Medicaid and VA Benefits
Eligibility and Estate Recovery

Bret H. Davis, JD, CPA
Davis Law Firm, P.A.
1110 London Street, Suite 201
Myrtle Beach, SC 29577
(843) 839-9800
www.davislawfirm.us
bdavis@davislawfirm.us

September 29, 2011

I. The Issue - Need for Resources to Take Care of The Elderly Client.

There is a developing crisis in the United States regarding elderly people that will have to be addressed. Under the current trends, people are living longer than ever before, more medical opportunities are available to help people live longer, the cost for health care is more than ever before, the economic climate has caused the net worth of the elderly to sharply decline, the current government is taking measures to shift governmental support for heath care from the elderly to the younger generations, and the social security system is rapidly becoming insolvent. All these factors indicate that something will have to give when it comes to paying for the long-term care of the elderly. There are essentially four ways that health care for the elderly can be funded: 1) the elderly can self-insure and pay for the care out of their assets and income, 2) the children or other family of the elderly can provide or pay for the care, 3) long-term care insurance can pay for the care, or 4) the elderly can become eligible for and receive government benefits to pay for the care.

II. Can the Client Self-Insure?

Based on information obtained from Genworth Financial, the following table shows the annual cost of care for different types of services for the year 2011.

Type of Care	National Average	South Carolina
Nursing Home (Private Room)	$77,745	$67,525
Nursing Home (Semi-Private Room)	$70,445	$63,875
Home Health Aide Services (Licensed)	$43,472	$38,896
Homemaker Services (Licensed)	$41,184	$37,752
Assisted Living Facility	$39,135	$36,840
Adult Day Health Care	$15,600	$12,805

Determining the amount of money that the folks may need is not an easy task. While industry information indicates that the average stay in a nursing home is somewhere around 3 years, it would be difficult to establish an average time frame during which a person may have to pay for some type of services related to an infirmity brought on by old age. People often require services long before having to go into a nursing facility, and many people do whatever they can to avoid a nursing home because of a preconceived opinion about the quality of care and quality of life that a person would experience in a nursing facility. Therefore, using an estimate of 3 years for the time period in which care is needed and/or obtained would not be conclusive.

Elderly clients like to use the phrase "I do not want to be a be a burden on my children." To accomplish this objective the elderly person would have to make sure that they have enough resources to take them beyond the averages and closer to a time period that represents a worst case possibility for the need for care. An obvious planning conclusion is that it is better to have too much resources available for the elderly clients than not enough. When planning for the cost of care for the clients, an assumption that should take care of any worst case potential needs of the elderly clients is that having resources to fund 10 years of care should be enough. This assumption then directs us to the amount of money needed to achieve the desired care for the 10 year period.

Depending on the services provided and the skill level of the providers, in home care (or what could be referred to as "pamper care") could cost a great deal more than a nursing home facility would cost. A figure of $1,200,000 has been used by practitioners as a benchmark to determine whether a husband and wife should engage in Medicaid planning. This number is reached by assuming the worst case scenario of continuous care for both husband and wife for 10 years. This means that if the clients have assets worth $1,200,000, then they should be able to self-insure against any long-term care needs.

III. Can the Family Take Care of The Client?

Taking care of family members is costly in more than one way. The obvious cost concerns the money required to pay for the care needed. The more subtle and less identifiable cost of taking care of a family member is the emotional and familial strain which results from caring for a family member. Additionally, given the strain caused to the person providing the care, the quality of the care that they provide would logically be reduced. Moreover, family members are normally not qualified to give the kind of skilled care necessary to adequately take care of the elderly person.

Therefore, while it does work on occasion and should not be completely discounted as an option, having a family member care for a disabled elderly person is not the best option.

