Understanding Long-Term Care

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Avoid Being Unprepared & Overwhelmed

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To our clients: past, present and future.
Without you we would not be the
success we are!

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Disclaimer

I know this book is written by lawyers. Notwithstanding, you should not read it and then rely on it for legal advice. It is not intended to be legal advice, nor create any type of attorney client relationship and is only a discussion of legal issues by the authors.

If you have questions about any of the items discussed in the book, please go see an attorney well versed in these issues. Laws and regulations surrounding these issues are constantly changing and you need to consult with an attorney who is current on the law in this area.

Where the law and regulations intersect with reality you will find the interpretation and the implementation of the laws vary from county to county in Colorado. They shouldn't vary as they should all be applied the same. The fact of the matter is the different counties interpret the laws differently from time to time.

If this isn't frustrating enough, keep in mind there is further implementation of the law and regulations from one technician to another in any given county. So, keep this in mind when trying to figure out how to navigate through this complex area of the law.

Introduction

WHAT ARE THE FACTS I NEED TO KNOW ABOUT LONG-TERM CARE COSTS?

It is easy to find facts on the cost and the likelihood of needing assisted or long-term care. Just do an internet search of any question you want to ask and you will find lots of facts. Many of the facts should be viewed from the provider of the facts and their perspective. Over the last 25 plus years of counseling clients regarding the cost and financial planning surrounding long-term care, we have developed some of our own guideposts. They are as follows:

1. 1/3rd of men and 2/3rd of women over the age of 65 will spend some time in an assisted or skilled facility before they die.
2. Men will spend an average of 9 months in a facility. (Why? Many have a female companion who will care for them until they die or shortly before they do.)
3. Women will spend an average of 30 months in a facility. (Assuming the woman is living alone, having lost their male companion before their need to move to an assisted or skilled facility.) Simply put the female is less likely to have anyone living in the home to care for them.
4. With the average cost of care in Colorado according to the Colorado Department of Health Care Policy and Financing, being $8,609 per month for skilled

nursing care (one of the highest levels of care following only home health care 24/7) men may spend $77,481 and women may spend $258,609. (Note: Some sources peg the length of stay at 5 months for men and 8 months for women. So much depends upon your own health, genetics and other factors specific to you.)

Keep in mind these guideposts, based on our experience, are estimates and we view them as averages. Many individuals are not average. Those individuals with a dementia diagnosis, or "blessed" (or cursed) with longevity genes, may have a stay much lengthier than the averages. Those with an acute illness may need much less.

These averages (and the assumptions you make) are important in doing your planning. If you are purchasing long-term care insurance, how much coverage do you need? If you are an average male, then possibly a "bucket" of benefits you purchase may need to be only $75,000 - $80,00 adjusted for inflation based on your age and family history. If you are a female with a family history of both longevity and dementia (of one type or another) then you may need an insurance policy of coverage greater than $250,000 - $270,00.

Don't take our word about the high costs of long-term care. According to Genworth (a life insurance and long-term care insurance company from Richmond, Virginia) in their 2021 Annual Survey, in Grand Junction, Colorado:

- 70% of those over age 65 will need some form of long-term care services over their lifetime.
- 70% of caregivers had to miss some time for work.

- 66% of caregivers helped pay the cost to support the care from their own savings/retirement funds.
- In Grand Junction a private, one bedroom assisted living room costs $4,250 per Month or $51,000.
- A semi-private room in a nursing home in Grand Junction is $101,472 annually.

These are sobering numbers. With the current Consumer Price Index (CPI) for the first quarter of 2022 rising by more than 8%, the cost of long-term care is likely to rise by corresponding increases in the months ahead.

CHAPTER 1

2022 MEDICAID LONG-TERM CARE PLANNING GUIDE

There are generally five options available for payment of long-term care as we discuss in this guide. Not any one option is right for everyone. You must decide, based on your own situation, which of the options makes the most sense to you.

We explain to our clients the sooner you start thinking about planning for long-term care the more options you will have available to you. For example, if you are already in a skilled care facility the ability to purchase long-term care insurance is no doubt eliminated! You would end up with the same result if you wait to purchase the insurance until after you have been diagnosed with a terminal illness.

As you will see below (and elsewhere in this book) planning five years in advance of any need for assisted or long-term care can provide additional planning options. This is particularly the case where you are trying to protect assets for your heirs (perhaps your residence), while relying on the Medicaid program to help fund part of your cost of care. Medicaid has very strict rules about giving away your assets to artificially impoverish yourself. These so called transfer penalty rules exist in the Federal Medicaid

program, which are carried over in the Colorado rules of eligibility.

It is important to take into consideration the income tax aspects of any chosen option. Specifically, when transfering assets to heirs (perhaps in an effort to secure financial support from the Medicaid program) you are also giving your heirs your tax basis, which could cause them income tax issues (capital gains) when the asset is later sold. We see this frequently when parents try to give their residence to their children. Such transfers are trickier than you would think.

For example, let's say the parents transfer/gift their house to their children, and the house is currently worth $200,000. Let's assume the parents paid $100,000 for the house and therefore have $100,000 of gains, if they were to sell it. If the parents sell the house there is no tax on the $100,000 of gain because it is the parent's residence and under the tax code they do not need to pay any tax on this amount of gain as it is their primary residence.

Currently, an individual can exclude up to $250,00 of gain, while a couple can exclude up to $500,000. If the heir inherits the residence the heir gets a basis adjustment equal to date of death value. In this case the heir would get an "inherited basis" of $200,000. When the heir sells the residence he or she only pays tax on any gain if the property sells for more than $200,000 (the date of death value).

Now, what happens if the parent or parents give the house to the heir during his or her lifetime? Well, the heir gets the

house and also gets the parents basis of $100,000. This is referred to as "carry-over" basis. (See Internal Revenue Code section 1014) Therefore, when the heir sells the house the heirs must report gain of $100,000 ($200,000 minus $100,000).

There are planning options to avoid this result. The house can be transferred for purposes of the Medicaid transfer rules, yet transferring the new date of death value to the heir for his or her basis purposes. This assures the heir does not sell the house during the donor/parent's lifetime. This is done through the careful use of a "power of appointment".

Parents beware of transferring your house to your heirs or placing their name on the house. This should not be done without professional advice.

The point of this discussion is to let you know there are planning options, which can be employed to help you with preserving wealth for your heirs. You just need to ensure you do it correctly to avoid any unintended consequences.

