise' also encompasses changing the form of ownership between the grantees, i.e. the grantees are the same, but their ownership is changed from Tenants in Common to Joint Tenants. Again, I would suggest a specific statement that this deed revises and supersedes the prior one.

Since there is now a suggested 'statutory' deed. Using that form should create a 'safe harbor', and avoid future interpretation problems or challenges. The new statute, and use of the prescribed form should avoid the problems highlighted in and following Weed vs. Weed, 2008 Vt 121, August 29, 2008, where there began a search for the proper term in the document to support the action purportedly taken.

The new statute also resolves the issue that had been emerging in the last few years as to whether a mortgage given subsequent to the ELED, effectively cut off the remainder interest. The new statute makes clear that the granting of a mortgage does not operate to 'revoke' or 'revise' the ELED. It also makes clear (as was understood in prior law), that the remaindermen take the property subject to any mortgage or encumbrance.

I would also now suggest, since we do have a statutory name for this type of conveyance, to title the deed as "Enhanced Life Estate Deed". It will avoid the current confusion (mostly in clients) in identifying which deed is an ELED when they are all titled Warranty Deed or Quit Claim Deed (not Quick Claim Deed as popularly thought).

See Exhibit 2 for the Statutory ELE Deed.

N. Retirement Accounts

Retirement accounts are touched on in Sec. 29.07(b)(2)(vi), but not much is really discussed there. For specific information about the treatment of retirement accounts, we must look to 29.08(i)(5).

29.08(i)(5)(iii) provides that when pension funds are held in a retirement account as defined in the rule or in a work related pension plan and owned by the institutional spouse no change in ownership is required for those funds to be considered as an excluded resource for the benefit of the community spouse when applying for Long Term Medicaid. If the spouse (or other person in the "financial responsibility group") is the

owner of the funds, they won't be counted as an asset, but the person must be drawing them down and the payments will be considered in calculating the spousal support allowance.

Retirement accounts include IRA's, pensions, Keogh plans, SEPs and 401K plans. The definition may also include certain forms of life insurance, annuities, and other forms of investments. The test for a Retirement Account is not, initially, what form it takes, but whether the individual has set the account aside to provide for support when they stop working.

DCF excludes from consideration funds owned by a member of the financial responsibility group which:

(i) require the individual to terminate employment to access the funds; or

(ii) for which the individual is not eligible for a lump sum distribution; or

(iii) the individual is not eligible for periodic payments; or

(iv) if the member of the financial responsibility group with the funds has reached retirement age, they must be drawing on the funds at a rate consistent with the Medicaid life expectancy tables (not the IRS RMD rate).

For most clients, the above subsection (iv) proves most valuable. Most clients are already taking their RMD's and are familiar with the idea. It is sometimes difficult to explain that they'll have to increase the amount and why, but they grasp the concept. It is a relatively simple matter to do new calculations based on the Social Security life tables (which Medicaid uses) to derive a new figure. The basic formula is:

Account value / life expectancy = annual amount

annual amount / 12 = monthly amount to withdraw

When you do the calculations, be sure to save the statement from which you did the calculation and use that figure in the Medicaid Application. Also, please note, that medicaid wants documentation of receipt of the first withdrawal, before they will exempt the account.

Exhibit 1

BASIC MEDICAID INFORMATION

Allowable Resources

- Individual $ 2000.00
- Spouse at home $128,640.00
- Burial fund (each) $ 10,00.00

Income Allowances

Individual

- Personal needs allowance $47.66 / mo.
- Medicare Part B, Medigap premiums

Spouse at home

All personal income (no required contribution for spouse)

- A portion of nursing home spouse's income to bring 'home spouse' to between $2113.75 and $3216.00, depending on expenses.

Treatment of various Assets

Primary residence:

- Exempt as long as either spouse alive and considers it home, maximum equity value of $595,000.00 if no community spouse.
- Subject to recovery in probate after death
- Easily protected with an ELED (Enhanced Life Estate Deed)

Real Estate (other than home): Countable, unless Joint Tenancy with others.

Car: Exempt if used for personal use.

Personal Property: Items like furniture, clothing, jewelry, electronics, all exempt if used for personal use.

Life Insurance: Countable if over $1500.00 in cash value, term insurance is exempt.

Burial Funds: Exempt up to $10,000.00.

Bank and Investment Accounts: Countable.

Joint Bank Accounts: Generally countable.

