

RISK MANAGEMENT WORKSHOP SERIES

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MEDICAID: PLANNING FOR LONG TERM CARE IN THE FARM AND RANCH CONTEXT

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Medicaid rules, and Medicaid planning, can be complicated. This material is intended to provide the reader with a useful summary of certain rules and issues that arise in planning for long-term care. However, the regulations and policies which govern these issues are subject to change. (It is important to note that the Nebraska Legislature has mandated reform of the Medicaid program through the passage in 2005 of LB 709 and that significant change in the Medicaid program is to be expected.) This material is not intended to be exhaustive or to serve as a substitute for competent legal advice.

This material has been prepared in the context of the rules and regulations of the State of Nebraska. Medicaid laws vary from state to state. Many of the basic principles discussed in this article will prevail across the states, and may serve as a useful introduction to the issues of Medicaid planning. However, to paraphrase the adage, the devil may be in the details.

In Nebraska, nursing home care may cost from \$36,000 to \$50,000 a year. Most people pay for nursing home care out of savings, until the savings run out. They then apply for Medicaid. Medicaid is designed to pay nursing home costs for those elderly who cannot otherwise afford long-term care. It is a welfare program. It is funded federally and by the state. It is administered in Nebraska by the Department of Health and Human Services (DHHS). A person needs to prove eligibility in order to receive Medicaid benefits. The test to determine whether or not a person is eligible for Medicaid benefits has three parts: status, resources, and income.

ELIGIBILITY

Status

To be eligible for Medicaid, an individual must meet certain status requirements. In general, a person must be a US citizen (there are also separate provisions for resident aliens and refugees), reside in Nebraska, be 65 or older, or, if younger than 65, be blind or disabled. Residence in a public institution, such as a Veterans facility, disqualifies the applicant. If long term care occurs in a nursing home, the facility must be certified by Medicaid. An applicant will be denied coverage if he has deprived himself of resources or income in violation of Medicaid rules. (See section on *Deprivation of Resources*.)

Resources

A person can keep certain assets, or resources, and still be eligible for Medicaid. Generally, a single person's resources must be less than \$4,000, a married couple's resources less than

\$6,000. In a situation where only one spouse in the marriage requires nursing home care, a couple may apply for Medicaid under the **spousal impoverishment program**. In this program, if the combined assets of the couple are worth less than \$18,552, the spouse who is not going into the nursing home (“community spouse”) may keep all of the assets plus the \$4,000 for the nursing home spouse. If the couple’s combined assets exceed \$18,552, then the community spouse may keep one-half of the assets up to a value of \$92,760, plus the \$4,000 for the nursing home spouse.

Certain assets are not counted at all; they are called **excluded resources** and include:

- a) real property occupied as a home, if the applicant, the spouse, or a dependent lives in it (where a single person is applying for Medicaid, the house is still excluded as a resource if the applicant plans on returning to the house within six months of entering the nursing home; see *Protecting the Home*);
- b) cash surrender value of life insurance policies with combined value of \$1,500 or less;
- c) household goods and personal effects of *moderate* value;
- d) burial spaces, burial funds, and irrevocable burial trusts up to \$3,000 plus purchase of casket, plot, monument, and liner;
- e) one motor vehicle per person or per married couple (a single person must demonstrate that vehicle is needed for employment or medical transportation);
- f) certain trusts;
- g) life estates in real property, where no deprivation has occurred in transfer of the remainder interest (income from the life estate is included in the Medicaid budget);
- h) land contracts, where no deprivation of assets has occurred in the terms of the contract and where the contract is not saleable (again, income from the contract would be included in the Medicaid budget);
- i) business equipment, fixtures and machinery, which may include real estate and fixtures used for a trade or business, where the applicant, or spouse or another responsible relative (not including offspring) are actively involved in the trade or business; and
- j) a trailer or mobile home occupied as a home. (The exclusions for life estates, land contracts, and business property are further discussed in the section on *Deprivation of Resources*.)

All other assets (**available resources**) must be sold and the proceeds used to pay nursing home costs before Medicaid will step in to pay.

Income

To put it simply, in the nursing home context, a person who applies for Medicaid must first pay all of his or her income, minus a minimal deduction for personal needs, to the nursing home. Medicaid will then pay the remaining nursing home costs.