For more information, read through our 2022 Medicaid Long-Term Care Planning guide, which can be found below, as well as on our webite. (www.brownandbrownpc.com)

2022 MEDICAID LONG-TERM CARE PLANNING GUIDE

NOTE: the "numbers" set out in this guide usually change each year. To ensure you are using the correct numbers consult with a professional regarding the current numbers as they might impact your planning. (Source: Colorado Department of Health Care Policy and Financing.)

Long-term Care Sources of Payment

Private Pay

- $8,609 average per month in skilled care statewide, according to the Colorado Department of Health Care Policy and Financing

Medicare

- Covers only medically necessary skilled nursing facility or home health care for a limited time per spell of illness
- Part A Hospital Insurance: no premium if more than 40 quarters worked; $274 premium per month if 30-39 quarters worked; $499 premium per month if less than 30 quarters
- Part B Medical Insurance: The standard monthly premium is $170.10There is an annual deductible of $233.
- Doesn't pay for custodial care
- 100% cost coverage first 20 days $194.50 patient co-pay per day for days 21 through 100 for skilled nursing facility stay each benefit period (spell of illness)

Veterans Benefits

- Long-term benefits generally provided only if you have a service-connected disability
- VA facilities (or contracted facilities) and must be receiving VA benefits
- May provide some home health care
- Co-payments may apply

Long-term Care Insurance

- Coverage and cost depend upon policy terms
- Helps pay the cost of custodial care such as housing, bathing, eating and dressing
- Doesn't usually pay rehab costs
- Hybrid policies may provide a death, respite or other care benefit

Medicaid

- State and Federal government program that generally pays for certain health services and nursing home care for older people with low incomes and limited assets
- Provides financial assistance in varied amounts for care in skilled nursing, assisted living and private home
- Five Criteria for Eligibility
    1. Health- must pass a health screen with a ULTC 100.2 exam to demonstrate need for care
    2. Residency- must be a Colorado Resident
    3. Income- applicant income must be below $2,523 per month; if it's above, but below the

average cost of care in the region ($8,980 for Mesa, Delta, Garfield, Montrose, Archuleta, Dolores, Eagle, Gunnison, Hinsdale, La Plata, Moffat, Montezuma, Ouray, Pitkin, Rio Blanco, Routt, San Juan and San Miguel Counties) an "income cap" trust can be established; long-term care insurance benefits do not count as income; and an applicant can keep $93.17 of his or her income monthly for personal needs

4. Personal Assets- program allows the applicant to keep certain limited assets such as a home equity maximum in a residence below $955,000 for singles and unlimited for couples; $2,000 of resources, such as cash; burial spaces and plans; life insurance policy with less than $1,500 in cash value; an automobile used to transport the applicant and personal effects. All other assets are deemed to be "countable" and could cause the applicant to be ineligible for Medicaid benefits.
5. Transfers prohibited- giving away assets will cause a period of ineligibility to exist during which Medicaid benefits will not be paid; all asset transfers within 5 years preceding the filing of an application will be counted, and the application should only be filed when the applicant is otherwise eligible for benefits.

Medicaid Planning Opportunities

- Special rules and benefits apply when the applicant is married. See discussion in Chapter 5
- Disability (d4a) Trust - shelters assets of those disabled and under 65, disabled beneficiary is sole beneficiary during life, CDHCPF (Colorado Department of Health Care Policy and Financing, agency who administers the Medicaid program) must be the primary beneficiary on death of the disabled applicant to extent of benefits paid on the disabled applicant's behalf
- Pooled Trust - trusts for a group of beneficiaries who are disabled
- Conversion of Countable assets to Exempt assets - buying residence, burial plans, paying down a mortgage, etc.
- Conversion of Countable assets to Income – purchase of a Medicaid qualified annuity
- Gifting of assets can be effective provided they are properly structured and timed
- Trusts created by a third party for a disabled individual are not deemed countable
- Personal Service Contract can remove Countable assets and provide for care by caregiver

Mental Capacity

- Critical to do planning while individuals have mental capacity
- Without capacity, it may be necessary to involve a court in appointing a conservator or guardian

When not to consider Medicaid

- If you have sufficient assets to private pay
- If you don't like relying on public assistance
- You prefer a facility that does not accept Medicaid (and have assets to cover your care)

Cautionary notes about Medicaid planning

- Rules are constantly changing, and the rules today may not be the same as when you actually apply
- There may be tax implications to different planning techniques which you should consider
- The CDHCPF looks upon planning for public benefits under the Medicaid program with very critical eyes and will deny eligibility where at all possible. Because of this, there is risk to undertaking Medicaid planning as there can be no guarantee you will be approved and thus your planning may be unsuccessful.

CHAPTER 2

CHECKLIST WHEN MOVING TO AN ASSISTED OR SKILLED FACILITY

Clients find this checklist a useful tool to remind you what it is you need to be thinking about, if and when you may need to consider moving to an assisted or skilled nursing facility. This checklist can also be found as a Special Report on our website (www.brownandbrownpc.com). Make sure you have checked all of the boxes which apply to you!

If you are planning to move to an assisted or skilled living facility, be prepared for a challenging task requiring extensive forethought. We know because our law firm helps clients with their transition. Based on our experiences, we've developed a checklist of questions you need to make sure you have addressed before moving day. If you answer any question "No" then you have some work to do before making your move. Seek professional advice if you need help with any of these items.

Checklist for Moving to Assisted or Skilled Care

☐ **Are my advance directives up-to-date**? Make sure you have the correct person(s) named to assist you in your medical and financial powers of attorney.

☐ **Does my will and/or trust name the person I want to administer my estate after I die?** If not, then you will need to make a change to your will and/or trust.

☐ **Is my will and/or trust up-to-date**? Make sure the heirs set out in your will are the ones you want to inherit your estate.

☐ **Have I determined how I will pay for this move**? The average cost of skilled care for 2022 in Colorado, according to the Colorado Department of Health Care Policy and Financing, is $8,609per month.

☐ **Have I carefully read through the admissions contract to make sure I understand it**? The admissions contract is binding, so make sure you understand the terms.

☐ **If I have a revocable trust estate plan, are all of my assets titled in the name of my trust**? You must coordinate the titles and beneficiary designations of retirement accounts and insurance policies with your trust. *Cautionary Note: If you own a home and plan to rely on Medicaid, it may not be best to own your home in your revocable trust.*

☐ **If I have a will estate plan, are my assets titled properly?** If you are titling assets in joint tenancy – even if it is just to provide assistance in bill paying –

you may defeat the terms of your will. Be careful!

