

10 ESTATE PLANNING TIPS FOR CLIENTS WITHOUT ENOUGH NURSING HOME INSURANCE

1. The new/old non-qualified annuity rules for annuities purchased or used on or after November 1, 2009. FSSA issued a notice, excerpt shown below, explaining the specific requirements.

2. The look back period gradually increases from 36 months to 60 months starting in November 2009. FSSA issued a notice, excerpt shown below, explaining the specific requirements.

3. Loan Agreements. These rules are unbelievable! FSSA issued a notice, excerpt shown below, explaining the specific requirements.

4. Veterans Benefits—The non-service related pension benefit for veterans and spouse of veterans.

5. The new Medicaid penalty start date for “transfers” made after November 1, 2009. FSSA issued a notice, excerpt shown below, explaining the specific requirements.

6. Funeral Purchases—how one family spent \$160,000 in one afternoon at the funeral home.

7. Transfer Penalty Hardship Exemption—The Ostrich Defense. FSSA issued a notice, excerpt shown below, explaining the specific requirements.

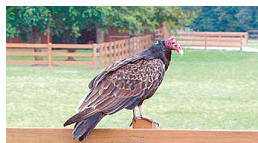


8. Advise client on the need for nursing home insurance.

9. Personal Service Agreements—Paying the family to keep mom and/or dad at home.

10. Gifting the home without penalty.

11. Medicaid Estate Recovery—The Basics



12. Special Needs Trust

Annuities

New Provisions Regarding Disclosure and Treatment of Annuities

The new provisions require disclosure of annuities, specify the circumstances in which a purchase or transaction involving an annuity will be treated as an improper transfer, and require the State to be beneficiary. The new provisions apply to purchases and certain transactions as described below occurring on and after November 1, 2009.

Transactions that are subject to the new provisions include any action taken by the individual that changes the course of payment to be made by the annuity, or the treatment of the income or principal of the annuity, including such actions taken on annuities purchased before November 1, 2009. These actions include:

- additions of principal;
- elective withdrawals;
- requests to change the distribution of the annuity;
- elections to annuitize the contract;
- a change in ownership; or
- any other non-routine action not listed below.

The following types of changes and events would not subject an annuity purchased prior to November 1, 2009, to treatment under the new rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;

- Changes that occur based on terms of the annuity which existed prior to November 1, 2009, and which do not require a decision, election, or action to take effect; or

- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic condition.

Any interest in an annuity must be reported.

The requirement to disclose all resources when applying for Medicaid has always been in effect for Long-Term Care ("LTC") applicants/recipients. These new provisions specifically require disclosure of any interest that the LTC

applicant/recipient and or spouse have in annuities. The failure to disclose and provide all necessary documentation will result in denial or closure due to failure to cooperate. At minimum, the applicant/recipient must provide a copy of the complete annuity contract and documentation of transactions that occur after the purchase. The application and redetermination forms have been revised to allow for annuity disclosure as required by federal law.

The State must be beneficiary.

Annuities purchased and transactions made on annuities owned by the applicant/recipient and spouse must name the State as a remainder beneficiary in accordance with the rules that follow below. If these rules regarding the beneficiary assignment in the correct position are not met, the full purchase price of the annuity is considered an improper transfer and a penalty must be imposed.

1. An annuity must name the State as the remainder beneficiary in the first position unless there is a community spouse and/or a minor or disabled child. A disabled child is one who meets the SSI or SSDI disability criteria.
2. If there is a community spouse and/or minor or disabled child, the State must be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child.
3. If the State has been named as a remainder beneficiary after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State must then be named beneficiary in the first position.
4. The requirement is waived if the individual has purchased a long-term care insurance policy that protects the annuity as approved by the Indiana Long-Term Care Partnership (ILTCP).

As remainder beneficiary, the State is entitled to receive the total amount of medical assistance paid on behalf of the annuitant.

Additional Criteria Applicable ONLY to the person in LTC

The rules explained below do not apply to annuities owned by or transactions made by community spouses.

There are two separate sets of criteria that, if met by the terms of the annuity, will

not result in a transfer penalty. The first set will be referred to as “soundness” criteria. The second set will be referred to as “class exceptions”. The annuity does not have to meet both sets of criteria— it has to meet the criteria from either set.

The purchase of an annuity or transactions completed will not result in a transfer of property penalty if the following conditions, referred to as soundness criteria, are met:

1. The annuity is irrevocable and non-assignable in that it cannot be cashed in nor ownership transferred to another individual or entity; *and*
2. The annuity is actuarially sound in that it is expected to return full principal and interest within the institutionalized individual’s life expectancy; *and*
3. The annuity provides payments in approximately equal amounts with no deferred or balloon payments;

The methodology for determining actuarial soundness is the same that is in the IPPM 2640.10.25.10, captioned below. However, do not use the Life Expectancy Table in that section for these new rules. Use the Period Life Table referenced for loans and promissory notes at the end of this document.

If the individual does not (will not) receive compensation in the amount of the full purchase price within his lifetime (or within the contract’s specified time period if shorter than the life expectancy), the uncompensated amount is the difference between the purchase price and the amount that the annuity will pay out to the individual within the individual’s life expectancy, or term of the contract if shorter than life expectancy.