IV. Long-Term Care Insurance.

When an elderly person is shown the benefits of long-term care insurance, the immediate conclusion is normally very positive. However, when the monthly or annual cost of the insurance is disclosed, the person quickly reevaluates. It is the age old problem: long-term care insurance is great but the cost makes it impractical. Also, the fact that if the insurance is not used it is lost makes it less attractive. The important component of acquiring long-term care insurance is the age at which

it is purchased. With regard to the cost issue, the younger and healthier a person is when they purchase the coverage, the less expensive the coverage will be.

A few insurance companies have heard the cry of the people with regard to long-term care insurance and have fashioned a few products that appear to address their concerns. There are now long-term care insurance products on the market that are similar to annuities. The person purchasing the coverage puts down a large lump sum of money (typically, somewhere around $100,000 to $300,000) and purchases the product. The benefits of the product include long-term care insurance, possibly some life insurance benefit, and the benefit of an annuity in that if the long-term care insurance feature is not used, the lump sum amount may be returned to the family after the insured's death. This type of product addresses the issue of losing the premiums if the coverage is not used. It also makes the coverage more economical because the insurance company receives the cash up front to invest, which offsets the costs of the coverage. This type of product is not suitable for all clients because some clients either a) cannot use the cash they have to purchase the insurance because they need access to it or b) their cash is tied up in some sort of a retirement plan and to access that cash would cause an immediate income tax burden.

V. Government Benefits.

Three main types of government benefits are available for long term care costs, which are Medicare, Medicaid, and Veterans Administration (VA) benefits. Medicare is a benefit that people are entitled to through their participation in the government's forced retirement and insurance programs. Medicaid for long-term care is a needs-based benefit that is available if the applicant can demonstrate that he or she is essentially without any other personal resources to pay for their care. VA benefits are similar to Medicaid benefits in that they are needs-based; however, VA benefits are

designed to help those that have served in the military during a time of war (the actual dates of the various wars are set forth in more detail below).

A. Medicare Benefits for Long-Term Care.

While Medicare provides some long-term care benefits, it has its limitations. Medicare covers only nursing home stays of up to 100 days, and only if skilled nursing, such as administering intravenous drugs, is required. Additionally, a patient must spend at least 3 days in a hospital before entering the nursing home to qualify. Even then, only the first 20 days are fully covered; a daily co-payment of $141.50 (in 2011) is charged for days 21 through 100 for skilled nursing care.

B. Medicaid Benefits for Long-Term Care.

There are two times in which a person becomes interested in qualifying for Medicaid. The person can do what practitioners call pre-planning or, if the person needs benefits immediately, they can do what practitioners call crisis planning. With either type of planning, there are two aspects to consider; the first is whether the person will qualify for the benefits, and the second is which assets would be subject to estate recovery. With eligibility there are two parts to consider; the first is the applicant's income, as well as the spouse's income, if any, and second is the amount of assets or resources owned by the applicant. The long-term care benefits available include funds for a nursing home or funds for a skilled person to come into the applicant's home to provide services.

1. Eligibility for Medicaid Benefits for Long-Term Care.

As mentioned above, Medicaid eligibility has a two part test. The first is whether the applicant's income is below the required threshold or limit and the second is whether the applicant's assets or resources are below the required threshold or limit.

(i) Income Limit. For income purposes, South Carolina is called an income cap state because it caps the amount of income an applicant can receive without considering the income in light of the applicant's medical costs. The monthly income threshold (or cap) for Medicaid eligibility is $2,022.[1] This income amount includes all income that the applicant receives, which is normally social security and some type of pension. Some clients also receive monthly income from other sources that would have to be included in the calculation, such as rental property income, dividend income, or income from a family business venture. Monthly gifts of support from family or friends (whether given directly to the client or paid to a provider for the client's benefit) are generally not considered income received by the client for eligibility purposes.