☐ **Have I consolidated my investment accounts, making it is easier for my Agent to manage them**?

☐ **Is my "stuff" in order**? Use a personal property memorandum to identify the heir to receive specific items of personal property. Consider making lifetime gifts, so long as no-one is unduly influencing you.

☐ **Do I have a plan in place for getting my bills paid**?

☐ **Have I reviewed my plans with my attorney, accountant, and investment advisors to make sure everything is coordinated, and my wishes are reflected**?

If you are able to answer the above questions with "Yes," then you may have covered most, if not all, of the legal questions to ask yourself to ensure your move is as worry-free as possible. Every situation is different, so when in doubt, seek professional advice.

CHAPTER 3

LONG-TERM CARE INSURANCE

As discussed above, you can private pay for long-term care. To get an idea of how much it would cost to self-pay, let's take a husband and wife who spend the average amount of time in a facility (men – 9 months, women – 30 months). The cost of their combined care may be approximately $335,751.
An alternative to private paying is purchasing long-term care insurance. This type of insurance helps pay for the cost of long-term care. It normally covers home care, assisted living, adult daycare, respite care, and skilled nursing facilities.

You purchase insurance when there is a risk with a large price tag. For example, you have home insurance to cover the risk the house could be damaged or destroyed. The insurance will cover the costs if, and when needed.

With 1/3rd of men and 2/3rd of women over the age of 65 spending some time in an assisted or skilled nursing facility, there is a definite risk that comes with a large price

tag.

3.1 ESTATE PLANNING OBJECTIVES ACCOMPLISHED THROUGH INSURANCE

We believe the answer to this question lies in your estate and retirement planning goals. For instance, if you have sufficient assets to privately pay for the cost of long-term care, then you may decide to simply open your wallet and make the payment.

On the other hand, if you are trying conserve assets to pass to your children or provide for your spouse after death, then you may want to purchase long-term care insurance to insure against the loss of assets expended on long-term care costs. Ultimately, your decision will depend on your motive and ability to privately pay without depleting your estate if your objective is to provide for a surviving spouse or other heirs.

If you are concerned about providing for a spouse or not leaving an inheritance, you may consider purchasing life insurance instead. With long-term care insurance (which may cover assisted care or home health care in addition to skilled nursing home care) you are insuring against something which may never happen. The odds of you needing long-term care can never be 100% as you may die before a long-term care need arises.

Now death is another matter. With 100% certainty, you can guarantee you are going to die someday. This bet is a sure thing. You can buy life insurance to pay when you die and be assured the beneficiary on the life insurance policy will

receive the death benefit, thereby replenishing the amount (or at least some of it, if not more) spent on long-term care. Buying life insurance can be a bit tricky. You must buy a life insurance policy which is guaranteed to be there when you die. A term insurance policy will likely not work in this instance. Instead, you are going to need some type of permanent life insurance (whole or universal life insurance) which will be there when you die. However, if you need long-term care Medicaid, life insurance is a countable asset if the surrender value is more than $1,500.

3.2 TYPES OF LONG-TERM CARE INSURANCE

When shopping for long-term care insurance there are various options available. You should discuss the pros and cons of each type of policy with your financial advisor or insurance professional.

In particular, you can purchase a "stand alone" long-term care insurance policy which provides coverage for defined insurable events like home or auto insurance. Insurance companies are moving away from stand-alone policies due to greater difficulty in pricing these products and properly evaluating the risk.

Certain stand-alone policies qualify for Colorado's Long-

term Care Partnership Program. This program encourages

Coloradoans to purchase long-term care insurance by allowing Medicaid applicants to protect one dollar of personal assets for every dollar that their qualifying policy pays for them in long-term care benefits.

For example, if you had a qualifying long-term care insurance policy which paid out $100,000 and you still require care, you would be able to keep $102,000 and still qualify for long-term care Medicaid if otherwise eligible.

More insurance companies are now offering what is called a “hybrid” policy, which provides coverage for long-term care needs and a death benefit. In essence, it is a combination of life insurance and long-term care coverage. If you are evaluating long-term care policies, then you should keep the following in mind: (1) what is the triggering event for the policy (i.e. when will the insurance start covering me)?; (2) what is the deductible period?; (3) is there an inflation rider built into the policy to protect against increasing daily costs of care; and (4) what does the policy cover and exclude from coverage (i.e. is home health care covered, assisted living, or just nursing home care)?

If you decide to purchase long-term care insurance, make sure you understand your contract. You will need to know when the benefits are triggered. Is it triggered when you need assistance with 2 or 3 activities of daily living? Once you need assistance, how long until the insurance starts to pay?

Things to keep in mind:

- LTC insurance payments are not counted as income for eligibility purposes. The income is available for the patient payment.
- Make sure you look at a plan with inflation built into the payout. The cost of LTC services continues to rise.
- Plans are more user-friendly now and sometimes include a death benefit to the extend the LTC insurance wasn't used.
- Make sure you review the Benefit Triggers and understand when the insurance will pay and when it will not.

Remember, long-term care insurance is not always right for every situation. It is simply an option everyone should review to see if it helps you reach your estate planning objectives. Even if you decide long-term care insurance is not right for you, it behooves you to at least give it some consideration given the ever-increasing costs of long-term care.

CHAPTER 4

VETERANS ADMINISTRATION LONG-TERM CARE SERVICES

If you are a veteran and are planning to rely on the Veteran's Administration to help provide assisted or long-term care services for you, be prepared for a complex journey. Financial support to assist with payment of assisted and long-term can be attained, provided you qualify under very strict rules. Keep in mind the program is difficult to navigate and you will need to pull together a specialized team to assist you.

It is important to note, just because you are a veteran, it does not mean a bed is available should you need assisted or skilled care. There are facilities in Colorado which label their facility as a Veterans nursing home (or some variation), but the cost is usually subsidized, if at all, based on the veteran's ability to qualify for Medicaid.

Below, you can review in very general terms, the veteran's benefits, which may be available to you. These benefits,

along with other programs, such as Medicaid, can help pay in part the cost of assisted or long-term care.

4.1 OVERVIEW OF SERVICES FOR VETERANS

All “enrolled” Veterans are potentially eligible.

You must have a clinical need for the services.

The services you may be eligible to receive may include: Geriatric evaluation, Adult Day Health Care, Respite Care and Skilled Home Health Care.