Ownership of an annuity in one of the following classes of retirement annuities will not result in a transfer of property penalty:

1. An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC); or
2. A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC); or
3. The annuity is purchased with proceeds from a traditional IRA (IRC Sec. 408a); or

4. The annuity is purchased with proceeds from certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)); or
5. The annuity is purchased with proceeds from a simplified retirement account (IRC Sec. 408 §(p)); or
6. The annuity is purchased with proceeds from simplified employee pension (IRC Sec 408 §(k); or
7. The annuity is purchased with proceeds from a Roth IRA (IRC Sec. 408A).

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced above, rely on verification from the financial institution, the employer or the employer association that issued the annuity. The burden of proof is on the applicant or recipient (or his/her authorized representative) to produce this documentation.

Sample Beneficiary Designation Language and Life Expectancy Table

Primary Beneficiary: The State of Indiana for the amount of any medical assistance provided to Sam Smith or Mary Smith.

Contingent Beneficiary: In equal shares to each child of mine who survives me and the descendants who survive me, collectively, by right of representation, of each child of mine who predeceases me.

Period Life Table		
	Life Expectancy	Life Expectancy
Age	Male	Female
60	20.42	23.53
61	19.66	22.70
62	18.91	21.88
63	18.17	21.08
64	17.44	20.28
65	16.73	19.49
66	16.02	18.70
67	15.32	17.93
68	14.63	17.17
69	13.96	16.42
70	13.30	15.69
71	12.66	14.97
72	12.04	14.27
73	11.43	13.58

74	10.84	12.90
75	10.26	12.24
76	9.70	11.59
77	9.15	10.96
78	8.63	10.34
79	8.11	9.74
80	7.62	9.16
81	7.14	8.59
82	6.68	8.04
83	6.24	7.52
84	5.82	7.02
85	5.41	6.54
86	5.03	6.08
87	4.67	5.65
88	4.34	5.25
89	4.02	4.87
90	3.72	4.52
91	3.45	4.19
92	3.20	3.89
93	2.97	3.61
94	2.77	3.36
95	2.59	3.13
96	2.43	2.93
97	2.29	2.75

A complete table will be in the IPPM and can be found at www.ssa.gov/OACT/STATS/table4c6.html. This will then be updated in the IPPM for 2010.

The Look-Back Review Period

The law does change the look-back period from 36 months to 60 months for all transfers. However, with the implementation date of 11-1-09, the full look-back period won't materialize until 2014, and except for trust transactions which have been 60 months for many years, a look back of more than 36 months won't occur until 2012. Therefore, the look back period is as currently stated in the IPPM.

Treatment Of Loans Established On Or After 11-1-09 As A Transfer Of Assets

This new provision applies to loans established on and after November 1, 2009. It applies to individuals who loan money directly to another as well as those who may purchase a loan or promissory note that was originally entered into between two other persons. The likelihood of the latter may be small, however, given the concern that many private loans are merely gifts appearing to be loans, it is important to understand the possible transactions that may occur by someone trying to shelter assets to become eligible for Medicaid.

Whenever an individual has a promissory note, loan agreement, or mortgage as presumed evidence that a transfer of money was not a gift but was made with the expectation of full repayment, the arrangement will be considered an improper transfer unless all of the following criteria are met:

- a) The repayment term is actuarially sound in accordance with the attached Period Life Table;
- b) The agreement provides for payments to be made in equal amounts during the term of the loan, with no deferral of payments and no balloon payments; and
- c) The promissory note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan or mortgage, that does not satisfy the requirements above and is established on or after 11-1-09, the value of such contract considered as an improper transfer will be the outstanding balance due as of the date of the individual's application for Medicaid or date of LTC admission, whichever is later. In the case of HCBS, the balance to be used is the amount as of the date of the Cost Comparison Budget approval. When determining if the loan is actuarially sound, refer to the person's age on the Period Life Table as of the date the loan is established. If the loan

cannot be repaid within the person's life expectancy, it is not actuarially sound, and is, therefore, an improper transfer.

The amount of the loan payments are countable income as usual.

VA Aid & Attendance Award

Many individuals are not aware that there is a special pension available to eligible veterans, their spouses and dependents. This special pension is called the Aid & Attendance Award. The Aid & Attendance Award provides benefits of up to \$1,644 per month to a veteran, \$1,055 per month to a surviving spouse, \$1,945 per month to a couple, or \$2,580 to a veteran married to another veteran. For many, this award can make the difference between a comfortable retirement and constant worries about making ends meet.

In order to determine whether a veteran, surviving spouse, or qualifying dependent is eligible for the Aid & Attendance Award:

1. The veteran must have not been dishonorably discharged in order to be eligible.
2. The veteran served at least one day during the following periods and had 90 days of continuous military service for veterans entering the service before September 7, 1980:
 - A. World War II (12/7/41 to 12/31/46)
 - B. Korean War (9/27/50 to 1/31/55)
 - C. Vietnam War (8/5/64 to 5/7/75)
 - D. Gulf War (8/2/90 to present)
3. To qualify financially, a married couple must have less than approximately \$80,000 in assets, excluding their home and vehicle; while a single individual must have less than \$50,000 in countable assets.
4. The veteran's income is compared to the veteran's unreimbursed medical expenses to determine eligibility.

The VA will require that your physician fill out a form establishing that the claimant requires daily assistance from others in order to dress, bathe, cook, eat, leave home, etc. The claimant does not have to require help in all areas. There simply must be adequate medical evidence that the claimant cannot function without assistance.

Please note that you will need the following paperwork to attach to your claim: the veteran's discharge papers (please go to www.vetrecs.archives.gov to request them if not readily available); the veteran's death certificate (if surviving spouse is claimant); the veteran's marriage certificate; a physician's form for the claimant; a nursing home form filled out by the assisted living facility or nursing home, if applicable; and a letter from

the home health care provider stating frequency of visits and cost per month (if applicable).

