PLANNING FOR LONG TERM CARE IN OREGON

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Few individuals or couples have enough income to pay for the high monthly cost of nursing home care ($3500-7500). If no planning is done, the couple will often exhaust their savings (resources) before applying for Medicaid.

By utilizing the state and federal laws governing eligibility for Medicaid, much can be done toward preserving the estate and/or preventing impoverishment of the spouse remaining in the community.

A. LONG-TERM CARE OPTIONS AND COSTS

Long-term care needs can range from around the clock medical treatment to simply requiring assistance with the daily activities of life. In the past, a nursing facility was the only option for care outside the home. Today, Oregon leads the nation in providing alternatives to the traditional nursing home-type care.

1. Nursing Home Care. Nursing homes, licensed by the State, provide several different levels of nursing care to residents. These range from intensive nursing and rehabilitative care for people with unstable medical conditions to routine care for people with chronic medical problems. Current estimated costs range from **$3500** to **$7500** per month, depending on the level of care needed.

2. Adult Foster Care. An adult foster home provides care to five or fewer residents. The operator or resident manager lives in the home. Personal care, cooking and cleaning are provided. Other types of care depend upon the qualifications and license of the provider. Estimated costs range from **$2500** to **$3500**.

3. Residential Care. Residential care facilities serve six or more residents and have staff on duty around the clock. Meals and housekeeping services are provided, but the amount of personal care and supervision varies.

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"Assisted Living" is a particular type of residential care, with its own administrative rules. The focus is on providing care through a social model that emphasizes independence.
Estimated costs for residential care range from **$1500** to **$5500.**

4. In-home Services. A range of services can be provided at home, from a short visit to meet a particular need for assistance, to live-in help. In-home services, generally, are not licensed by the state, although some providers carry their own license. Estimated costs vary according to the hours of service and the type of provider used.

B. WHO PAYS FOR LONG-TERM CARE EXPENSES?

1. Health Insurance and Medicare. Health insurance, including Medicare, is primarily focused upon the payment of hospital and physician care for illness or accidents. Few health insurance carriers cover long-term care expenses. If they do, it is usually only for **skilled** care (the services of a doctor or nurse available 24 hours a day). Even if the insurance covers long-term care, it is often limited to a certain number of days (often only 100 days or less).

2. Long-term Care Insurance. This is an insurance policy that helps to pay for the care of chronic conditions. This insurance may cover the cost of services for nursing, diagnostic, preventive, therapeutic, and rehabilitative care. Policies are offered on an individual or a group basis. Policies sold in Oregon must include coverage for alternatives to nursing home care. Like all insurance, many long-term care policies contain limitations or exclusions. It is important to seek advise from a specialist in long term care insurance and to shop carefully.

3. Private Pay. Currently, just under half of the cost of long-term care in Oregon is paid from personal or family funds. The funds of both spouses are considered **available** to pay for care. The assets of adult children are not available assets unless they have signed as a guarantor for the nursing home expenses.

4. Medicaid. The Medicaid program is the largest source of payment for long-term care in Oregon. Medicaid is a joint Federal and State program. Medicaid covers the full range of long-term care services, including skilled, intermediate and custodial care, adult foster home and in-home services.

C. MEDICAID IN OREGON

The Medicaid program is the largest source of payment for long-term care in Oregon. Medicaid is a joint Federal and State program. Medicaid covers the full range of long-term care services, including skilled, intermediate and custodial care, adult foster home, and in-home services.

Medicaid eligibility is based upon a "service" (or health-related) need and upon a financial need. To be eligible for Medicaid, the applicant must meet three (3) criteria for eligibility: (a) a health need; (b) an income need; and (c) an asset or resource need. Generally, individuals with severe health issues, whose monthly incomes are at or below $2,022 (since January, 2009) and whose assets are below 9,000 for an individual and $21,912 (since January, 2009) for a couple will be eligible. Couples with assets above $21,912 may be required to split their assets and spend down before eligibility.

