Making sense of Medicaid rules for long-term care needs

Medicaid: The government safety net

Medicaid is the primary source of long-term care funding in the United States and provides coverage for approximately 60% of all nursing home residents.[1] In some states, Medicaid coverage was expanded after the Affordable Care Act became law. It is a widely used resource for people who need help paying for their long-term care. The rules and regulations for navigating and accessing this program can be confusing, since they vary by state. However, there are a number of universal guidelines as well as resources where you can find information about the state-by-state differences. Here are the answers to some common questions.

What's the difference between Medicaid and Medicare?

Although the names are similar, Medicaid and Medicare are different programs. Both programs provide health coverage, but Medicare is an "entitlement" program, meaning that everyone who reaches age 65 and is entitled to receive Social Security benefits also receives Medicare. Medicare also covers people of any age who are permanently disabled or who have end-stage renal disease.

Medicaid, on the other hand, is a public assistance program that helps pay medical costs for individuals with limited income and assets. To be eligible for Medicaid coverage, you must meet the program's strict income and asset guidelines. Also, unlike Medicare, which is entirely a federal program, Medicaid is a joint federal and state program. Each state operates its own Medicaid system, but this system must conform to federal guidelines in order for the state to receive federal money, which pays for about half the state's Medicaid costs.

Which pays for long-term care?

Medicaid does. According to the U.S. Department of Health and Human Services, a person turning age 65 this year has a roughly 70% chance of needing some type of long-term care or support in later years.[2] In 2019, the average cost of an assisted living facility was $4,051 per month, while a semiprivate nursing home room averaged about $250 per day—more than $7,513 per month.[3]

Who's eligible for Medicaid?

Eligibility generally depends upon a number of factors including the following:

Income: Money that you receive in salary, wages, interest, dividends, pensions, veteran's benefits, rental income, Social Security and other sources are used in determining your Medicaid eligibility. Most states provide Medicaid to individuals age 65 or older who are at or below the poverty level. Because income thresholds for Medicaid eligibility vary by state, you will need to determine the amount for the state in which you live.

Countable assets: Eligibility is based, in part, on "countable assets," or those assets that the program evaluates in determining whether you qualify. Usually, you may have no more than $2,000 in countable assets, although some states may have higher or lower thresholds.

Countable assets include:

- Checking and savings accounts
- Certificates of deposit
- Investments, including retirement accounts
- Life insurance policies with face values of more than $1,500
- Real property (whether your primary residence counts depends upon other factors)
- Motor vehicles, with some exceptions[4]

Assets that are not typically used in calculating Medicaid eligibility include:

- Equity in your primary residence up to certain thresholds may not be counted
- Personal property furniture and household items
- Life insurance policies with face values of less than $1,500
- Up to $1,500 in burial funds
- Assets held in certain types of trusts[4]

Because Medicaid is a joint state-federal program, the Medicaid eligibility rules vary from state to state. Some states have their own names for the program, such as "Medi-Cal" in California and "MassHealth" in Massachusetts. Rules tend to vary, so consulting with your attorney is important.

If you or a loved one is eligible for Medicaid assistance, the program may cover all or most of the costs of nursing homes or assisted living facilities. Typically, the program first requires that you use any assets you own to pay for your care. Different states allow you to retain different assets, including cash or home equity, so it's a good idea to visit your state's Medicaid website to find out the requirements in your state. You can find a directory of those sites at **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** to help you determine eligibility.

Are my retirement accounts "countable" assets?

For many Medicaid applicants, retirement accounts, including 401(k), 403(b) and individual retirement accounts (IRAs) are one of their biggest assets. The rules regarding IRAs and Medicaid are complicated and vary from state to state. Some states will not count retirement assets if they are in "payout status."

At age 72, individuals must begin taking required minimum distributions from their retirement accounts, which means the account is in payout status. You may be able to put your retirement accounts in payout status as young as age 59½ if you elect to take regular, periodic distributions based on life expectancy tables. If the retirement account is in payout status, depending on your state, it may not count as an available asset for the purposes of Medicaid eligibility, but the payments you receive will count as income.

If the account is not in payout status at the time you are seeking Medicaid coverage, the account is a countable asset, which means the total amount may be counted as an asset, affecting your Medicaid eligibility. Very few states do not count the principal balance of retirement accounts as a countable asset. Consult your attorney to learn your state's rules.

Note that the rules for a Roth IRA may be different than those for other retirement accounts. If you have a Roth IRA, depending on the rules in your state, it may not be exempt because Roth IRAs do not require minimum distributions.

How do annuities affect Medicaid eligibility?

Some people may consider the use of "immediate" annuities as a Medicaid planning tool. With an immediate annuity, you invest some or all of your retirement savings, and the annuity provider sends you a check based on factors including the schedule and for the time period upon which you agree.