This process may seem daunting if done alone, but County Service Officers are available to help guide you through this process, which you can access at the following [link](#). Please contact your local Officer in order to assist you in applying for the Aid & Attendance Award. For more information, please refer to www.vetassist.org, <http://veteranaid.org>, or contact the Indiana VA Regional Office, 575 North Pennsylvania Street, Indianapolis, Indiana 46204-1526, Fax (317) 226-7422.

Dale, Huffman & Babcock
Revised July 2010

Penalty Start Date

For transfers of property occurring on and after 11-1-09, the penalty period will begin on the **later** of:

- The date on which the individual would be otherwise eligible for LTC Services under Medicaid based on an approved application were it not for the imposition of the penalty period; or
- The first day of a month during which assets have been transferred for less than fair market value; *and*
- The penalty does not occur during any other transfer of property penalty. The following examples illustrate the determination of the penalty start date.

Example - 1

Individual entered LTC facility on 10-15-09.

12-05-09	Gifted money.
05-10-10	Applied for Medicaid.

The months covered by the application are Feb, Mar, April, and continuing. During the eligibility process it is determined that the gifting was an improper transfer, and that the applicant had excess resources for the months of Feb and Mar.

Therefore, Medicaid is effective 04-01-2010 and a transfer penalty is imposed starting the same date, 04-01-10. Assume the penalty period is 5 full months. The penalty begins on 04-01-2010 and ends on 08-31-2010.

Under the old rules (pre -11/09), the transfer penalty would have begun on 01-01-10, the month after the month of transfer, and ended on May 31, 2010.

Example 2

Individual entered LTC on 10-15-09.
Transfers of property were made on 07-01-09 and 02-01-10.
Medicaid application was filed on 06-10-10.

Because the dates of the transfers were before and after 11-01-09, the rules in effect for both periods must be used to establish the penalty start dates. Assume both transfers were improper and that based on the calculated uncompensated value, the first transfer invokes a 10 month penalty and the second transfer invokes a 4 month penalty. Using the rules for pre- 11/09 transfers, the penalty for the first transfer starts 08-01-09 (month after transfer) and ends 05-31-10. The applicant is determined otherwise Medicaid eligible beginning 03-01-10 (the first retroactive month based on the date of application.) Based on the 2nd transfer alone, the penalty period would begin on 03-01-10; however this would cause penalty periods to overlap which the rules do not allow. Therefore, the 2nd penalty starts 06-01-10, when the first one has ended. The entire transfer penalty is 08-01-09 through 09-30-10.

Once a penalty period has been determined and invoked for an individual in LTC, it runs continuously until the end date regardless of the individual's circumstances. For example, discharge from a facility or closure of Medicaid does not result in a termination of the penalty period. In other words, the penalty does not stop and re-start. Similarly, if an application is denied, a transfer penalty is not established. In a denial situation, a transfer penalty does not run its course, without ever having an impact on LTC eligibility.

The above policy and examples only explained the new way in which the penalty start date is determined, without consideration of the actual calculation of the length of the penalty. The second significant change in the transfer rules is how the penalty is determined using a new methodology that, in accordance with the federal law, does not permit rounding down of partial months. In this way, the penalty is served on the full amount of the improper transfer.

Calculation of the Penalty Period

All improper transfers occurring on and after 11-01-09 are accumulated into one total amount to determine the penalty period. The uncompensated value determination must take into consideration the de minimis transfer allowance as explained in IPPM 2640.10.15.10. Transfer penalties using the specific method explained below may end on any date in a month not just the last day of a month.

Two standard values are used in the penalty period calculation:

- Monthly Standard of days in a month - 30.42 days. (365 days divided by 12).
- Average Monthly Facility Private Rate - Refer to IPPM 3006.00 for the applicable rate to use based on the date of an application.

Once the final uncompensated value (UV) of all improper transfers made on and after 11-01-09 has been determined, the steps below are to be followed to determine the length of the penalty period:

- Divide the UV by the current Facility Private Rate. Round up at 2 decimal places. (For example, 2.26216807 is 2.27 months.) This result is the length of the penalty period.
- If the above division happens to result in whole months, the calculation of the penalty is complete.

- If the length of the penalty period as calculated above includes a fractional month, the next step is to convert the fractional month into days. Multiply the partial month by 30.42 and round up to determine the number of days in last month of the penalty period.

For Example: UV = 10,129.24 Private Rate = \$4,611

\$10,129.24 divided by \$4,611 = 2.1967555 2.20 months

Partial month .20 x 30.42 Standard of days = 6.084 rounded up to 7 days

Penalty period is 2 months, 7 days.

Example #1

Individual admitted to LTC facility on 10-08-08; Application filed on 11-20-09.

Facility Private Rate \$4,611

First month of eligibility is 10-09. (Applicant ineligible for August and September due to excess resources.)

Transfers:

11-03-08:	\$10,000 cash gift to sister
11-09-09	\$800 cash gift to son
11-14-09	\$20,000 cash to best friend

Evaluation:

All transfers are determined to be improper and subject to penalty. Because the application was filed after 10-1-09, the \$1,200 de minimis transfer allowance rule applies to each year of transfers. The \$10,000 transfer is reduced to \$8,800 because the gift was to a family member. \$8,800 divided by \$4,611 = 1.91 rounded down = 1 month penalty, beginning 12-1-08 and ending 12-31-08. Note, this penalty is over by the time the person applied for Medicaid and has no impact on eligibility.