1. Service or Health Need of Medicaid. Medicaid benefits are available only to those persons who have severe health or disability needs and require assistance. These are referred to by Medicaid as "service needs."

Medicaid evaluates applicants on a scale of 1-18 to determine their service need. (This has also been referred to as their "survivability" need. In other words, the applicant's ability to "survive" without assistance.)

Level 1 is the highest level. A Level 1 patient needs full assistance with all of his or her "activities of daily living" (ADLs). ADLs include mobility, eating, elimination, cognition, dressing, and bathing.

Level 18 is the lowest level on the scale. Level 18 patients are independent and need little or no assistance, although they do require a structured environment. Level 17 patients need assistance with dressing and bathing.

Medicaid is currently allowing eligibility for **Level 1-13 applicants only**. Applicants in service levels 14-18 may not receive assistance. No new applications for levels 14-18 are currently being accepted.

The Medicaid intake workers are trained to evaluate the level of assistance an applicant requires in various activities of daily living. This consists of the worker visiting the applicant and asking a number of very personal questions. It is critical that the applicant answer honestly, even if it is embarrassing. Eligibility for benefits may depend on the applicant's answers.

The service levels are briefly defined as set forth in items 1-18 below. For a full description, see Oregon Administrative Rules at: http://arcweb.sos.state.or.us/rules/OARS_400/OAR_411/411_015.html:

(1) Requires full assistance in mobility, eating, elimination, and cognition.
(2) Requires full assistance in mobility, eating, and cognition.
(3) Requires full assistance in mobility, or cognition, or eating.
(4) Requires full assistance in elimination.
(5) Requires substantial assistance with mobility, assistance with elimination, and assistance with eating.
(6) Requires substantial assistance with mobility and assistance with eating.
(7) Requires substantial assistance with mobility and assistance with elimination.
(8) Requires minimal assistance with mobility and assistance with eating and elimination.
(9) Requires assistance with eating and elimination.
(10) Requires substantial assistance with mobility.
(11) Requires minimal assistance with mobility and assistance with elimination.
(12) Requires minimal assistance with mobility and assistance with eating.
(13) Requires assistance with elimination.

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(14) Requires assistance with eating.
(15) Requires minimal assistance with mobility.
(16) Requires full assistance in bathing or dressing.
(17) Requires assistance in bathing or dressing.
(18) Independent in the above levels but requires structured living for supervision for complex medical problems or a complex medication regimen.

Applicants who believe they are in the wrong service level need to request hearings immediately and request that they receive aid pending their hearing.

Planning Note: It is crucial that clients maintain the most flexibility possible in their planning documents and also their financial investments. It is virtually impossible at this time to plan for long-term care with certainty. It does appear that the most impaired and vulnerable will still be able to access services. However, those individuals who need a great deal of care and have not met the service level will be refused services. An individual may return home, worsen, and reapply - at which time the individual's declined health will qualify him or her for services.

2. Income Need for Medicaid.

a. **Eligibility Level:** In 1991 (as a result of Ballot Measure 5 cutbacks), Oregon changed Medicaid eligibility rules to require that an applicant's monthly income be less than 300% of the SSI income standard, currently $2,022. Prior to July, 1991, Oregon's "Medically Needy" program covered nursing home residents

whose incomes were over this limit but were not enough to pay for their nursing home expenses. Now, a Medicaid applicant whose monthly income is more than $2,022 cannot qualify for Medicaid assistance for long-term care, no matter how much the care costs are.

Income consists of such fixed items as Social Security, pensions, certain VA benefits, workers compensation, fixed annuities, and real property contracts. Only the income of the institutionalized spouse is considered. The community spouse's income will not be counted when determining income eligibility.

b. **Income Cap Trust** : A special trust, known in Oregon as an "Income Cap Trust," is available to assist those individuals over the Medicaid Income Level to obtain Medicaid eligibility. The Income Cap Trust was created through a joint effort between elder law attorneys and the State. Be sure to contact Fitzwater Meyer, LLP, for help from an experienced elder law attorney if you are over the Medicaid income level.