Retirement Accounts: May be excluded if taking distributions properly (NOT RMDs only)

Annuities: DANGER! Annuity rules have changed and annuities are often countable. If you are concerned about Medicaid planning, consult an Elder Law attorney BEFORE you purchase or annuitize an annuity.

Gifting Penalties

- All "Gifts" made within 5 years (60 months) of applying for Medicaid will be subject to penalty.

- The penalty starts when you apply and are qualified for Medicaid, NOT when you make the gift.

- The penalty is a disqualification from Medicaid benefits for the number of days the gift would have paid for nursing home care, based on the current state "Penalty Divisor" not the private pay rate at the nursing home.

- NOTE; The '$15,000.00 tax free gift' does not apply to Medicaid. Those gifts are subject to Medicaid penalties.

Exhibit 2

ENHANCED LIFE ESTATE DEED

Vermont Statutory Form Deed

KNOW ALL PERSONS BY THESE PRESENTS that [!Grantorpronoun!I/We] , [CLIENT NAME] of [Client Address], [!Grantorpronoun!**Grantor/Grantors]**, in the consideration of One Dollar and Other Good and Valuable Considerations paid to [!Grantorpronoun!my/our] full satisfaction by [GRANTEE ONE of Grantee One Address;] [GRANTEE TWO of Grantee Two Address;] [**Grantee/Grantees]** by these presents do freely **Give, Grant, Sell, Convey And Confirm** unto the said [**Grantee/Grantees]** , [GRANTEES NAMES], AS TENANTS IN COMMON, and [!Granteegender!his/her/their] heirs, successors, executors and assigns forever, a certain piece of land known as [Property Address] in [Property Town], in the County of [Property County] and State of Vermont, described as follows, viz:

Being [all/a part of] the land and premises conveyed to [Client Name] by [warranty/quit claim/Executor's/Administrator's] deed of [Prior Grantor] dated [Date of deed in] and recorded [Date deed in recorded] in Book [book recorded] at Page [page recorded] of the land records of the [City/Town] of [Property Town].

Reference may be had to the above-mentioned deeds and their records and to all other deeds and records in the chain of title for a more complete and particular description of the land and premises herein conveyed.

This conveyance is made subject to and with the benefit of any utility easements, public rights-of-way, spring rights, easements for ingress and egress, and rights incidental to each of the same as may appear more particularly of record, provided that this paragraph shall not reinstate any such encumbrance previously extinguished by the Marketable Record Title Act, Chapter 5, Subchapter 7 of Title 27, Vermont Statutes Annotated.

[!Grantorpronoun!GRANTOR/GRANTORS] RESERVED RIGHTS:

This is an enhanced life estate deed executed pursuant to, and with the rights and privileges set forth in, 27 V.S.A. chapter 6, the Enhanced Life Estate Deed Act. The [!Grantorpronoun!GRANTOR/GRANTORS], OR THE SURVIVOR OF THEM, hereby reserve unto [!signergender!himself/herself/themselves]: (a) a common law life estate, with the exclusive use, possession, and enjoyment of the property; and (b) the right to convey the property, including the right to revoke or revise this conveyance.

Deed prepared based on information supplied by Grantor(s) without title search

To Have And to Hold said granted premises, with all the privileges and appurtenances thereof, to the said [**Grantee/Grantees]**, [GRANTEES NAMES] , AS

TENANTS IN COMMON, and their heirs, successors, executors and assigns, to their own use and behoof forever; And , [!Grantorpronoun!I/we], the said [Client Name], [!Grantorpronoun!**Grantor/Grantors],** for [!Grantorpronoun!myself/ourselves] and [!Grantorpronoun!my/our] heirs, executors and administrators, do covenant with the said [**Grantee/Grantees]**, [GRANTEES NAMES] , AS TENANTS IN COMMON, and their heirs, successors, executors and assigns, that until the ensealing of these presents [!Grantorpronoun!I/we], [!Grantorpronoun!am/are] the sole [!Grantorpronoun!owner/owners] of the premises, and have good right and title to convey the same in manner aforesaid, that they are **Free From Every Encumbrance,** except as aforesaid**;** and [!Grantorpronoun!I/we] hereby engage to **Warrant And Defend** the same against all lawful claims whatever, except as aforesaid.