Income that the community spouse receives in his or her name is not counted as part of the nursing home spouse’s income for Medicaid purposes; the community spouse simply keeps that income. If income is received in both spouses’ names, then it is typically divided pro rata between them. But what happens in those cases where most of a couple’s income arrives in the name of the nursing home spouse and the community spouse’s income is not enough to live on? If the application for Medicaid has been made under the Spousal Impoverishment Program, Medicaid rules provide that the community spouse is entitled to a portion of the institutionalized

spouse's income, called the minimum monthly maintenance needs allowance, or **MMMNA**. If the community spouse's income is less than \$1,562 per month (an amount that changes annually), he or she may keep as much of the nursing home spouse's income as is necessary to bring the income up to \$1,562. This amount may also increase depending on rent or mortgage payments of the community spouse.

DEPRIVATION OF RESOURCES

Congress imposed a penalty on people who transfer assets for less than fair market value that could otherwise have been used to pay for their long term care. This type of transfer is called a **deprivation of resources**. A deprivation occurs when an individual, or someone on behalf of that individual, reduces or eliminates the individual's ownership or control of an asset for less than fair market value.

The penalty works like this: the value of the asset that was transferred for less than fair market value is divided by the monthly cost of the nursing home and the person becomes *ineligible* for Medicaid for however many months that asset would have paid for the nursing home care. (This is called the **period of ineligibility**, and it begins on the first day of the month in which the transfer was made.) The value of the transferred asset is the fair market value less any encumbrances, less any compensation received in the transfer, and less the \$4,000 exemption amount. In making a deprivation of resources determination, the DHHS only considers transfers that have occurred within the last 36 months, or, in the case of transfers to or from a trust or annuity, within the last 60 months. This 36 or 60 month period is called the **look back period**.

For example, assume that an elderly person as part of his estate plan transferred ownership of his farm to one of his children on September 1, 2004, that this same person later came to need nursing home care, and that after he had used up his savings in paying for the nursing home he applied for Medicaid on June 30, 2006. Assume that the farm had a net or equity value equal to \$500,000 at the time of the transfer, and that the private pay cost of the nursing home at the time of the transfer was \$3,500 a month. Medicaid would presume that the transfer of the farm was a deprivation of resources and that the \$500,000 value of the farm was available to pay for long-term care. They would therefore consider the applicant to be ineligible for Medicaid for approximately 143 months: \$500,000 divided by \$3,500.

Under the law, therefore, there is an effective 36 month (or, with trusts, 60 month) limit on the period of ineligibility that may be caused by a transfer of assets. It is critically important, therefore, that people who make large transfers not apply for Medicaid until after the 36 or 60 month period has passed. It also means that it is possible to look ahead, if circumstances permit, and make transfers well in advance of the need for Medicaid in such a way that the transfers will not affect eligibility.

So, if we assume that our farm owner is going into the nursing home and has an intention to transfer the farm to one of his children, the better course would have been to set aside 36 months worth of assets, or approximately \$126,000, to pay for his nursing home costs. He would then give away his remaining assets, and then, should he live more than 36 months, a Medicaid application could be made. In the meantime, he uses the assets set aside to pay for the nursing home care. If an application is made in the 37th month after the gifting, the gifting would not be

deemed a deprivation of resources. Clearly, timing in these circumstances can be critically important, as well as ensuring that the funds set aside to pay for long-term care are sufficient.¹

Installment Contracts

Assume the time for entering the nursing home is too close at hand to gift away the farm. It is a permissible means of increasing an applicant's income while reducing his other available resources to sell real estate for fair market value pursuant to an installment contract. In order for the sale under the contract not to be considered a deprivation of resources, the contract can last no longer than the life expectancy of the applicant and must provide for equal payments over the course of the contract's term. The price should be set at fair market value, which can be the assessed value. (Medicaid can, however, question assessed value.) The interest rate should be reasonable. Also, if we assume that there are two parents on the title as tenants in common and that only one parent is going into nursing home care, then each parent would receive only half of the land contract payment and the community spouse's half would not be included in the Medicaid budget.

(Question: Can the price for the land contract include the uncompensated work that an offspring has done on the farm or ranch over a course of years? This is a question of intent and no certain answer can be given. The regulation does mention "other valuable consideration" as a factor to be considered. It would be best to have as much documentation as possible about how the reduction in price was determined and how the compensation was calculated and factored into the price. These understandings should be incorporated into the sale agreement and in contemporaneous affidavits.) If the installment contract is entered into more than three years before the application for Medicaid, it would not be subject to a deprivation of resources analysis.