The uncompensated value of the transfers in 2009 = \$20,800. Only the \$800 gift to a family member is subject to the de minimis; the gift to the friend is not reduced.

The uncompensated value subject to penalty is \$20,000.

$\$20,000 \div \$4,611 = 4.3374539$ 4.34 months

Convert the .34 partial month to days:

$30.42 \times .34 = 10.3428$ rounded up to 11 days

Penalty period is 4 months 11 days: Starts on 10-01-09, ends on 02-11-10.

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Current through the 7/21/2005 Issue of the Federal Register except 70 FR 40420 7/13/2005

Title 20 - Employees' Benefits
Chapter III - Social Security Administration
Part 416 - Supplemental Security Income for the Aged, Blind, and Disabled
Subpart L - Resources and Exclusions

20 CFR 416.1231

§ 416.1231 Burial spaces and certain funds set aside for burial expenses.

(a) Burial spaces -

(1) **General.** In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.

(2) **Burial spaces defined.** For purposes of this section "burial spaces" include burial plots, gravesites, crypts, mausoleums, urns, niches, and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

(3) **An agreement representing the purchase of a burial space.** The value of an agreement representing the purchase of a burial space, including any accumulated interest, will be excluded from resources. We do not consider a burial space "held for" an individual under an agreement unless the individual currently owns and is currently entitled to the use of the space under that agreement. For example, we will not consider a burial space "held for" an individual under an installment sales agreement or other similar device under which the individual does not currently own nor currently have the right to use the space, nor is the seller currently obligated to provide the space, until the purchase amount is paid in full.

(4) **Immediate family defined.** For purposes of this section, immediate family means an individual's minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household will be a factor in determining whether a person is an immediate family member.

(b) Funds set aside for burial expenses.

(1) **Exclusion.** In determining the resources of an individual (and spouse, if any), there shall be excluded an amount not in excess of \$1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion

applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.

(2) **Exception for parental deeming situations.** If an individual is an eligible child, the burial funds (up to \$1,500) that are set aside for the burial arrangements of the eligible child's ineligible parent or parent's spouse will not be counted in determining the resources of such eligible child.

(3) **Burial funds defined.** For purposes of this section "burial funds" are revocable burial contracts, burial trusts, other burial arrangements (including amounts paid on installment sales contracts for burial spaces), cash, accounts, or other financial instruments with a definite cash value clearly designated for the individual's (or spouse's, if any) burial expenses and kept separate from nonburial-related assets. Property, other than listed in this definition, will not be considered "burial funds."

(4) **Recipients currently receiving SSI benefits.** Recipients currently eligible as of July 11, 1990, who have had burial funds excluded which do not meet all of the requirements of paragraphs (b) (1) and (3) of this section must convert or separate such funds to meet these requirements unless there is an impediment to such conversion or separation; i.e., a circumstance beyond an individual's control which makes conversion/separation impossible or impracticable. For so long as such an impediment or circumstance exists, the burial funds will be excluded if the individual remains otherwise continuously eligible for the exclusion.

(5) **Reductions.** Each person's (as described in §§416.1231(b)(1) and 416.1231(b)(2)) \$1,500 exclusion must be reduced by:

(i) The face value of insurance policies on the life of an individual owned by the individual or spouse (if any) if the cash surrender value of those policies has been excluded from resources as provided in §416.1230; and

(ii) Amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expenses.

(6) **Irrevocable trust or other irrevocable arrangement.** Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds which are held in an irrevocable burial contract, an irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified as available for burial expenses.

(7) **Increase in value of burial funds.** Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which occur beginning November 1, 1982, or the date of first SSI eligibility, whichever is later, are excluded from resources if left to accumulate and become part of the separate burial fund.

(8) Burial funds used for some other purpose.

(i) Excluded burial funds must be used solely for that purpose.

(ii) If any excluded funds are used for a purpose other than the burial arrangements of the individual or the individual's spouse for whom the funds were set aside, future SSI benefits of the individual (or the individual and eligible spouse) will be reduced by an amount equal to the amount of excluded burial funds used for another purpose. This penalty for use of excluded burial funds for a purpose other than the burial arrangements of the individual (or spouse) will apply only if, as of the first moment of the month of use, the individual would have had resources in excess of the limit specified in §416.1205 without application of the exclusion.

(9) Extension of burial fund exclusion during suspension. The exclusion of burial funds and accumulated interest and appreciation will continue to apply throughout a period of suspension as described in §416.1320, so long as the individual's eligibility has not been terminated as described in §§416.1331 through 416.1335.

Transfer Penalty Hardship Exception

The hardship procedures explained in this section are used when a transfer penalty has been imposed on an individual for a transfer of property occurring on and after November 1, 2009, except when the penalty is due to an annuity purchase. There is no hardship exception for an annuity purchase.

POLICY

When a penalty is imposed, the ICES generated notice will explain that an appeal based on the merits of the penalty determination can be filed, or a hardship exception can be requested if the individual alleges and can document that such a hardship exists. Procedures for filing the Request for Hardship Exception-Transfer of Property directly to the FSSA Office of Medicaid Policy & Planning (OMPP) are explained in the notice. (The text of the hardship language on the eligibility notice is at the end of this section.) The request for an undue hardship exception will serve as admission by the individual that a transfer of assets for less than adequate consideration was made and that the agency's penalty determination was correct.