The purchase of an immediate annuity may be a way for people with assets in excess of Medicaid's limits to turn the assets into an income stream while avoiding a penalty for transferring the assets.

Generally, an annuity must meet the following requirements in order to avoid a transfer penalty:

- The annuity must be irrevocable.
- The annuity must be actuarially sound, which means the annuity cannot cover a term longer than the purchaser's life expectancy and the payments expected during the annuitant's life expectancy must at least equal the cost of the annuity.
- The payments must begin immediately.
- Unless there is a spouse, minor or disabled child, the state must be named as the remainder beneficiary—the person or entity that gets any leftover money—up to the amount of Medicaid provided.

Some experts believe that the best use of an annuity for Medicaid planning is for married couples, one of whom needs Medicaid-covered long-term care. An immediate annuity allows the couple to turn their excess assets into income for the Medicaid recipient's spouse. If a spouse purchases an annuity that meets the requirements, he or she will receive the income from that annuity without having to contribute it to the Medicaid recipient's long-term care. However, the spouse will have to name the state as the remainder beneficiary for costs incurred by the Medicaid recipient as well as herself if he or she ever receives Medicaid.

Annuities can be helpful as a Medicaid planning device for single individuals but the benefit is limited. As with other planning, the rules vary from state to state.

If I need to spend down all of my assets for eligibility, how will my spouse's support needs be met?

If you are married, the government provides an allowance to ensure that the spouse who does not need care is allowed income and assets to live. These "spousal impoverishment" provisions allow some of the couple's combined income and assets to be set aside for the spouse who is not in the nursing home or assisted living facility, called the "community spouse."

Minimum Monthly Maintenance Needs Allowance (MMMNA)

Generally, the community spouse may keep his or her income; however, the income that the medicaid recipient would otherwise receive will be used to pay for his or her care. The community spouse may keep all of his or her income even if it exceeds the maximum monthly maintenance needs allowance, which is the amount of money he or she is permitted to keep to meet living expenses and other needs. If the community spouse does not have adequate income to meet the MMMNA, he or she is allowed to keep all or a portion of the income from the institutionalized spouse.

In determining how much income the community spouse is allowed to retain from the other spouse, states must abide by an upper and lower range set by the federal government. In July 2020, these were increased to:

- Monthly maintenance needs allowance: $2,155.00 to $3,259.50 (more in Alaska and Hawaii)
- Monthly housing allowance: $646.50 (more in Alaska and Hawaii)

Community Spouse Resource Allowance (CSRA)

In addition, the community spouse may set aside a certain amount of resources for himself or herself without jeopardizing the eligibility of the spouse that needs care.

- 2021 Minimum and Maximum Resources/Assets: $26,076 to $130,380[5]

For example, let's say Mr. and Mrs. Jones have a joint income of $4,000 a month, including a $2,500 pension Mr. Jones receives and $1,500 in Social Security benefits paid monthly to Mrs. Jones. Then, Mr. Jones enters a nursing home and applies for Medicaid. The Medicaid agency determines that Mrs. Jones's MMMNA is $3,100. Because Mrs. Jones's own income is only $1,500 a month, the Medicaid agency allocates $1,600 of Mr. Jones's income to her support. Because Mr. Jones also may keep a $50-a-month personal needs allowance, his obligation to pay the nursing home is $850 a month, which is calculated as $2,500 - $1,600 - $50 = $850.

In exceptional circumstances, community spouses may seek an increase in their MMMNAs either by appealing to the state Medicaid agency or by obtaining a court order of spousal support. Your elder law attorney can explain these options to you.

Home equity limits

Medicaid will not cover long-term care services for applicants whose homes are valued above a certain limit. In 2021, depending on the state where you live, you are allowed to have as much as $603,000 to $906,000 in equity. But the house may be kept with no equity limit if the Medicaid applicant's spouse, child under age 21, or blind or

disabled child is living in the home. The rule may also be waived by the state if it would cause an undue hardship.[4, 5]

Do these allowances extend to my domestic partner?

Yes, depending on your state. The Department of Health and Human Services announced that it will permit states to extend Medicaid long-term care protections, long available to spouses of nursing home residents, to same-sex domestic partners; if and how this is followed in your state is up to the state agency.

What is spousal refusal?

In some states, if a spouse refuses to contribute his or her income or resources toward the cost of care of a Medicaid applicant, the Medicaid agency is required to determine the eligibility of the nursing home spouse based solely on the applicant's income and resources, as if the community spouse did not exist. Very few states recognize spousal refusal, so it is important to consult your attorney to determine if your state will allow this.

What do I need to consider if I think I might need Medicaid in later years?