4.2 SERVICE CONNECTED DISABILITY

A service connected disability is assigned a rating between 0%-100%. The rating generally equates to the severity of the disability. The greater a person’s disability is the higher the rating. If your disability is a total disability, then your rating would be 100%.

Depending on the extent of your disability and your rating, the Veteran will receive a monthly payment. A 100% disability and rating would entitle the veteran to the highest disability payment.

4.3 VETERAN'S PENSION

If a veteran has 90 days of active duty service, with at least one day during a wartime period the veteran may be eligible for a pension. (*Note: This is why it is so important to place the correct label on what the military is doing from time to time. Are we at war or not?)* For those serving after 1980 the veteran must have served at least 24 months or the full period for which you were called or ordered for active duty with at least one day during a wartime period.

Additionally, the veteran must be:

- Age 65 or older, **OR**

- Totally and permanently disabled, **OR**
- A patient in a nursing home receiving skilled nursing care, **OR**
- Receiving Social Security Disability insurance, **OR**
- Receiving Supplemental Security Income.

4.4 AID AND ATTENDANCE

A Veteran who needs assistance with activities of daily living, is bedridden, lives in a skilled nursing facility, or has poor eyesight can apply for Aid and Attendance. There is a monthly payment which is designed to pay for services. If a Veteran is housebound, he or she can receive funds to help pay for services in their home.

There are also income and net worth limits to be able to receive these benefits. For more detailed information on the available programs we recommend you start with, the website for the U.S. Department of Veteran's Affairs.

(www.benefits.va.gov/pension/vetpen.asp). From this website you will be able to see how it is the VA calculates the benefit they pay to you to help you pay the cost of any assisted or long-term care.

CHAPTER 5

MEDICAID – PLANNING OPTIONS

5.1 WHAT IS LONG-TERM CARE AND WHAT DOES THE MEDICAID PROGRAM COVER?

Long-term care is a range of services and supports you or a loved one may need to meet personal care needs. This includes assistance with the basic personal tasks of everyday life, referred to for Medicaid purposes as "activities of daily living" (ADLs). ADL's include bathing, dressing, using the toilet, transferring (to or from bed or

chair), caring for incontinence and eating.

If the Medicaid recipient requires skilled nursing facility (aka nursing home) level of care, Medicaid will pay for the costs of placement entirely, and Medicaid will pay for most physician services and the majority of prescriptions. However, any income the applicant receives will be paid to the skilled nursing facility except the first $93.17 (for 2022), which will go to the Medicaid recipient as the "personal needs allowance". An applicant also must meet the eligibility requirements as discussed in Chapter 1. Medicaid also has Home and Community Based Services (HCBS) which is a program designed specifically to keep people in their homes longer, thus avoiding placement in an assisted living or skilled nursing facility. The specific benefit that HCBS provides is for Home Healthcare workers to come into the patient's home for a set number of hours per week based upon the Medicaid recipient's needs. Also, HCBS Program will cover basic health care costs including doctor visits, hospitalization, and prescription medication costs. If you are staying at home, you will not have to pay most of your income to a facility.

HCBS will pay for the cost of an assisted living facility, which is generally between $3,000 and $4,500. In this case,

once again most of your income will go towards paying the costs of the assisted living facility.

Home Modification: There is a $14,000 lifetime Home Modification benefit *(Yes! If you qualify they will pay you!)* which can pay for home modifications that:

1. Are necessary to ensure the health, welfare, and safety of the Medicaid recipient; and
2. Enable the Medicaid recipient to function with greater independent in the home, and
3. Is required due to the Medicaid recipient's illness, impairment or disability; and
4. Prevents institutionalization of the Medicaid recipient.

5.2 I AM MARRIED. ARE THERE SPECIAL RULES WHICH APPLY TO MY SITUATION?

Community Spouse Planning Considerations and Techniques

Applying for Medicaid for a spouse can be emotionally difficult but add the application and eligibility criteria on top and the whole process can be daunting. The spouse that is not receiving Medicaid benefits is referred to as the Community Spouse. Community Spouses hear stories of

houses being taken and having to spend down all their assets to qualify their spouse for Medicaid. The alternative to Medicaid is not overly enticing either, as the cost of care for facilities keeps rising. For 2022, the average cost of skilled care in Colorado is $8,609 per month. For most people this cost alone would decimate a couple's savings in no time. Add the community spouse's living expenses on top of that and couples sometimes spend $9,000 - $11,000 a month just to live minimally. Rightfully so, we see many community spouses in a manic state trying to decide how to adequately care for their spouse and still be able to pay for their own living expenses.

The good news is Medicaid regulations carve out protections for Community Spouses. The Department understands Community Spouses need to afford to continue to live in the community and sustain expenses unrelated to the Institutionalized Spouses. The three main protections afforded Community Spouses are the following:

1. Community Spouses can keep $137,400 of additional assets above the exempt resources. (Referred to as the Community Spouse Resource Allowance (CSRA)).

2. Community Spouses are allocated a portion of the Institutionalized Spouses income depending on certain factors.

3. The Department gives separate treatment to resources post-eligibility.

These three protections allow Community Spouses to have a nest egg of money they can use for their own expenses and their long-term care in the future. Additionally, in some circumstances, income can be diverted to the Community Spouse from the Institutionalized Spouse. This increases the monthly income for the Community Spouse to assist with paying bills. Finally, once the institutionalized individual has been approved for Medicaid, there is separate treatment of resources between spouses. This allows the Community Spouse to plan for his or her own long-term care planning.

Explaining the Minimum Monthly Maintenance Needs Allowance (MMMNA)

As stated in #2 above, the community spouse may receive a Minimum Monthly Maintenance Needs Allowance (MMMNA). The basic MMMNA for 2022 is $2,177.50. This means that $2,177.50 of the Medicaid spouse's income can be given to the community spouse as the MMMNA. Additional allowances can be made, for excess shelter allowances (a mortgage to pay) for example, for a maximum of $3,435.00. This applies if the community spouse has less income than the MMMNA. This shifts income from the Medicaid spouse to the Community Spouse prior to any funds going to an assisted living or long-term care facility.

Let's make a plan

To best explain the planning considerations and techniques, let's look at John and Mary, our imaginary couple. John is

85, recently suffered a stroke and will need skilled care for the remainder of his life. Mary is 83, lives at home and is in relatively good health. Their resources include a house owned free and clear worth approximately $400,000, investments worth $100,000, checking and savings accounts worth $70,000 and two vehicles (one worth $5,000 and the other worth $10,000). John's gross monthly income is $2,500 and Mary's is $1,000. In order for John to qualify for Medicaid, he and Mary will need to spend down approximately $35,600 (includes institutionalized spouses $2,000 exempt amount) of their resources in excess of the CSRA.