The penalty will be removed or modified under a hardship exception if documentation substantiates that the recipient's health is endangered as result of the penalty or that the recipient will be deprived of food, clothing, shelter, or other necessities of life.

PROCEDURE

A hardship exception request must be filed within 30 days of the notice imposing the transfer penalty. The following persons can apply for a hardship exception:

- The recipient;
- The recipient's authorized representative; or
- The nursing facility in which the recipient currently resides, if written consent from the recipient or the recipient's personal representative is given for the nursing facility to file the request.

The OMPP will make the decision to waive all or a portion of the transfer penalty based solely on the evidence submitted with the request. The Notice of Decision on Transfer of Property Hardship Exception Request will be issued by OMPP to the requestor within 45 days of receiving a request for an exception. A denial of a hardship exception is subject to administrative appeal.

A copy of the Notice of Decision on Transfer of Property Hardship Exception

Request will be sent to the Division of Family Resources. An approval of a hardship exception must be acted upon by the Division within 10 days (normal change processing requirements) to remove or shorten the penalty as approved.

NOTICE TEXT

If you disagree with this determination, you have the right to appeal as explained at the end of this notice. The appeal would be about the merits of the determination. For example, you may disagree with the value of the property, what you received in return for the property, or the way the rules were applied to your circumstance.

If you believe that this restriction on your Medicaid benefits will cause you a hardship, you can file for a hardship exception. In filing for a hardship exception, you agree that you have no dispute about the facts or interpretations of law that we used to apply the penalty. If you file an appeal on the merits, you cannot file for a hardship exception.

A hardship exception to the penalty must be requested within 30 days of the date of this notice if you choose not to file an appeal. In a hardship request, you must substantiate that the transfer penalty will cause you to be deprived of food, clothing, shelter, or other necessities of life, or will deprive you of medical care such that your health is endangered.

A "Request for Hardship Exception-Transfer of Property" form can be obtained on the internet at www.in.gov/fssa/ompp, or by calling the Office of Medicaid Policy and Planning at 317-232-4966. A hardship exception can be requested by

The applicant;

The applicant's personal representative; or

The facility in which the applicant currently resides if written consent is provided by the applicant or applicant's personal representative.

Please note that if the penalty has been imposed due to the purchase of an annuity or transaction involving an annuity, a hardship exception is not approvable.

Nursing Home Insurance to Buy or Not to Buy

The fear that nursing home costs will financially ruin their retirement has led many people to consider the purchase of nursing home insurance. We encourage people to purchase nursing home insurance. You should consider the following information in making your decision.

The younger you are when you purchase nursing home insurance, the smaller the premium. Generally, you should consider purchasing nursing home insurance when you are 59 years old. The premium should not exceed 10% of your income (as you are trying to protect--not spend--your retirement savings).

The average age for nursing home admission is 81 for men and 84 for women. If you are in good health and do not have a family history of illnesses resulting in nursing home care, you will want to consider how long you are likely to pay premiums.

Generally, people with assets of more than \$150,000 and less than \$800,000, excluding their home, are candidates for the purchase of long-term care insurance.

Married people should carefully consider their options under existing laws designed to permit one spouse to be institutionalized without impoverishing the spouse that stays at home. Generally, the spouse at home can keep their home, car, and one-half of their non-exempt assets up to a maximum of \$109,560 without the need for long-term care insurance. Prior to committing to spend thousands of dollars in insurance premiums over a long period, they should spend \$100-\$200 and have a professional advisor explain these laws to them.

What are the chances that the insurance policy will make any payment to a nursing home? The average 65-year-old male has a 20% chance of spending a year in a nursing home and a 10% chance of spending five or more years in a nursing home. This means there is an 80% chance that you will need care for less than one year. When you compare this to the risk of filing a major claim against your homeowner's insurance company, which is one in eleven hundred, nursing home insurance may be a good investment for your family.

If you are considering purchasing a long-term care policy, you should compare policies and premiums from at least two companies. In purchasing a policy, you should consider:

- Home Care. Many policies now provide for limited health and housekeeping care in your home to avoid a spouse having to enter a nursing home.
- Benefit Period. You can purchase a long-term care policy for the rest of your life, but generally coverage for four or five years is sufficient. This is particularly true in Indiana if the nursing home policy is approved by the State of Indiana as a qualified policy under the Indiana Long Term Care Program. This program allows you to qualify for Medicaid and for every dollar the insurance policy pays for nursing home care, the amount you can keep and qualify for Medicaid increases by a dollar. This program features a second policy that allows you to keep all of your assets. This second policy currently requires a qualified policy to pay the nursing home \$251,419. This amount is adjusted each January 1st for policies purchased after that date.
- Elimination Period. By paying for the first 30 or 90 days of nursing home care, you can save a great deal on premiums.
- Inflation Protection. You generally should have a policy that increases your benefits by 5% each year, especially if you are under age 65 when you purchase the policy.

The purchase of a nursing home insurance policy is a major financial decision. You should carefully review and compare actual policies and rates before you buy.

The State Of Indiana Department Of Insurance Senior Health Insurance Information Program has additional information and counselors available to discuss these issues in more detail. Please use their hotline at 1-800-452-4800 to request information. Fred Taube serves as the local representative of this program. Fred can be reached at (260) 373-7952.

The link for the Long Term Care Partnership Program is <http://www.dehpg.net/ltpartnership/StateReciprocity.aspx>.

Personal Service Agreement

The new Medicaid rules make gifts to family members very complicated for gifts made on or after November 1, 2009. The use of a Personal Service Agreement for a caregiver can many times be used instead of making gifts with more benefits for all members of the family.