3. **Resources.** An individual can have up to $2,000 in cash or other non-exempt resources. An additional $1,500 can be set aside in an interest-accumulating savings account dedicated as a "burial fund."

Jointly held liquid assets, such as joint bank accounts, are considered available to the Medicaid applicant. However, the State cannot force a co-owner to sell a jointly held parcel of real property.

A life estate interest in real property is an available asset. Value will be established by considering the fair market value for the property and life expectancy of the Medicaid applicant.

The value of a resource is determined by its "equity value." Equity value is the fair market value of the resource minus encumbrances. "Fair market value" is defined as "the amount a resource can be expected to sell for on the open market." The State uses the county tax appraised value for real property and the blue book for automobiles. These values can be successfully disputed by presenting evidence of actual fair market value (i.e. real estate appraisal).

4. **Exempt Resources.** Certain resources are exempt and not counted in determining eligibility for Medicaid benefits. These include the person's home (see below), one motor vehicle, household items, personal effects, medical equipment, "hardgoods" for burial (including burial space, casket, liner, headstone), and a funeral or burial fund up to $1,500.

As of January, 2006, Medicaid will no longer consider a home with an "equity value" in excess of $500,000 to be an exempt asset. If you need to apply for Medicaid and your home has equity at or near $500,000, contact Fitzwater Meyer, LLP, for assistance with this rule.

5. Penalty for Transfer of Resources. The Medicaid recipient may desire to give away or transfer property or other assets to a (non-spouse) family member, friend, or charity as part of his or her estate planning goals. Unfortunately, a very complex set of rules governs a future Medicaid applicant's ability to transfer property. Simply put, a transfer of resources may make the Medicaid recipient or his or her spouse **ineligible** for Medicaid benefits for a period of time.

a. **Period of Ineligibility:** The disposal of a resource for less than fair market value, by the applicant or applicant's spouse, will result in a period of time in which **both** applicant and applicant's spouse are ineligible for Medicaid benefits. This period equals the time during which the uncompensated value of the transferred asset could have been used to pay for care at the average private pay rate in the State of Oregon, currently $6,494 per month.

   FOR EXAMPLE: A transfer of assets worth $64,940 would result in 10 months of ineligibility. In other words, that $64,940 could have been used to pay for care in a nursing facility for 10 months.

   The State is allowed to ask a Medicaid applicant about any transfer of assets made during a **60-month period** before applying for Medicaid (called the "look back period").

   Beginning July, 2006, Medicaid rules regarding transfers have added a requirement that the period of ineligibility for a transferred asset can **begin** (a) on the date the asset was transferred or (b) on the date the person applies for Medicaid and is otherwise eligible, **whichever date occurs later.** Using the example above with a 10-month period of ineligibility, the Medicaid applicant may be ineligible as long as 10 months from the date the person actually applied for Medicaid. **This is a substantial change from old Medicaid law.** Be sure to contact an attorney at Fitzwater Meyer, LLP, before making transfers that could adversely affect your eligibility or a family member's eligibility for Medicaid.

b. **Exempt Transfers:** Certain transfers are exempt from the above rules and will not result in a period of Medicaid ineligibility. These include transfers to a spouse, transfers to a blind or disabled child, and transfer of the primary residence to a care giving son or daughter, or a sibling with an equity interest (certain conditions must exist).

6. Protecting the Spouse who Remains at Home.

a. **Spousal Impoverishment Rules.** The Medicare Catastrophic Coverage Act of 1988 ("MCCA") significantly changed previous Medicaid laws, providing greater protection to the income and resources available for the maintenance of the spouse who remains at home ("community spouse"). Prior to MCCA, a spouse's eligibility for Medicaid often resulted in the **impoverishment** of the community spouse.

b. **Treatment of Resources.** The non-exempt assets ("available resources") of both spouses are pooled together, regardless of how title is held. The equity value of pooled resources are "deemed" available to the institutionalized spouse subject to the spousal impoverishment rules discussed below.