So, keeping John and Mary in mind, here are the techniques and planning considerations they need to consider.

Income techniques and planning considerations.

Paying down debt

- If we change the facts of John and Mary's financial situation slightly and add credit card debt of $10,000 and an encumbrance on the $10,000 vehicle of $8,000, you can see how this approach works. This technique can be used for all kinds of debt, but some debt is more advantageous to eliminate than others. The monthly payments on credit card debt and car loans can be daunting along with all the other house bills if John's income is not available to assist with those bills. Paying down debt so there are no monthly payments can ease the monthly financial burden on Mary. Using $18,000 of the $35,600 is a good way to spend down the assets so Mary does not have monthly payments.

Again, this strategy likely will need to be implemented along with another strategy to complete the spend-down.

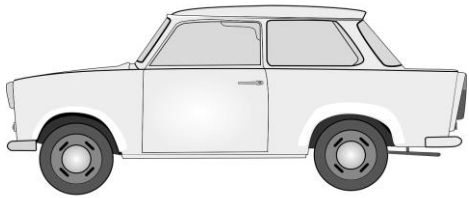
Purchasing a Medicaid compliant annuity

- The Community Spouse has the ability to purchase an annuity to increase income. Medicaid compliant annuities are used as a spend-down technique to turn a lump sum of money into an income stream for the Community Spouse. In this example, let's say John and Mary do not have any debts to pay off making them $35,600 over resourced. Rather than spending down the funds, Mary could purchase a Medicaid qualifying spousal annuity which would turn the funds into an income stream for Mary and immediately qualify John for benefits (assuming otherwise eligible). These types of annuities are tricky and are not something purchased in advance of applying for Medicaid.

- This type of planning should be done with much consideration because there are certain restrictions with using these types of annuities. Beneficiary designations must comply with the Medicaid Regulations in order to effectuate the purchase without causing a transfer penalty. This type of planning is especially important if the Institutionalized Spouse is not likely to live very long and there are no survivor benefits associated with the Spouse's income. Protecting the Community Spouse in this way is extremely important.

Increase expenses

- The amount of the Institutionalized Spouse's income which will be transferred to the Community Spouse is dependent on the expenses of the Community Spouse. In some circumstances, it makes sense to increase the Community Spouse's expenses, so more income is allocated to the Community Spouse. In our example, if Mary and John's resources were $50,000 and they owned their house free and clear, it may be a good idea to take out a mortgage on their house of $30,000. If they did so, their resources would be $80,000 and they would have a monthly mortgage expense. Mary would be allocated additional income from John each month to pay the mortgage. The effect of this type of planning would be to free up additional cash for Mary if she needs it, while also paying for the mortgage with John's income, which Mary otherwise would not have received. This can work nicely in certain circumstances.



Resource techniques and planning considerations

Upgrading a residence or vehicle

- One planning tool Mary has is to use the $35,600 which needs to be spent down on making upgrades or modifications to her home. Keeping her own long-term needs in mind, she may want to install grab aides and/or ramps or remodel her bathroom or

bedroom to anticipate her future needs. Improving the house so Mary can stay at home as long as possible is good forethought and planning. Additionally, Mary may want to sell both cars and purchase a newer vehicle which will provide her safe, comfortable transportation as she ages.

Prepaying for funeral and burial plans

- Converting non-exempt assets to exempt assets has long been a valuable way to spend down assets to

  qualify for Medicaid. With the $35,600 Mary and John need to spend down, they can purchase funeral and burial plans. Unless they intend to have exceptionally extravagant funerals, they will likely not spend the entire $35,600 on prepaid funeral plans so additional spend-down techniques will need to be employed. This strategy allows John and Mary to be able to use the spend-down money on something which will retain value. One concern many of our clients' share is not burdening their children financially after their death with funeral costs. This is an excellent way to pass value on to their children.

Estate Planning techniques and planning considerations.

Transfer assets to Community Spouse

- During the application process, and within a year from the determination of eligibility for the Institutionalized Spouse, all of the assets should be transferred into the Community Spouse's name. This is important to make sure the Institutionalized Spouse is not over-resourced at their

redetermination. It is important also because if the Community Spouse dies, any assets held jointly between the spouses will be transferred back to the Institutionalized Spouse, which could be problematic.

Updating estate planning to protect the institutionalized spouse

- One of the most important things a Community Spouse needs to do is to update his or her estate planning. A typical estate plan for a married couple is what we call "I Love You" wills where the spouses leave everything to each other. This type of planning is counterproductive once one spouse is on Medicaid. If the Community Spouse dies with an "I Love You" will, then all the assets in the Community Spouse's name will be transferred to the Institutionalized Spouse, causing the Institutionalized Spouse to lose Medicaid benefits. It is important to update the Community Spouse's estate plan to protect the Institutionalized Spouse as much as possible.

- It is also important to know a Community Spouse cannot disinherit the Institutionalized Spouse. Colorado has statutory law which does not allow for one spouse to completely disinherit the other spouse. This is called a spousal election. The law allows for a disinherited spouse to elect against the other spouse's estate plan and take some of the assets, depending on the asset's allocation. In the Medicaid regulations, if Mary tries to disinherit John, the regulations will require John to make an

election against Mary's estate should she predecease him. This election right needs to be considered when preparing estate planning for the Community Spouse.

Make transfers after institutionalized spouse is on Medicaid

- The regulations state after an Institutionalized Spouse has been determined eligible for Medicaid, the Community Spouse's assets are no longer

  considered for redetermination purposes. This allows a Community Spouse to employ long-term care strategies which may include making transfers of assets which do not impair the Institutionalized Spouse's benefits. In our example, Mary may want to make a transfer of her residence or cash to implement an asset protection long-term care plan for herself. She will need to wait until John has been determined eligible for Medicaid and then she can make the transfer, but very careful planning is needed with any gifting.

Using a Personal Service Contract to stay at home

- In some circumstances, Community Spouses discover living alone is more difficult than they anticipated. To facilitate the Community Spouse staying at home as long as possible, we often use Caregiver Agreements (also known as Personal Service Contracts) in which the Community Spouse hires a family member or friend to provide services for them at home. This allows for a transfer of assets between the Community Spouse and children

or other relatives. In our case, if Mary needs assistance with personal care or financial management, she can enter into an agreement with her daughter to provide care. The agreement spells out exactly the services to be provided and compensation to be paid. Keep in mind, this is income to the child and must be reported. It is imperative under the rules the agreement be in writing and notarized prior to any services being commenced.