Normally, all of the applicant's income would have to be surrendered to the nursing home when the applicant starts receiving benefits. However, if the applicant's spouse[2] needs to retain the applicant's income, there is something that can be done. If the applicant's spouse's income is below $2,739 per month, then the applicant's income can be allocated to their spouse up to the amount of $2,739. For example, assume that the applicant's spouse receives $1,000 in income on their own each month. Also assume that the applicant receives $1,500 per month in

[1] Medicaid is a federal program that is administered by each individual state. The funding for the program is provided jointly between the federal government and the respective state. Through its administration of the program, the South Carolina Department of Health and Human Services (SCDHHS) has promulgated the South Carolina Medicaid Policies and Procedures Manual, which can be found on the internet at https://medsweb.scdhhs.gov/mppm/mppmtoc.htm. It is also important to note that the Medicaid laws are influenced by the laws relating to eligibility for certain Social Security programs. The manual for Social Security programs is the Programs Operations Manual System (POMS).

[2] The applicant's spouse is commonly referred to as the "community spouse" and sometimes as the "healthy spouse." The applicant (or the person who needs care and Medicaid benefits) is also referred to as the "institutional spouse."

income. In this example, a maximum of $1,739 ($2,739 - $1,000) can be allocated to the applicant's spouse. Since the applicant is receiving only $1,500 per month in income, all of the applicant's income can be retained by the applicant's spouse.

If, after all considerations, the applicant's income is still too high, there is one final thing that can be done. Because South Carolina is an income cap state, based on relief provided by our beloved Congress, an applicant can use an income trust to funnel all of his or her income to the Medicaid office[3] and still qualify for benefits. Of course, this means that all of the applicant's income would be surrendered in exchange for Medicaid qualification. The practitioner should make a thorough analysis to determine if it is in the applicant's best interest to forfeit all of his or her income for the benefits that would be obtained.

(ii) Asset or Resource Limit. The asset and resource threshold or limit is $2,000 for the applicant. If the applicant is married and their spouse is not also applying for Medicaid, the spouse can have up to $66,480 in assets and/or resources. This means that if a practitioner is working with a couple and one needs Medicaid, the couple can have up to $68,480 ($2,000 + $66,480) in assets or resources.

(iii) Exempt Assets. Certain assets may be retained by the applicant or the applicant's spouse and not be included in the countable assets for eligibility purposes. The primary asset that is exempt is the residence, up to $500,000 in equity value when there is no community spouse, and with no limit when the community spouse resides in the residence. The only tricky part

[3] The term "Medicaid office" is used loosely. The technical name for the office is the South Carolina Department of Health and Human Services (SCDHHS). There are several local offices or branches of the SCDHHS. The term Medicaid office is intended to refer to the local office or branch of the SCDHHS.

with the residence, for eligibility purposes, is that if the applicant is not married they will have to demonstrate that they have an intent to return to the residence after their stay in the nursing home. Conceptually, this seems like a very difficult matter to accomplish because when a person goes into a nursing home they are normally not able to return to their residence to live. However, in practice, the Medicaid office makes it easy to establish that the applicant intends to return to the residence by simply having them or their agent sign a form that says that the applicant intends to return to the residence. The applicant's primary vehicle of, any value, can also be excluded from the calculation for eligibility, along with pre-paid burial or funeral services up to $7,500, and paid up life insurance for insurance with a death benefit that does not exceed $10,000.

2. Estate Recovery for Medicaid Benefits.

The South Carolina Department of Health and Human Services can recover an amount of money from the estate of a deceased Medicaid recipient that is equal to the benefits that were provided.[4] The claim would be against the probate estate of the deceased Medicaid recipient; assets passing outside of probate generally would not be subject to the SCDHHS' claim.[5] However, SCDHHS may be precluded from enforcing an estate claim if the deceased Medicaid recipient is survived by a spouse or a child who is: a) under the age of 21, b) blind, or c) disabled.[6] There is also a hardship provision that may provide relief to the estate beneficiaries of a deceased Medicaid

---

[4] See 42 U.S.C. § 1396p(b). Also see generally Moore and Landsman, 816 T.M., *Planning for Disability*.