In Witness Whereof, [!Grantorpronoun!I/we] hereunto set [!Grantorpronoun!my/our] [!Grantorpronoun!hand/hands] and [!Grantorpronoun!seal/seals] this _____day of [Month signed] , [year signed]

In Presence Of

_____ L.S.
[Client one name]

_____L.S.
[Client two name]

State Of Vermont

County of [County Where Signed], ss. At [Town Where Signed] , this _____ day of [Month Signed], [year signed] [Client Name] personally appeared, and [!signergender!he/she/they] acknowledged this instrument by [!signergender!him/her/them] sealed and subscribed, to be [!signergender!his/her/their] free act and deed.

Before me_____Notary Public

Long-Term Care Medicaid Planning: Post-Eligibility Issues

By

Peter L. Potts, Esq.

Clarke Demas & Baker, PLLC
346 Shelburne Road, Suite 602
Burlington, Vermont 05401

(802) 652-1400 Telephone
(802) 652-1405 Facsimile

E Mail: ppotts@cdbesq.com

I. What Follows After Long-Term Care Medicaid Application Approval

In General: Congratulations! If you are a Long-Term Care (LTC) Medicaid planning attorney and your client has received approval by the State Medicaid Agency of his/her LTC Medicaid Application, then your efforts and those of your client or the client's representative have been crowned with victory. As I always tell my LTC Medicaid planning clients, there is never any guarantee of approval because we are dealing with individual third-party decision makers. So, you may enjoy the moment. It is not, however, the end of the matter.

What remains are some important issues that cannot be neglected. If they are, it could result in a client's LTC Medicaid eligibility being lost and perhaps requiring a re-application to be submitted. At a minimum, even if there are issues that do not require being specifically addressed, they may still require monitoring for the duration of the client's life, or for the duration of the period during which they need to be receiving long-term care services.

A. Post Approval Matters

Although some post-eligibility issues (such as the titling of assets) can be addressed before approval is received, many cannot.

1. Notification of Eligibility

Usually, even when an attorney is known by the State Medicaid Agency (in Vermont, the Agency for Human Services, by and through the Department of Vermont Health Access) to be involved with a LTC Medicaid application, it is the applicant who will receive the notification of eligibility. It is only if the client signs an alternate reporter form that the attorney will receive copies of correspondence from the State Medicaid Agency. In any event, it is still good practice to have the client know to inform the attorney once the client receives the notification of eligibility.

Together with the notification of eligibility, there should be calculations on the Community Spouse Resource Allocation (known as the "CSRA" and, in Vermont in 2020, up to a maximum allocation of $128,640 in countable assets) and any monthly income allocation to the Community Spouse, the countable assets relative to the LTC Medicaid recipient and the patient share that will be due and owing monthly. It is always prudent to review these calculations for accuracy.

2. Patient Share, Permitted Allowances and Monthly Income

The person responsible for paying the LTC Medicaid recipient's bills must usually pay out from the recipient's monthly income all but the personal needs allowance (in Vermont for an individual recipient, $72.66 monthly in 2020). What must be promptly paid are patient share, any permitted allocations to any Community Spouse or other family members, health insurance premiums or other outstanding

medical bills not covered by LTC Medicaid, any home-upkeep deduction (where there is no Community Spouse) during the first six-months of receiving LTC Medicaid, or any other allowed offsets to patient share.

One of the important reasons for paying out income promptly during the calendar month of receipt is because income only remains income during that calendar month. Any income received becomes a countable resource if retained into the subsequent calendar month. A LTC Medicaid recipient can lose Medicaid eligibility if retention of too much income beyond the calendar month of receipt causes the LTC Medicaid recipient's countable resources to exceed the $2,000 limit for an individual. While there is no requirement that the LTC Medicaid recipient spend the personal needs allowance, it may be necessary to do so before it accumulates enough to exceed the $2,000 countable resource limit.

3. Annual Review of LTC Medicaid Eligibility

By each yearly anniversary of a LTC Medicaid recipient's initial determination of eligibility, the State Medicaid Agency will conduct a review to ensure that eligibility is maintained. It is possible for an audit to be conducted before a yearly anniversary either to confirm the accuracy of a State Medicaid Agency caseworker's determinations or if Medicaid fraud is suspected.

During an annual review, the LTC Medicaid recipient's countable and excluded assets will be verified. Where there is no Community Spouse, the valuation of a LTC Medicaid recipient's owned primary residence may be checked with the assessment in the assessor's/lister's records to ensure its value does not exceed the substantial home-equity limit (in Vermont in 2020, $595,000).

If there is a Community Spouse, all countable assets to be part of the CSRA must be retitled solely in the name of the Community Spouse prior to the first anniversary of the LTC Medicaid recipient's eligibility determination. Although transfers between spouses are unlimited, these are still not permitted to occur any later than the first anniversary of LTC Medicaid eligibility.