The benefits of having a Personal Service Agreement include:

- Mom and Dad is much more likely to live at home.
- Mom and Dad do not burden their children.
- The child (daughter and/or son) providing the services is fairly compensated among the siblings.
- Mom and Dad's money stays in the family instead of being spent at the nursing home.
- Compliance with all taxes and Medicaid laws

Personal Service Agreements have tax complications and should be prepared by an Elder Law attorney. Please contact us for more information about these agreements. For more information about Personal Service Agreements please visit the seminar link at our website www.dhblaw.com, and review the materials prepared by Keith P. Huffman for a continuing education seminar presented to other lawyers in Indianapolis on October 8, 2009.

Giftng the Home

Once a week mom shows up in your office. She wants to give her home to her children. The home usually makes up the majority of her assets, and she is scared to death the nursing home is going to take it. How do you advise her?

The first thing you need to do is to gather more information. Hopefully, you have had mom fill out an intake sheet and asked mom to show:

1. All of her assets.
2. All of her income.
3. Does she have a disabled child?
4. Was she or her spouse in the military during a war?
5. Does anyone currently live with her?
6. Does she have nursing home insurance?

You will need to obtain a copy of the current deeds for all real estate mom owns, the value of the real estate and the cost basis. You should never accept what the family tells you about ownership of real estate—always get copies of the current deeds. With this information, we are now able to begin the conversation with mom.

The Pitfalls. The story is simple for mom. She wants to give the home to her child/children. When you tell her she will lose her homestead and senior exemptions, she quickly wants to know what other options are available.

Deed with retained life estate. You explain to mom she can deed the home to a child/children and keep a life estate. This sounds simple, but is not.

Benefits

Mom continues to live in the home and receives all property tax exemptions. Mom does not notice the difference between owning it outright and having a reserved life estate. Mom pays all the expenses and keeps any rental income. At mom's death, property included in Mom's estate so kids get a step up in basis to avoid capital gains tax on the sale. The home goes to the children outside of probate.

Detriments

Should mom decide to sell the home, she pays no capital gains tax but the children likely will unless the basis is high. The children's financial problems are mom's problems (i.e. should a child die, get divorced, be in an accident without enough insurance, lose their health insurance, etc.) No one is in charge after mom's death. The transfer will be penalized if mom needs nursing home care.

You must explain all of these items to mom in a way she understands it. She then wants to know what her alternatives are. This is greatly complicated when you attempt to explain the 5 year floating penalty created by the new DRA Medicaid rules.

You explain to the family mom is permitted to gift her home without incurring a Medicaid penalty if a child has lived with mom for more than two years before she enters a nursing home and provided care for her that allowed her to remain at home. When a Medicaid application is filed, you will need an affidavit from the child documenting the services the child has provided to help mom. You will also need a physician statement to document this care allowed mom to stay at home.

You explain to the family mom can make improvements to the home while the child is living in the home without incurring a penalty. The plumbing, electrical, appliances, etc. can all be upgraded as needed to make the home more marketable/habitable. The home can be deeded to the child without penalty under the Medicaid rules after the child has lived in the home for the required period and performed the required services. The child will receive mom's basis in the home until the child lives there for two more years when it becomes the child's principal residence, even if mom continues to live in the home.

You also explain mom can give the home without penalty to a spouse, a minor or disabled child, or blind child. These situations occur infrequently.

Use of Personal Service Agreements. The home presents an interesting planning option for PSA. The son may live with mom and perform services. Mom could pay the son periodically by deeding a portion of the home to son. A home equity loan could be set up to pay the income taxes mom and son incur. Mom and son could own the home periodically by different percentages as joint tenants with rights of survivorship.

Should mom need to enter the nursing home, the portion transferred to son for fair market value for his services is protected. The home is also not available to mom under the provision of ICES Section 2605.10.05 if son refuses to sell his interest in the home. The interest in the home owned by mom may be subject to Medicaid estate recovery during the nine month period following mom's death.

Claims Against the Estate—The Basics

Follow the Money

The federal estate recovery laws are designed to help states replenish funds to provide care for more needy individuals. The estate recovery programs have been successful. In 2005, \$411,133,981 was recovered in the United States—almost 81 million dollars more than in 2003. The national average estate recovery in 2005 was \$8,061,451, almost identical to Indiana’s recovery of \$8,160,208. Indiana’s estate recovery increased to \$9,770,222 in 2007.

We should expect additional estate recovery efforts in the future. The Service Center Processes and Procedure Manual in Section 3.6.5.12 requires the caseworker to refer death notices to the Estate Recovery Office.

These recovery efforts should not come as a surprise to the families of our clients. Estate recovery rules should be mentioned in our initial conference with a client and should be covered in writing with the family.

The 2007 AARP study developed a model notice to inform families about the potential for estate recovery (Protection in Medicaid Estate Recovery: Findings, Promising Procedures, and Model Notices www.aarp.org/research/assistance/medicaid/2007_07_medicaid.html). While these forms are not specific to Indiana, you should consider providing these forms or similar information to your clients at the beginning of your representation so there are no surprises at the end of your representation.

Federal law and Indiana law do not require estate recovery if the cost of recovery exceeds the amount collected. Many states have adopted a de minimus amount so estate recovery is not required in small estates. Georgia first enacted its estate recovery using \$25,000 as the exemption amount for estate recovery. In 2006, the legislation in Georgia increased this amount to \$100,000; however, CMS did not approve this change. Indiana does not have an estate recovery de minimus level.