Life Estate Deeds

An owner of real estate can transfer a remainder interest in the real estate and retain a life estate. For practical purposes, retention of life estate means that the life tenant owns the property but only for the duration of his or her life. Any transfer of a remainder interest for less than fair market value would be subject to the 36-month look back period. Where possible, such a transfer should occur more than 36 months before applying for Medicaid. A transfer made within the 36-month period could result in a finding of a deprivation of resources and might extend the ineligibility period beyond 36 months, depending on the value of the remainder interest. The value of the remainder interest is determined by Medicaid actuarial tables. (The transfer of a remainder interest and retention of a life estate is considered by the IRS to be an incomplete gift and therefore entitles the remainder holder to a step-up in basis at the time of the life tenant's death.)

Assuming that the 36 month period has passed, the life estate is considered for its income to the applicant. The income must be contributed to the applicant's care if the applicant is the sole owner, or divided pro rata among a number of owners. Income is considered unearned income. Deductions from the gross amount are allowed for any condition of the life estate. In essence, the

¹ It may be worth noting that transfers to children in the farm context may reflect not only a gifting intention, but more likely the transfer reflects the fact that the son or daughter who receives the farm may in fact have been working on the farm for years, may have a family him or herself that depends on that farm for their livelihood, and may have committed those years of their life to the farm in the expectation that they would one day own and operate the farm on their own or with their own children.

life estate needs to generate a fair rental, less any costs. The life estate could be sold by the applicant for either a lump sum or under an installment contract, subject to the same life-expectancy and equal payment provisions of an installment contract.

Protecting the Home

It is not a deprivation of resource for an applicant to transfer title to his or her home to a) a spouse, b) a son or daughter who is 20 or younger, or who is blind or disabled, or who resided at the house for at least two years before his or her parent applied for assistance or entered a long-term care facility and provided care to the parent which permitted the parent to stay at home rather than be institutionalized, or c) a sibling who has an equity interest in the home and who was residing in the home for at least one year immediately before his or her sibling requested assistance or entered into a care facility. (In addition, a life estate deed arrangement, as previously discussed, might be used to protect a family home.)

Business and Trade Property

In general, property is excluded as a resource, and therefore not subject to the deprivation rules, regardless of value, if that property is used in a trade or business. In the farm and ranch context, this exclusion may be important. Under the right circumstances, an entire farming or ranching operation may be considered an excluded resource. But there are conditions.

This can happen only if the Medicaid applicant or the **responsible relative** is actively involved in the day-to-day operation of the trade or business as a primary means of earning a livelihood. A responsible relative can be a spouse or a parent, but not a son or daughter. It appears that a farm jointly owned by husband and wife is an excluded resource if the community spouse continues to work the farm. This rule on exclusion of trade or business property may be important for another reason: it makes it possible, as part of permitted transfers, to invest available resources in excluded resources, by, for example, purchasing land, buildings, livestock, farm machinery, tools, etc., that are used in the trade or business.

SPOUSAL IMPOVERISHMENT PROGRAM

As discussed, the spousal impoverishment program to some extent protects the community spouse's income and resources. As part of an application under the spousal impoverishment program, an assessment of resources is completed in which the couple lists their available resources. (This does not include excluded resources, such as the family home.) A designation of resources is then completed and the community spouse is entitled to retain in his or her name designated resources with a value up to \$92,760. (This figure changes annually.) The couple must then spend down the remaining resources until only \$4,000 in available resources remain, which the nursing home spouse is entitled to retain.

The community spouse keeps all of the excluded assets and the designated assets. The excluded and designated assets may be transferred into the community spouse's name alone; this is not considered a deprivation of assets. However, the community spouse cannot transfer the designated or excluded assets to a third party *for less than fair market value* while the other spouse is in the nursing home. Such a transfer would be considered a deprivation of assets.