- ***Note***: An Agent under a power of attorney, guardian, conservator or Trustee of the Medicaid recipient cannot execute the agreement and also be the caregiver in a caregiver agreement. Otherwise, Medicaid will count any payments as a gift, especially for family members.

5.3 CAN'T I JUST GIVE AWAY ALL OF MY ASSETS TO QUALIFY FOR MEDICAID?

Back in the late 1980s you could do just that. The day before you entered a skilled nursing home you could gift (usually by deed or bill of sale) your residence to your heirs. When applying for Medicaid you would not have any assets and would qualify for Medicaid assistance.

In 1993 the laws were changed, and a period of ineligibility was instituted as part of the eligibility process. At the time an application was filed a question was asked if any transfer (gift) was made within the last two years (the

"look-back" period), preceding the application. If a gift was made the value of the gift (say $50,000 in cash or an interest in a residence) was divided by the statewide average monthly cost of care. If the average cost of care was $5,000 then the period of ineligibility would be 10 months and the ineligibility period would start on the first day of the month in which the gift was made. Today such penalties start only after you are otherwise eligible—much more onerous.

This made planning fairly easy. Give away cash or other

assets and retain enough cash to private pay for the skilled nursing home care for the period of ineligibility. If done properly, the period of ineligibility expired about the time you run out of money and from that point forward you were eligible to receive Medicaid benefits.

Fast forward to today. The look-back period is now 5 years (60 months). The period of ineligibility is now imposed starting with the date a Medicaid application is filed demonstrating you are eligible, but for the running of any period of ineligibility. In English, this means it is important to make gifts of assets more than 60 months preceding the time you may need to apply for Medicaid (be in assisted or skilled care or receive HCBS).

Try to put this calculation in your crystal ball! To us, planning more than five years out with a combination of nursing home insurance and gifting is called "non-crisis planning". Waiting until less than five years before the need arises is the norm. We call this "crisis planning". Very few clients avoid crisis planning, so don't feel too bad.

Let's assume you (or a parent, other relative or friend) is in crisis mode. Crisis planning is the only option. Well, don't give up hope. There are still options, including gifting and saving assets for the heirs. The options are more limited, and will no doubt involve converting assets into income (through the purchasing of an annuity) rather than simply giving the assets away.

5.4 HOW DOES BUYING AN ANNUITY HELP ME WITH OBTAINING ELIGIBILITY FOR MEDICAID BENEFITS?

Individual: This gets a bit complex, but stick with me. If a person is trying to "spend down" and not gift assets to reduce those assets below the allowable amount ($2,000 for a single individual) then an annuity is one way to spend down resources. For example, let's assume Mr. Doe has $102,000 of cash. He can buy an annuity for $100,000 leaving him the exempt amount of $2,000.

The annuity has to be an "immediate pay" annuity meaning it must pay out over the lifetime of the annuitant and no longer. Let's assume Mr. Doe has a 5-year life expectancy. The annuity must begin to immediately pay out over the lifetime of Mr. Doe.

From a Medicaid eligibility perspective Mr. Doe no longer is deemed to have $100,000 of assets. Instead he now has income which must be taken into consideration in determining his eligibility and once he is eligible then the annuity payment will be paid toward his cost of care.

Spouse: Purchasing an annuity for a single applicant, such as Mr. Doe, may not make any sense. If there was a Mrs. Doe then purchasing an annuity might make some sense. For a married couple, the allowable amount of resources is $2,000 plus any Community Spouse Resource Allowance (the "CSRA"), which is currently $137,400.00. Whether an income annuity is a good idea is based on several factors including Mrs. Doe's income, the amount of the annuity to be purchased, the income it will kick off and be paid to Mrs. Doe, and the life expectancy of Mr. Doe. Purchasing an annuity can create greater income for Mrs. Doe while moving Mr. Doe toward eligibility and enhance the lifestyle of Mrs. Doe.

***Gifting*:** The way this option works is to gift as much away as possible and buy an annuity that will pay an income stream which will be enough to private pay for care during the period of ineligibility. Normally, gifting causes issues when trying to qualify for Medicaid. Therefore, this option requires careful planning. This option allows a person to gift out some of their assets rather than using assets to pay for care until eligible for Medicaid.

As an example, let's take Mr. Doe. He has $100,000 in nonexempt resources before he can qualify for Medicaid. Let's also assume he receives $1,000 in income a month,

and the cost of his care will be the State average of $8,609. In this case, he could make a gift of $53,082 which equals 6.16 months of ineligibility for Medicaid. Mr. Doe could purchase a Medicaid qualified annuity with the remaining $46,918 that would pay approximately $7,609 a month for 6.16months. The annuity with his income would cover the cost of Mr. Doe's care until he is eligible for Medicaid.

Warning: While the period of ineligibility is running, Mr. Doe has to maintain eligibility for Medicaid. One of the eligibility rules is his income cannot be above the average cost of care for the region in which he lives, and that amount varies across Colorado (see chart below).

Nursing Facility **Income trust gross income limits & average Private Pay Rate**	
	January 2021
Region I Counties: Adams, Arapahoe, Boulder, Broomfield, Denver and Jefferson	$9,500
Region II Counties: Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld and Yuma	$8,627
Region III Counties: Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, and Teller	$8,166

Region IV Counties: Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan and San Miguel	$8,145
Average Private Pay Rate	$8,609

For 2022, the Colorado Department of Health and Human Services has determined that the average cost of care for

Mesa County is $8,145 per month while in Denver it is $9,500. This means that Mr. Doe's income with the annuity cannot exceed the income he is permitted depending on where he lives.

Particularly in a county with a lower income cap, there may be a shortfall even with the annuity. For example, if Mr. Doe is at a facility that costs $9,000 but he can only receive total income of $8,145 to maintain eligibility, the facility is still owed $855 a month. This is another reason why this type of planning requires careful consideration.

5.5 WILL MEDICAID TAKE MY HOUSE? WHAT IS THE ESTATE RECOVERY PROGRAM?

Becoming eligible for Medicaid is one thing but protecting the exempt assets (such as your residence, vehicle, etc.) to pass to your heirs is another. Colorado, as does many other states, has a program allowing the State of Colorado to file a claim in the "probate" estate of any decedent who collected benefits in the form of payment of long-term care costs.