[5] However, see S.C. Code Ann. § 62-6-107 for specific instances when certain assets that pass outside of probate may be reached by creditors.

[6] 42 U.S.C. § 1396p(b)(2).

recipient.[7] Additionally, as discussed in more detail below, when an irrevocable trust is established as part of a pre-planning case, the assets would not be part of the probate estate and not subject to estate recovery.

3. Planning Considerations for Medicaid Benefits.

Traditionally, to obtain Medicaid for long-term care, the applicant would spend down all of their assets and then when they were essentially completely out of resources, they would apply for Medicaid benefits. The current laws regarding Medicaid allow a person to achieve eligibility through advance planning. Whether the case involves crisis planning or pre-planning, the practitioner can normally help the client preserve their assets and/or achieve eligibility more efficiently than the client could do on its own.

(i) Crisis Planning Case. When a person needs benefits immediately, there are two main ways to preserve the clients assets and help them qualify for Medicaid:

a) Care Agreement. When a family member or friend is taking care of the person in need of Medicaid benefits, the person providing the care may enter into a binding agreement with the person needing the care, so that the person providing the care would receive compensation for providing such care. The payment from the person needing the care would be considered a compensated transfer (as opposed to an uncompensated transfer that would be viewed as a gift for eligibility purposes) as long as the agreement was actuarially sound based on the person's age and the amount paid for the services was reasonable in the industry for the level of care provided. The payment for the services could be made in one lump sum amount or paid in

[7] 42. U.S.C. § 1396p(b)(3).

installments. It is important to note that any payment to the person providing the benefits would be taxable to that person as ordinary income.

b) Medicaid Complaint Annuity. If the person needing care is still married and their spouse is healthy and able to participate in the planning, there is another technique that has shown to be very useful. If, after the eligibility calculation, the couple has too much in assets or resources, and such assets are in the form of cash, the healthy spouse can purchase an annuity that pays the healthy spouse an amount each month equal to or less than the amount of their spousal allowance that has not been used. As mentioned above, the healthy spouse is allowed to receive income of up to $2,739 per month. If their income is below that amount, then they can purchase an annuity that meets the Medicaid requirements (which includes, without limitation, that SCDHHS be named as a beneficiary), and receive an annuity benefit each month equal to an amount that does not exceed the healthy's spouse's remaining resource allowance. For example, using the information from the example above, the healthy spouse receives $1,000 per month, so their remaining allowance would be $1,739 ($2,739 - $1,000 = $1,739). The remaining allowance of $1,739 is used as the divisor to determine the minimum number of months that the annuity can repay the healthy spouse. If the couple is over their resource limit by $50,000, then the payout period of the annuity would be 28.75 months (50,000 / $1,739). This means that the healthy spouse can buy an annuity and receive payments of $1,739 per month for 28.75 months and have their spouse qualify for Medicaid benefits for long-term care.

(ii) Pre-Planning Case. Generally, the best way for a practitioner to assist the client plan in advance for Medicaid eligibility for long-term care is to put the client in an income only or no income and no principal irrevocable trust. The income only trust provides that the client

would have access to all of the income of the trust but could not reach any of the trust's principal. The assets transferred to the trust would be removed from client's estate for Medicaid eligibility purposes after the expiration of the sixty (60) month look back period.[8] The trust's principal could be transferred to the trust beneficiaries and those beneficiaries could chose to use the assets for the client. The important thing to remember in this case is not to counsel the client to set up what some practitioners call the "wink wink, nod nod deal" where the client and the client's children (who are most often the trust beneficiaries) start a circular chain of events that shows money going from the trust to the children and then back to the parents in some sort of pre-arranged agreement.