Federal law requires states to assert claims against a recipient’s probate estate and gives states the option to assert claims against various types of non-probate transfers. 42 U.S.C. §1396p(b). When the recipient dies, the Indiana DFR can assert a preferred claim for any Medicaid benefits received after age 55. I.C. 12-15-9-1; 42 U.S.C. §1396p(b)(1)(B). For Medicaid provided before October 1, 1993, no claim can be enforced unless the recipient was 65 years or older when the benefits were received. No claim will be asserted for the amount of the Medicare Part B premiums which Medicaid pays for a recipient. ICES Manual 4650.00.00. A trial court has no discretion to reduce

the amount of a valid claim. *In the Matter of Estate of Cripe*, 660 N.E.2d 1062 (Ind.App. 1996).

Until 2002, Indiana only asserted claims against the probate estate. The 2002 Indiana legislature expanded the definition of estate in order to include some non-probate transfers. First, the definition of estate was broadened to include any interest in real estate that the recipient held as a joint tenant with rights of survivorship, if the joint tenancy was created after June 20, 2002. The expanded estate definition does not apply to joint survivorship tenancies created before July 1, 2002. The claim extends to the recipient's interest at the time of death. I.C. 12-15-9-0.5(a)(2). Although the statute refers to the recipient's interest at the time of death, the statute actually intends to extend the claim to the interest the recipient held immediately before death.

In addition, the statute allows OMPP to assert a claim against property distributed by other types of non-probate transfers where immediately before death the recipient had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and use the property for the recipient's own benefit or use the property to satisfy claims. I.C. 12-15-9-0.5(b). This section is modeled after I.C. 32-17-13 to make the beneficiaries of certain non-probate transfers subject to creditor claims and statutory allowances. The expanded definition of non-probate transfers does not apply to any assets that were transferred out of the probate estate before May 1, 2002, or that the DFR had determined were exempt or unavailable before May 1, 2002. I.C. 12-15-9-08. The statute specifically states that it does not include the transfer of a survivorship interest in property held as tenants by the entirety or to the payment of the death proceeds of a life insurance policy. I.C. 12-15-9-0.5(b). Although not specifically listed, the statute does not extend to the transfer of a remainder interest in real estate, as a life estate holder cannot prevent the property from passing to the remainderman at death. Joint financial accounts with a survivorship interest are included in the definition, provided that the recipient had full access to the funds before death. Property held in a revocable trust where the grantor has full authority to revoke the trust or withdraw all of the funds is included in the definition. If the revocable trust provides that a third party's agreement is needed to revoke or withdraw assets, then it would not be included. An irrevocable trust is not included.

Both state and federal law now specifically address annuities. I.C. 12-15-9-0.5(a)(4) includes within the definition of "estate" any sum due to a person after the death of a Medicaid recipient on an annuity contract purchased after May 1, 2005, with the assets of the recipient or the recipient's spouse. I.C. 12-15-9-7 provides that a person receiving beneficiary payments from an annuity contract of a deceased Medicaid recipient is liable to the State for Medicaid benefits paid. This section does not specifically refer to a contract of a recipient's spouse. The DRA also addresses annuities.

OMPP must commence enforcement of a claim against assets not included in the recipient's probate estate within nine months after the recipient's death. I.C. 12-15-9-0.6(b). I.C. 32-17-13 provides that a creditor must first demand that the personal representative of the estate file a proceeding against the non-probate transferee(s), and if the personal representative declines or fails to file a proceeding, then the creditor may file a proceeding. This would seem to require that the creditor would need to open an estate if an estate has not already been opened. This is an important reason to use a TOD Deed or trust in almost every Medicaid planning situation if the client owns real estate!

In 2005, the Indiana legislature expanded recovery against a recipient's spouse. I.C. 12-15-9-1 now allows recovery "upon the death of a deceased Medicaid recipient's spouse" against the spouse's estate. Recovery against the non-recipient spouse is allowed only if that spouse dies after the recipient spouse dies. Subsection (b) provides that if the spouse remarries, no claim can be made against that part of the estate attributable to the subsequent spouse. No exception is made for any assets the spouse may have accumulated herself after the recipient spouse's death. This extension of recovery to the estate of a spouse appears to go well beyond the recovery allowed by 42 U.S.C. 1396p(b)(2). That section only allows recovery from the recipient's estate. The estate is defined as including "any other real and 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 such assets conveyed to a survivor, heir, or assignee of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement." §1396p(b)(4)(B). Assets that the surviving spouse accumulates after the death of a recipient spouse, even if not attributable to a subsequent spouse, are beyond this definition.

There continues to be some statutory exceptions from enforcement of OMPP's claim. No claim can be enforced against real estate or personal property while needed for the support of the surviving spouse, dependent children under age 21, or a dependent who is non-supportive because of blindness or other disability. There is no requirement that the dependent have any certain relationship to the deceased. I.C. 12-15-9-2(1) and (2). 405 IAC 2-8-1(c) and ICES Manual §4650.05.00 go even further, as they provide that no recovery can be made until after the death of the surviving spouse.

The claim cannot be enforced against the deceased's "personal effects, ornaments, or keepsakes." I.C. 12-15-9-2(3). Also, the claim cannot be asserted against assets which were disregarded under the Indiana Long Term Care Insurance Program. 405 IAC 2-8-1 (e)(2); ICES Manual 4650.05.00.