The community spouse is allowed to keep the exempt assets and some of the non-exempt assets. The amount of non-exempt assets which the community spouse is permitted to keep is subject to a limit referred to as the "community spouse resource allowance" or "CSRA."

The community spouse may retain one-half of the couple's combined assets. The value of the assets is determined at the beginning of the "Continuous Period of Care." The amount allowed to the community spouse is subject to a minimum of $21,912 and a maximum of $109,560 (since January, 2009).

Once the community spouse's resource allowance has been calculated, the excess resources must be **spent down** before the institutionalized spouse can be eligible for Medicaid benefits.

IMPORTANT NOTE: Much is currently being done by elder law attorneys to allow the community spouse to keep more than one-half of the couple's assets. The process known as a "Revision of the Community Spouse Resource Allowance" should be evaluated in every case, before the spouse begins spending down the assets.

Once the institutionalized spouse has been determined eligible for Medicaid benefits, there is no need for future assessment of the community spouse's resources. The community spouse may accumulate additional resources without affecting eligibility.

c. **Treatment of Income.** The institutionalized spouse's monthly income (with two small deductions) determines the maximum that he or she can be required to contribute to the cost of care. Therefore, the community spouse's monthly income, regardless of the amount, will not increase the amount the couple will pay to the nursing home.

Conversely, if the community spouse's monthly income is low enough, it will reduce the amount the couple pays to the nursing home. In other words, the community spouse has no duty to contribute his or her monthly income, but has a statutorily defined right of support.

The Medicare Catastrophic Act of 1988 allows the community spouse to receive a significantly larger share of the institutionalized spouse's income than previously allowed. The community spouse is entitled to an amount sufficient to raise his or her monthly income to $1,750. (since April 2008). In determining the allowance, all of the community spouse's monthly income, from all sources, will be

considered. If all available income is less than the allowance, the institutionalized spouse's income will be used to make up the difference. (In addition, the community spouse is entitled to an additional allowance for his or her shelter expenses.)

IMPORTANT NOTE: Elder law attorneys are currently using court orders to increase the income allowance of the community spouse, above Medicaid levels. Again, any spouse in this situation should contact Fitzwater Meyer, LLP, to have an experienced elder law attorney review his or her income and assets.

7. Estate Recovery – Recovery by State of Oregon. The State of Oregon may have a claim against the (expanded) estate of a deceased Medicaid recipient. The claim cannot be collected until the death of the surviving spouse. The claim is limited to those assets transferred to the surviving spouse upon the death of the Medicaid recipient.

a. Law Governing Estate Recovery. OBRA '93 requires each State to establish estate recovery programs. 42 USC 1396p. Federal law defines "estate" to include all real and personal property and other assets included within the individual's estate as determined under State probate law. It also allows the States to expand the definition of estate recovery to non-probate assets. (The State of Oregon has had an aggressive estate recovery program in place for many years.) The estate recovery is for nursing facility services, home and community-based services, and related hospital and prescription drug services provided to individuals age 55 or older. If there is a surviving spouse, the estate claim is not collected at the death of the first spouse. If there is a minor or disabled child, the estate claim is not collected. There is a possibility that the State's ability to recover may soon expand to include the costs of institutionalized care received prior to the recipient reaching age 55.

b. Hardship Provisions. OBRA '93 requires the States to incorporate hardship provisions in their estate recovery programs. Transmittal #63 issued by the Health Care Financing Administration (HCFA) [now the Center for Medicare & Medicaid Services] in September, 1994, provides for "special consideration of cases in which the estate subject to recovery is (1) the sole income producing asset of survivors (where such income is limited), such as a family farm or other family business; (2) a homestead of modest value; (3) other compelling circumstances."