C. Veterans Administration (VA) Benefits for Long-Term Care.

There are three (3) levels of benefits that a veteran or the veteran's spouse can obtain from the federal government.[9] The first level is the basic level and it is based on the claimant's income and assets only and not any medical need. This benefit is difficult to obtain because it requires that income be reduced below the maximum pension amount. The second level is the housebound level and it is based on whether the claimant has the ability to take care of himself or herself in their own home. The third and most often used level is aid and attendance and it is a needs based assistance based on whether the claimant cannot perform at least two of the basic activities of daily living (ADL). The basic activities of daily living are toileting, bathing, eating, dressing, walking, taking medications, and transferring in and out of bed. The amounts of VA benefits for 2011 that may be obtained are as follows:

---

[8] See § 304.09 of the South Carolina Department of Health and Human Services Medicaid Policy and Procedures Manual.

[9] The majority of the information on VA benefits comes from the publication by Gilbert B. Fleming, Esquire and James Swain, Esquire, entitled VA Improved Pension for War Period Veterans *How the VA Helps Veterans Pay for Their Assisted Living*.

Person Claiming VA Benefits	Basic	Housebound	Aid and Attendance
Married Veteran	$1,291	$1,510	$1,949
Single Veteran	$ 985	$1,204	$1,644
Widow	$ 661	$ 808	$1,056

1. Eligibility for VA Benefits for Long-Term Care.

Eligibility for VA benefits involves a few different items than those discussed above for Medicaid benefits.

(i) War Time Dates. The first criteria for eligibility for VA benefits is whether the claimant served in the military during a time of war. It is not required that the claimant actually participated in the war, just that they were in the military for at least ninety (90) days and at least one of those days was during a time of war. However, service after September 7, 1980, requires a minimum of twenty-four (24) months of service. The dates for the various wars are as follows:

War	Starting Date	Ending Date
World War I	April 6, 1917	November 11, 1918
World War II	December 7, 1941	December 31, 1946
Korea	June 25, 1950	January 31, 1955
Vietnam	February 28, 1961	May 7, 1975
Persian Gulf Wars	August 2, 1990	TBD

(ii) Income Limit. The general rule with regard to the income limit is that the claimant's unreimbursed medical expenses must exceed the claimant's income by five (5%) to

receive the maximum benefit. A breakdown of the items that the VA asks for are included in the application documents for VA benefits that can be found on the VA website, which is located at http://www.va.gov [10]

(iii) Asset or Resource Limit. While there is no statutory limit as to the amount of assets that a claimant can have and still qualify for VA benefits, there is an amount that the VA and practitioners seem to have settled on as an amount that complies with the somewhat ambiguous resource provisions pertaining to VA benefits. The amount of resources that is most commonly used is $80,000 in assets.[11]

2. Estate Recovery.

Since VA benefits are claimed by the veteran or the veteran's spouse, they are viewed as an entitlement, and as an entitlement, the benefits are not subject to any estate recovery.

3. Planning Considerations for VA Benefits.

Unlike Medicaid, there is no look back period for transfers to family or friends for VA benefits. Therefore, a crisis planning case and a pre-planning case for VA benefits are treated similarly. The most popular among practitioners is to put the client in an irrevocable no income and no principal trust, assist the client with transferring their assets into the trust, and then the following month, have the client make application for VA benefits.

---

[10] It is important to note that the VA has taken the position that it does not want attorneys to assist their clients for a fee with the completion of the application for benefits. There is a registration process that practitioners can go through to get registered so that they can assist folks with their VA related matters, but the attorney cannot charge a fee for helping the client complete the application for VA benefits. There is no prohibition against the attorney charging a VA claimant a fee for assisting them with their Medicaid application or for other estate planning matters.

[11] In 38 C.F.R. 3.275, the Code of Federal Regulations provides language that is used to determine the asset limit.

VI. Conclusion.

As the population continues to get older and medical advancements continue, it is imperative that estate planning practitioners give the matter of long-term care its due attention. There are several options available for the client and all of them should be evaluated carefully. Many clients need government benefits that they may not even know exist. Practitioners should make an effort to either learn about the various benefits available or find another professional that has particular experience in this area.