Let's use an example to explain how this works. Assume Mr. Doe spent 1 year in a nursing home receiving benefits under the State of Colorado Medicaid program (administered by the Colorado Department of Health Care Policy and Financing). Furthermore, let's assume during this 12-month period Mr. Doe received support for his cost of care of $8,609 per month for a total of $103,308. (This amount would be reduced by Mr. Doe's patient payment amount. For our example, we will just use the state average cost of care per month).

Because Mr. Doe died owning his residence and it was in his name (more on this below). In order for the title of the residence to be transferred to the heirs of Mr. Doe, a probate proceeding must be commenced in the District Court of the county in which Mr. Doe lived at the time of his death. In this proceeding, the court would appoint a Personal Representative and empower the appointed person to distribute the estate assets in accordance with Mr. Doe's written estate plan (i.e. his will) or as provided in the

Colorado intestacy laws (the statutory provisions on the distribution of a person's estate should they die without a written directive in the form of a will). Let's assume the court appoints the daughter of Mr. Doe, Nancy.

In this court proceeding Nancy must give the creditors of Mr. Doe an opportunity to file a "claim" in the estate. In fact, if Nancy knows of a creditor it is a "best practice" to send the creditor a notice of the death of Mr. Doe and the time limit on when a claim should be filed.

What usually happens following the commencement of the probate proceeding is the filing of a claim in the estate by the Department of Human Services. In our example, a claim in the amount of $103,308 would be filed. Because

Mr. Doe was receiving Medicaid benefits his cash resources would likely be limited to a very small amount. To pay the $103,308 claim, it would be necessary for Nancy to liquidate (sell) the assets in the probate proceeding, i.e.- the residence of Mr. Doe. Let's say the residence is valued at $225,000. After it is sold for this amount, the amount available to distribute is $121,692 minus closing costs.

When Mr. Doe applied for Medicaid benefits it was necessary for him to file an application and disclose all of his assets and any transfers he may have made within the last five years. Upon approval of the application, the Colorado Department of Health Care Policy and Financing, can file a "lien" against the residence of Mr. Doe. A lien is a statement filed with the Clerk and Recorder of the county in which Mr. Doe owns his residence indicating Mr. Doe

may be receiving an indeterminable amount of benefits under the Medicaid program. Before the lien can be removed, allowing Nancy to sell or transfer the residence from the probate estate, the amount of benefits paid on behalf of Mr. Doe must be reimbursed by the probate estate to the Colorado Department of Human Services. Liens may be used when all five of the following conditions are met:

- The department determines that the medial assistance recipient cannot reasonably be expected to be discharged from the institution and to return home; and
- There is no spouse of the recipient lawfully residing in the home; and
- There is no child of the recipient under age 21 or blind or disabled dependent of the recipient lawfully residing in the home; and
- There is no sibling of the recipient who has an equity interest in the home and who was lawfully residing in the home for at least one year immediately prior to the date the recipient was admitted to the institution; and
- Later recovery from the estate is likely to be cost-effective.

In order for a residence to qualify as an exempt asset for Medicaid purposes, the residence must be in the name of the Medicaid applicant. If the home is in a revocable trust or there is a beneficiary deed, the home will not qualify as an exempt asset until the property is put back in the name of the Medicaid applicant (and/or spouse).

Planning for the receipt of benefits is a good move, in many

cases, but if the estate recovery program requires the repayment of the benefit, why go through the effort?

Assuming the preservation of assets for the benefit of Mr. Doe's heirs is a goal of his, there are a few reasons. First, the amount of subsidy paid to a skilled care facility is usually less than the private pay rate. The State of Colorado, because it has a volume of recipients across Colorado, is able to negotiate better rates for its beneficiaries in Medicaid approved facilities. To become Medicaid approved you must agree to acceptance of the lower rates without a surcharge to the resident. Had Mr. Doe used his own proceeds to pay for the 12-month period of time the private pay rate may have been 5-15% greater

than the amount needed to reimburse the Medicaid expenses.

Second, as in the example, Mr. Doe's home had enough equity value to repay Medicaid and pass on some assets to his heirs. This does not always work out, but with Medicaid Mr. Doe did not have to sell his residence to qualify for Medicaid, allowing him to keep the equity in his home until he passed.

Planning to avoid the estate recovery system can be undertaken and the effectiveness of such planning requires careful study. Each person has a unique situation and the solution for one may not be the same for someone else.

Additionally, the Department will not recover medical assistance costs from the sale of a deceased recipient's home if:

1. The deceased recipient is survived by a spouse, child under age 21, or blind or disabled dependent residing in the home;

   OR

2. There is a brother or sister who lived in the home for at least one year before the recipient went into a nursing facility, and who has lived there continuously since the date of the nursing facility entry;

   OR

3. There is a son or daughter who lived in the home for at least two years before the recipient entered a nursing facility, whose care allowed the recipient to delay nursing facility placement, and who has lived in the home continuously since the date of the nursing facility entry.

5.6 HOW DO I PROTECT MY HOUSE?

There is the myth that as soon as you or your spouse applies for Medicaid, Medicaid or the skilled nursing

facility will take your home. This is not true. As explained above, there may be a lien placed on the home and the home may have to be sold after the death of an individual receiving long-term care Medicaid benefits to reimburse Medicaid for care related expenses. However, it may be possible to protect your house from estate recovery and there may be instances where your home is exempt.

Non-Probate Asset

If your home is owned jointly with another owner, the home does not pass through probate and is not available for estate recovery under current law. However, if you add a non-spouse heir (for example) to the deed within five years before qualifying for Medicaid, it will count as a gift. For example, if Mr. Doe is trying to qualify for Medicaid and he added his daughter Nancy to the deed in 2017, 50% of

the value of the home would be counted as a gift because it was done less than five years ago. If Mr. Doe added Nancy to the deed in 2013, it is more than five years ago and there would not be a period of ineligibility for gifting. In either case, if the property is left in joint tenancy, the property will automatically pass to Nancy at Mr. Doe's death and will not be available for estate recovery. Note: Adding a spouse as a joint tenant is okay because there is unlimited gifting between spouses.

Spouse

If the spouse is the owner, joint owner, or lives in the residence that is owned by the Medicaid spouse, there will not be estate recovery on the residence. The Community spouse will be able to keep the residence.

Child Under 21, Blind or Disabled Dependent

The home may be transferred to a child under the age of 21, or a child that is blind or disabled without receiving a penalty when qualifying for Medicaid.