4. Unreported Income and Assets

I have occasionally been asked if, in disclosing assets and income on a LTC Medicaid application, it is necessary to tell the truth! I make emphatically clear that it is necessary, the applicant or the representative signing the application are doing so on pain and penalties of perjury, and to be knowingly untruthful is a criminal offense.

It is still frequently the situation that not all income and assets are reported to the State Medicaid Agency during the initial application process and are later discovered. This is usually, however, not because of an attempt to deceive but simply because of an oversight, because the person completing the application was unaware of the existence of an asset or certain income, or because of other factors. For example, an interest-bearing checking account is listed as an asset and verified as an asset. It does, however, pay interest at various intervals and the bank reports this to the Internal Revenue Service (IRS) on a 1099-INT. This interest can then be reported to the State Medicaid Agency as income and can lead to the issuance of an unreported income notice.

This can also occur when an interest-bearing account is moved from one bank to another, with the second bank, of course, not having been listed on the initial LTC Medicaid application. The State Medicaid Agency may then see interest being paid by two different banks on two different 1099-INTs during the same year, with the

second bank not having been listed before. This occurs as well when the interest-bearing account is not moved from a bank but the bank instead changes its name and starts issuing 1099-INTs under its new name. These situations can be resolved but until the State Medicaid Agency receives the full details the presumption by it can be that the applicant neglected to disclose an account in existence at the time of the initial LTC Medicaid application.

When an asset is only discovered after application, then it should be addressed as an after-acquired asset. Disclosure should specify that the applicant was unaware of the asset, perhaps requiring an affidavit, and the asset will need to be validly disposed of or spent down before the end of the calendar month in which it was discovered.

Whatever the cause of such a notice from the State Medicaid Agency, it is important to respond to it promptly and in writing. Sometimes simply setting forth the facts is all that is needed but I like to include any materials in support which are not unduly cumbersome and lengthy in order to help prove the assertion.

5. Notification of Change in Circumstances

Any significant change in circumstances, including the discovery and disposition of previously unknown assets, must usually be reported within ten (10) calendar days to the State Medicaid Agency. This change can be caused by such events as receiving a non-periodic payment, an inheritance, or discovering a previously unknown and unreported asset. If a Community Spouse is receiving an income allocation from the LTC Medicaid recipient then any change in the Community Spouse's income should also be reported.

Triggering events for such a notification do not usually include reporting interest on bank accounts. It may also be that changes in Social Security payments from cost of living adjustments or changes in Medicare premiums deducted therefrom do not have to be reported because the State Medicaid Agency is usually made automatically aware of these by the Social Security Administration. Significant changes in expenses, such as private health insurance premiums or shelter expenses for the Community Spouse, should also be promptly disclosed.

6. After-Acquired Assets

When a LTC Medicaid recipient receives additional countable assets after eligibility is determined, such as from an inheritance (including an elective share from a deceased Community Spouse), it needs to be properly addressed, usually as any other excess countable asset. Disclaiming the asset is not an option because that will trigger a transfer penalty.

The asset should be spent down or otherwise validly disposed of before the end of the calendar month in which it is received. Ideally, this will be done before the notification of the change in circumstances is due to the State Medicaid Agency so that information on the receipt of the asset and how it has been addressed can be provided at the same time.

B. Asset Treatment

1. Retitling Assets in the Name of the Community Spouse

As stated previously, when the LTC Medicaid eligibility notice issues and the CSRA for the Community Spouse is determined by the State Medicaid Agency, up to one (1) year is allowed from the date of the eligibility determination in order to

retitle any assets in the name of the Community Spouse alone. It is crucial that this retitling be done so as not to jeopardize the LTC Medicaid eligibility of the recipient. While it is not necessary, of course, for all assets which are allocated to the CSRA to be retitled prior to the LTC Medicaid application, the State Medicaid Agency will verify the retitling at the first annual review of eligibility.

2. Estate Planning Considerations for the LTC Medicaid Recipient

In Vermont, the State Medicaid Agency is authorized under Medicaid Covered Services Rule 7108.3 to "seek adjustment or recovery from the estates of individuals who died on or after January 1, 1994 provided that the individuals were 55 years of age or older when they received long-term care services paid for by the Medicaid program for nursing facility services, home-and-community-based waiver services, and related hospital and prescription drug services. . .The [Medicaid Services Agency] will file a claim with the probate court as a creditor of the estate to recover its expenditures for long-term care services only after the death of an individual's surviving spouse, if any, and when the individual has no surviving child who is under age 21, blind, or permanently and totally disabled as defined by the Social Security Administration."