As you plan for your care as you grow older and you anticipate needing Medicaid assistance, it's important to know both the allowances your state makes for income and assets as well as any allowable expenses that may help preserve them. Planning should start well before you need care, however.

Medicaid reviews any gifts or asset transfers made within five years of applying for coverage for long-term care. If you have given away money or property within that period, that action may cause you to be ineligible for benefits for a period of time, depending on the amount given away, because it is assumed that those assets were transferred to avoid using them to pay for care. The period of ineligibility varies from state to state.

However, there are a number of exceptions to that rule. Both federal and state authorities allow certain transfers and expenditures without triggering an ineligibility period. These include:

- Mortgage payments or rent
- Utilities
- Credit card bills, automobile or personal loans
- Medical bills
- Taxes
- Home or car maintenance
- Caregiver expenses
- Loan prepayment

You may also spend savings on noncountable assets, such as buying a home or making home repairs, paying off a mortgage or prepaying funeral expenses.

How do gifts affect Medicaid eligibility?

Many people believe that if they give away an amount equal to the annual gift tax exclusion—which for 2021 is $15,000 to any one individual—this gift will be exempted from Medicaid's five-year look-back at transfers that could trigger a waiting period for benefits. This is not the case.

For example, let's say a grandmother gave her grandson $10,000 for college tuition over four years. The gift in this instance may have to be repaid. Although it could be argued that Grandma's purpose in making the transfers had nothing to do with qualifying for Medicaid benefits, in which case the gifts should not be penalized, the burden of proof will be against Grandma. It may depend on how much other money she had. If she only had a little more than $10,000 to begin with, it will be a hard case to make. If she had substantially higher assets, it might be easier.

Will I remain eligible if my community spouse dies?

When one spouse moves to a nursing home, it is sometimes expected that this spouse will be the first to die, but this isn't always the case. If planning steps aren't taken, the death of a spouse can affect the nursing home resident's assets and eligibility for Medicaid.

If the institutionalized spouse inherits resources previously held by the community spouse, it can affect the amount of assets the Medicaid recipient has and therefore, his or her Medicaid eligibility.

Suppose a community spouse dies and her will leaves her estate to her husband who is in a nursing home and receiving Medicaid. The additional assets will make her husband ineligible for Medicaid. Even if the community spouse's will did not leave anything to her husband, most states allow a spouse to claim a share of the estate. Medicaid can assess a penalty even if the husband does not claim his share.

The couple's house can also become a problem. If the community spouse dies and the Medicaid recipient inherits the house, depending on the state, the nursing home resident may have to prove either an intention to return home or a likelihood of returning home in order for the house not to count as an asset. If the resident sells the house, the proceeds from the sale will make the resident ineligible for Medicaid.

To prevent a community spouse's death from affecting the institutionalized spouse's Medicaid eligibility, it is important that the community spouse update his or her estate plan. There are steps the community spouse can take to protect the spouse in the nursing home, including setting up a trust.

What do I need to do now if I think I might need Medicaid later?

Whether you're planning for yourself or on behalf of a loved one, if you think you'll need to access Medicaid for assistance in paying for care, it's important to make yourself familiar about the various programs and allowances your state permits. Because these variables fluctuate widely depending on where you live, it's important to work with a knowledgeable wealth or estate planning attorney to determine the best options for your situation and the sooner the better. If you wait, it may be too late to take some steps available to preserve your assets.

Do I need to consult with an attorney?

Consulting with an attorney is the best course of action to both ensure you're adhering to Medicaid guidelines and protect your interests. The best plan is to consult with a qualified professional who can advise you on the entire situation. What you learn can mean significant financial savings or better care for you or your loved one. This may involve the use of trusts, transfers of assets, purchase of annuities or increased income, and resource allowances for the healthy spouse.

Navigating the many federal and state Medicaid requirements can be a confusing process, especially because so much varies depending on the state in which you live. If you think you're going to need long-term care and may need Medicaid to pay for it, it's a good idea to look into these requirements well before you may need them and work with a qualified elder care or estate planning attorney to determine the best decisions for your situation.



[1] Henry J. Kaiser Family Foundation website, **http://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight**

[2] LongTermCare.gov, Department of Health and Human Services website, "How Much Care Will You Need?" **https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html**

[3] Genworth 2019 Cost of Care Survey Summary, **https://www.genworth.com/aging-and-you/finances/cost-of-care.html**

[4] LongTermCare.gov, a Department of Health and Human Services website, "Financial Requirements – Assets," **https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets.html**

[5] Medicaid.gov, "2019 SSI and Spousal Impoverishment Standards," **http://www.medicaid.gov/Medicaid/eligibility/spousal-impoverishment/index.html**

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