Funeral expenses can be paid out of the recipient's estate ahead of the preferred claim. Although I.C. 12-15-9-1 refers to only a small exempt amount for funerals of \$350, the Probate Code at I.C. 29-1-14-9(a)(2), through cross-reference to I.C. 12-14-27-4, provides for a larger funeral exemption. FSSA considers there now to be no limit on

how much of the recipient's estate can be used to pay for the funeral. However, I.C. 12-14-17-4 appears not to allow for any payment for funeral expenses if the recipient had a pre-paid funeral plan, no matter how small, even if that plan was not intended to cover the full cost of the funeral.

FSSA has issued a Bulletin notifying nursing homes to, in most circumstances, transfer funds remaining in a deceased Medicaid recipient's resident trust account to OMPP as repayment of the Medicaid claim. See Bulletin BT200726, issued October 4, 2007, available at www.indianamedicaid.com/ihcp/bulletins/bt200726.pdf. Some nursing home residents keep their personal funds in a trust account held by the nursing home. 410 IAC 16.2-3.1-6(h) requires a nursing home to transfer funds remaining in a trust account within thirty days of a resident's death. The Bulletin states:

At the death of a resident, OMPP should receive the resident's account fund if:

- The resident was at least fifty-five years old
- The resident was a Medicaid recipient
- The resident is not survived by a spouse
- The resident is not survived by a dependant child under twenty-one years old
- The resident is not survived by a dependant child who is blind or disabled
- The resident had pre-paid funeral arrangements, and
- No estate has been or will be opened in probate court.

Bulletin BT200726 at p.1.

Previously, each county contracted with a local attorney to represent it in estate recovery matters. Beginning in mid-2006, estate recovery was centralized. It is now being handled by Michael J. Staesnick, Estate Recovery Manager, Office of Medicaid Policy and Planning, Family and Social Services Administration, 402 W. Washington St., Rm. W382 MS 07, Indianapolis, IN 46204-2776, Phone: (317) 232-7382. He files claims in estates when he is notified of the opening of an estate. County offices have been instructed to notify him if it receives a notice of administration of an estate or if it learns of the opening of an estate. There appears to be no effort currently to identify non-probate transfers and assert claims against them, although ICES Manual 4650.10.00 does provide county offices with information about using a small estates affidavit to present a claim.

As a known creditor, notice must be given to FSSA where an estate is opened for a recipient or the recipient's spouse. The address of the Estate Recovery Manager to whom notice should be given is listed above. There is no time limit for FSSA, as a governmental entity, to file a claim. I.C. 29-1-14-1(a). If FSSA does not file a claim, then the estate can be closed under I.C. 29-1-17-2 with a final report and account and decree of distribution. If there is no appeal, the decree is final and should prevent the State from filing a belated claim.

If the estate contains real estate, one should be aware that delaying the opening of an estate might avoid the need to sell the real estate to pay FSSA's potential claim. I.C. 29-1-7-15.1(b) states: "No real estate situated in Indiana of which any person may die seized shall be sold by the executor or administrator of the deceased person's estate to pay any debt or obligation of the deceased person, which is not a lien of record in the county in which the real estate is situated, or to pay any costs of administration of any decedent's estate, unless letters of testamentary or of administration upon the decedent's estate are taken out within five (5) months after the decedent's death." Thus, if an estate is not opened within five months after death, real estate should not be subject to sale to pay a Medicaid claim. Frequently, there will be little, if any, property other than real estate in the estate.

LIENS

The Omnibus Budget Reconciliation Act of 1993 (OBRA) required every state to institute a Medicaid estate recovery system. The federal estate recovery laws are found in 42 U.S.C. §1396p. The CMS guidelines are found in Section 3810 of the State Medicaid Manual Transmittal 75 (2001).

The federal law contemplated estate recovery would be enhanced by placement of liens on real property followed by collection efforts after the recipient's death. While Indiana is not currently aggressively placing liens on real property, we should expect this as the State more aggressively pursues estate recovery and enhances the Medicaid estate recovery laws. The Indiana laws (IC 12-15-8.5) on liens closely follow the federal law.

The federal law requires each state to recover for Medicaid benefits provided to certain individuals and allows each state to recover for other Medicaid benefits. Indiana has elected to recover for all Medicaid benefits paid to Medicaid recipients after age 55, unless prevented from doing so by federal or state law.

The Medicaid office can place a lien on a Medicaid recipient's real property only if the recipient is in a medical institution and is not reasonably expected to return home. A lien cannot be placed on the home if any of the following persons live in the home:

The Medicaid recipient's spouse;

The Medicaid recipient's child who is:

- (a) less than 21; or,
- (b) disabled under the SSI criteria;

The Medicaid recipient's sibling if the sibling has lived in the home for 12 months and has some ownership interest;

The Medicaid recipient's parent; or,

The Medicaid recipient's child of any age who has lived in the home with the recipient for 24 months, provided care that kept the recipient at home, and has lived in the home continuously since the parent entered the nursing home.

The Medicaid office must give written notice of intent to place a lien to the Medicaid recipient and the recipient's representative 30 days before recording a lien. The Medicaid recipient has that period of time to file for an ALJ hearing to establish that the requirements for the placement of a lien have not been met.

The Indiana statute sets forth provisions for foreclosing the lien. The statute also sets forth provisions for releasing the lien should the recipient be able to return to live at home.

The estate recovery rules closely follow the lien rules.

Special Needs Trusts

Visit www.specialneedsalliance.org and print-off a handbook for trustees.

Self-settled special needs trust created with a disabled individuals funds.

Third party special needs trust created with funds from a third party such as a spouse, parent, grandparent, etc.