If the LTC Medicaid recipient has a surviving spouse then the State Medicaid Agency, pursuant to the above-referenced rule, shall defer filing any probate estate claim until the surviving spouse dies, at which time it shall usually seek reimbursement. Historically, the State Medicaid Agency is very attentive to the opening of probate estates and is diligent in seeking reimbursement. There are certain other exceptions in the Medicaid Covered Services Rules when the State Medicaid Agency will not pursue a reimbursement claim, such as undue hardship, but it is best not to assume a determination of undue hardship will be made.

Please note that in Vermont it is only against a probate estate that the State Medicaid Agency may file a claim for reimbursement. If a LTC Medicaid recipient is unmarried then the best approach for avoiding this is to ensure he or she does not leave a probate estate. Also, keep in mind that just because an asset is excluded for LTC Medicaid purposes does not mean that the State will not file a creditor's claim in probate court if the excluded asset is a probate asset.

Assets owned by revocable trusts avoid probate. However, the LTC Medicaid rules mandate that if a primary residence is owned by a revocable trust it automatically becomes a countable asset. That is, however, the only asset which cannot be owned by a revocable trust and there are ways of titling the primary residence in order to ensure it does not become a probate asset and which are acceptable under the LTC Medicaid rules in effect in Vermont, such as through an Enhanced Life Estate (or Lady Bird Johnson) Deed. Other assets apart from the primary residence can be owned by a revocable trust under the LTC Medicaid rules, although the simple act of titling them in the name of a revocable trust does not automatically render a countable asset excluded. Any assets titled in the name of a revocable trust for the LTC Medicaid recipient must either meet the LTC Medicaid excluded asset rules or not exceed the countable asset limit of $2,000.

3. Estate Planning Considerations for the Community Spouse

The Community Spouse is afforded wide discretion in the use and enjoyment of assets held by them as part of the CSRA. For the Community Spouse, after the initial qualification of the LTC Medicaid recipient, the State Medicaid Agency does not concern itself with any assets acquired through the accumulation of unspent income and/or the receipt of other assets, such as through inheritance, that add to the Community Spouse's net worth. Relative to such assets after the initial qualification, the Community Spouse may even gift them without impacting the

LTC Medicaid eligibility of the recipient. It may, however, affect the Community Spouse's own LTC Medicaid eligibility if such is sought within five years of the gift.

In Vermont, if the Community Spouse dies and leaves a probate estate but is predeceased by the LTC Medicaid recipient, the State Medicaid Agency is empowered to file a reimbursement claim for the LTC Medicaid recipient's cost of care in probate court. Realistically, I have wondered about the fact situation where a Community Spouse survives a LTC Medicaid recipient by a significant amount of time (such as a decade or more) and upon passing leaves a probate estate against which the State Medicaid Agency files a reimbursement claim for the cost of care provided to the LTC Medicaid recipient, and whether it would still be allowed by the probate court so many years later. I know at least one former probate judge who has stated such a claim filed so many years after the death of the LTC Medicaid recipient would be disallowed.

It is still prudent to ensure the Community Spouse does not leave a probate estate, however. Definitely if the LTC Medicaid recipient is dead, avoiding a probate estate can be accomplished through the use of a revocable trust, joint ownerships, transfer on death designations, payable on death designations and beneficiary designations.

If the Community Spouse predeceases the LTC Medicaid recipient, however, the concept of the "elective share" comes into relevance. If a Community Spouse only has a probate estate but chooses to disinherit the LTC Medicaid recipient, the State Medicaid Agency will require the LTC Medicaid recipient to take their elective share of their deceased spouse's probate estate. Pursuant to statute, 14 V.S.A. § 319, the elective share in Vermont is fifty percent (50%) of the deceased spouse's probate estate to the surviving spouse.

Keep in mind that much of this planning is predicated upon only one spouse needing LTC Medicaid planning. If, as can happen, a Community Spouse ultimately needs LTC Medicaid as well, then the only approach is to either spend down the countable assets to no more than the allowed limit in Vermont of $2,000 for an individual or $3,000 for a couple or seek to convert them to excluded assets, or use a combination of such approaches. Remember that any LTC Medicaid recipient can have an unlimited amount of excluded assets.