The period during which the spouses reduce their assets is called the **spend down** period. The assets being reduced need not all be used for the nursing home spouse's benefit. The deprivation

of resources rule is applicable, but many expenditures are permitted. In addition to paying for nursing home costs during the spend-down period, a person might use available resources to purchase excluded assets such as prepaying funeral expenses for both spouses, upgrading personal property (so long as it remains at a reasonable value), or paying off an outstanding mortgage on the residence. A person might pay outstanding bills or replace the family car. A person could pay for improvements on the family home such as new roofing, siding, paint, or remodeling. A person could purchase a good recliner, bedspread, television, stereo, headset, season tickets, artwork, etc. for the nursing home spouse.

Annuities and Spousal Impoverishment

A person might purchase an annuity and annuitize it for the community spouse. Assume that the couple needs to spend down \$100,000 of available resources, after accounting for the \$92,760 for the community spouse and the \$4,000 exemption amount. They can purchase an annuity if it meets very specific criteria.

The annuity needs to be a single premium, immediate annuity (“SPIA”). (Simply put, this is a contract with an insurance company under which the consumer pays a sum of money to the company and the company sends the consumer a monthly check for the rest of his or her life.) The annuity must pay out in equal sums over a fixed period commensurate with the nursing home spouse’s life expectancy. If the term of the annuity extends beyond this life expectancy then it will be treated as a deprivation of assets. (Sometimes the life expectancy of the community spouse is used.) Also, the designated beneficiary of the annuity must be either the estate of the nursing home spouse or the community spouse. If the annuity has a cash value, it will be considered an available resource.

If the community spouse has a low monthly income, the annuity may be less useful, in that the income the community spouse receives from the annuity will only replace income that the community spouse would otherwise have been entitled to receive from the nursing home spouse. Annuities are of little benefit to single persons, in that the monthly annuity income must simply be paid to the nursing home. Annuities make most sense where \$92,760 is less than one-half of a couple’s assets.

Half A Loaf

A person might undertake the “half-a-loaf” strategy. After the couple has paid other expenses, they might gift away one-half of their remaining assets. The transfer, because it is subject to the deprivation rule, creates a period of ineligibility equal to the value of the transferred assets divided by the monthly cost of care. The person then uses the remaining half of their assets to pay for the nursing home care while the period of ineligibility expires. After the period of ineligibility expires, the person can then apply for Medicaid. (In practice, it is necessary to consider other things like the applicant’s income and the actual costs of the nursing home before deciding the best amount to transfer.)

TRUSTS

Third-party trusts v. self-settled trusts: deprivation of assets concerns arise where the *applicant’s* assets have been transferred into trust. The look-back period is then 60 months. However, if the applicant is the beneficiary of a trust that was established by a third party from that third-party’s

own assets (a third-party trust), the deprivation rules typically do not apply, so long as applicant has no absolute right to any distributions from the third-party settled trust.

Generally, it is self-settled trusts (trusts funded and established by the applicant) that raise the specter of a deprivation analysis. A revocable trust, one that is set up by the applicant and that may be changed by the applicant, is considered by Medicaid to be an available resource. Revocable trusts are of little or no use in Medicaid planning. An irrevocable trust may be a useful tool in Medicaid planning. Irrevocable trusts are generally set up to provide a person with income for life but to leave the principal untouched. Bearing in mind the 60-month look-back period, the principal of an irrevocable trust, which we assume cannot be paid to the Medicaid applicant, may be considered an excluded resource. The income, of course, would have to go to the nursing home.

Certain types of self-settled trusts are Medicaid-safe, such as a) a Special Needs Trust (“a trust containing the assets of a client age 64 or younger who is disabled and which is established for the sole benefit of the client by a parent, grandparent, legal guardian, the client, or a court”), or b) a Pooled Trust (a trust containing the assets of a disabled applicant that is established or managed by a non-profit association and meets other criteria.) However, details of funding and drafting of these trusts is beyond the scope of this discussion.

CONCLUSION

There is a tension between the desire to protect one’s savings and assets for the benefit of spouse and family and the need to impoverish oneself in order to qualify for Medicaid. Clearly, however, the rules and regulations that govern Medicaid allow for planning. In some respects the Medicaid rules reflect the fact that Medicaid, in addition to being a safety net for the poor, has become the default long term care insurance for the middle class. Planning for Medicaid can be complicated and almost invariably requires an analysis of individual circumstances. It can also be an important part of estate planning. This may be particularly true for farms and ranches, in which the principal assets traditionally constitute more than a single generation’s livelihood.

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