c. Expanded Estate Recovery Rules. In 1995, Oregon expanded the laws governing estate recovery. The new law expands estate recovery to allow recovery against any real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including but not limited to property passing by joint tenancy, survivorship, Revocable Living Trust, or other arrangement. The State of Oregon takes the position that the claim survives and can be made against the estate of the surviving spouse if it can be traced back to the estate of the recipient at the time of

the recipient's death. Therefore, if a recipient wishes to avoid a State claim, he/she should consider transferring assets, such as the home, to the name of the surviving spouse.

8. Planning Strategies. Careful planning can go a long way toward preserving the couple's resources and preventing the impoverishment of the community spouse.

a. Spend Down. Often referred to as "split and spend down," this planning approach combines the Community Spouse Resource Allowance (discussed above) with spend down strategies to both prevent the impoverishment of the community spouse and expedite Medicaid eligibility for the institutionalized spouse.

The Resource Assessment is the beginning of the planning process. This "snapshot" of the couple's combined resources determines the amount the community spouse may have while the institutionalized spouse qualifies for benefits. Generally, the community spouse is best off with the highest possible allowance.

b. Exempt Resources. Spend down often begins by purchasing or **maximizing** exempt resources. Some examples are:

(i) Purchasing a residence;
(ii) Repairing the existing residence;
(iii) Purchasing car (with long-term warranty);
(iv) Purchasing personal property (appliances, clothing, home entertainment);
(v) Purchasing medical equipment;
(vi) Purchasing burial goods and merchandise; and
(vii) Travel expenses.

c. Converting Resources Into Income. Monthly income in the sole name of the community spouse is not considered available to the institutionalized spouse. Therefore, the community spouse may convert a non-exempt resource into an income source (i.e. real estate contract or loan) or he or she may use non-exempt assets to purchase an irrevocable income source (i.e. single premium, immediate annuity).

Beginning July, 2006, all annuities must be irrevocable, non-assignable, and must contain a provision making the State of Oregon the first remainder beneficiary of the annuity up to the full amount of medical assistance provided. Therefore, it is highly recommended that you or your family member contact an attorney from Fitzwater Meyer, LLP, before purchasing an annuity and applying for Medicaid.

d. Transfers by Gift. The gifting of assets should be considered a dramatic form of planning. While it may preserve assets, it also can be a significant risk.

Gifts can be made to a community spouse with no period of ineligibility for Medicaid. Gifts to individuals other than a spouse will trigger the period of ineligibility discussed above. Again, there is a 60-month look back period.

IMPORTANT NOTE: Remember, gifts are irrevocable. If your client is relying upon the recipient to return the funds (or portion thereof) if needed, consider what would happen if the recipient were to die, divorce, or become indebted.

e. **Transfers to Trust.** In the past, transferring assets to a specialized form of trust could protect some of the assets. However, Congress changed the rules governing trusts when it passed OBRA 1993, effective August, 1993. These new rules have substantially restricted the use of trusts for long-term care planning purposes.

IMPORTANT NOTE: **Special Needs Trusts.** The trust rules changed by OBRA '93 are trusts funded with assets **owned or previously owned** by the Medicaid applicant or spouse. The rules governing trusts that are funded by assets owned by third parties, with no legal duty of support (i.e. parents of adult children, children, grandparents) were not changed. Therefore, the commonly used "Special Needs Trust" established by a parent for the benefit of an adult disabled child is still an available and effective estate planning tool.

f. **Staying Off Medicaid.** Finally, the best plan may be to not apply for Medicaid benefits. Some disadvantages to receiving Medicaid benefits include (a) discrimination against Medicaid patients; (b) some facilities do not accept Medicaid; and (c) the impacts of estate recovery upon the death of the surviving spouse. Long-term care insurance may be the best way to prevent the need for Medicaid in the future.

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