Brother or Sister with Interest in the Home

The home may be transferred to a brother or sister who has an equity interest in the home and who was residing in the home for at least one year immediately before the applicant is institutionalized.

Son or Daughter of Individual

The home may be transferred to a son or daughter who was residing in the home at least two years before the recipient entered a nursing facility and whose care allowed the recipient to delay nursing facility placement. Documentation from the parent's attending physician will be required.

Gifting five years prior

As stated before, gifts that are made five years before applying for Medicaid will not incur a period of ineligibility under current law. Therefore, your home could be gifted, to your heirs for example, five years prior to applying for Medicaid. It is possible to lease the home back to continue to live in the home. This plan is assuming you will have enough assets to cover your care for five years, which is not guaranteed. Careful planning is required when considering such an option. Remember, be careful and make sure you consider income taxes when gifting a residence.

5.7 OTHER MEDICAID MYTHS

Donations to charity do not count as transfers. Unfortunately, any donation to a charity is considered a transfer without fair consideration under the Medicaid rules. Transfers create periods of ineligibility. A period of ineligibility means from the time the person is otherwise eligible and applies for Medicaid the person will have to privately pay until the end of the period of ineligibility. If you are charitably inclined but may need Medicaid in the future, it is important to talk to someone knowledgeable about planning in advance so you are aware of any consequences of your donations.

The account is a joint account, so it is not my asset. Many people add their children to their bank accounts as a way for their children to have access to the money should something happen to the parent. While this may seem like a convenient planning technique, it has adverse consequences. Upon applying for Medicaid, half of the amount may be considered a transfer to the child while the other half will be considered an available resource to the applicant. In order to remedy this, the child's name may need to be taken off the account. It is often difficult for banks to take one person's name off the account without closing the account and reopening it solely in the individual's name. This can be cumbersome

for automatic deposits of Social Security or other retirement income sources.

I can't give away any of my money and be qualified for Medicaid. Under the current regulations, a person can lawfully give away some of their assets and still qualify for Medicaid. This has to be done thoughtfully and carefully. A transfer creates a period of ineligibility. As discussed above, there are ways to pay for the individual's care during that period of ineligibility and still qualify them for Medicaid upon the exhaustion of the period of ineligibility. This should not be done without careful planning.

Both my spouse and I must have resources under $2,000.00 before one of us will qualify. If one person in a couple needs Medicaid but the other does not, the regulations provide for spousal protection for the community spouse. The institutionalized spouse must spend down their assets to under $2,000.00. Transfers between spouses do not create a period of ineligibility. The community spouse can keep assets valuing up to $137,400 for 2022. This number is above and beyond the exempt resources of a house, a car, a small life insurance policy and funeral or burial plans. If both spouses need Medicaid, their combined resources must be less than $3,000 for skilled care and $4,000 for assisted living.

5.8 WHAT IS THE ABLE ACT?

The federal ABLE Act was signed into law on December 19, 2014. It marked the end of a campaign that began in 2006 to approve the use of tax-free savings accounts for individuals with disabilities to cover expenses not covered

by government sponsored programs. It is important because it shines a light on the extra and significant costs of living for a person with disabilities and shows the need to have sustainable options for people with disabilities.

Goal: Allow those with disabilities to have a supplemental source of income beyond those provided by governmental programs, such as Medicaid and Social Security.

What does the Act do? Allows individuals who have been diagnosed with a disability before age 26 to open an ABLE account (limit 1 per person), which can accept up to the annual gift-tax exemption amount ($16,000 for 2022) per year, similar to a 529 college savings account. The account funds can then be used for the following: Education, housing, transportation, employment training and support, assistive technology and personal support services, health,

prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses, which are approved by the U.S. Secretary of the Treasury under regulations and consistent with the purpose of the Act.

Who Qualifies to Get an ABLE Account*?*

- Qualify in 2 ways:

    1. Anyone diagnosed as disabled before age 26 and receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

2. Anyone diagnosed as disabled before the age of 26 and *certified* as meeting the conditions similar to that required by SSI or SSDI.

    - Any individual who has been diagnosed with a disability before the age of 26 years old, who has a medically determined physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months or is blind, and provides a copy of their diagnosis by a physician.

    - Developmental disabilities probably will not be difficult to get certified for before the age of 26. More difficult will be mental health issues – when did they start and how to show? Need to save records of mental health issues to help get certified for an ABLE account when it is available.

ABLE Act and SSI

- If the beneficiary is receiving SSI benefits, when the assets in the account total $100,000, any monthly SSI benefits will be placed on suspension. (Actually, $102,000 because you can have $2,000 in assets and remain on SSI benefits).

- If the assets drop back below $100,000, the SSI benefit suspension ceases and any SSI benefits resumes.

- The beneficiary will not have to reapply for SSI benefits once the account drops back below the $100,000 threshold.

ABLE Act and Medicaid

- ABLE account beneficiaries **do not lose** Medicaid eligibility based on assets in their ABLE account or suspension of SSI benefits.

Penalties

- Withdrawals must be for qualified expenses or else the earning portion would be subject to regular income tax and a 10% penalty (state penalties would also apply).

Medicaid Payback

- In the event the qualified beneficiary dies with remaining assets in the ABLE account:
    - The assets in the ABLE account are first distributed to any State Medicaid plan that provided assistance to the designated beneficiary.
    - The amount of any such Medicaid payback is calculated based on amounts paid by Medicaid after the creation of the ABLE account.

- There is legislation pending regarding CO ABLE accounts, so be sure to review the current rules when setting up an account.

Administration of the ABLE Act

- The Colorado ABLE program is administered by CollegeInvest and additional information on setting up an account can be found at: www.coloradoable.org

CHAPTER 6

ESTATE PLANNING AND ADMINISTRATION

6.1 WHAT ARE ADVANCE DIRECTIVES?

What about Advance Directives? What are they?

An advance directive refers to a direction given in advance of a person's wishes should they not be able to make either medical or financial decisions on their own. These usually take the form of a medical power of attorney, living will or financial power of attorney. A person can appoint an individual or entity to make financial or medical decisions for them if they lose capacity. We often advise our clients to appoint successor Agents should their initial Agent not be able to act so there is some longevity to the documents.

Do I need Advance Directives?

Yes! We recommend all of our clients execute advance directives. According to the Alzheimer's Association, 1 in 3 seniors will die with Alzheimer's or other type of Dementia. This means 1/3 of the senior population will need assistance with making financial and medical decisions. The benefit for signing advance directives is the ability of appointing the person or entity you would like to make those decisions for you.

Advance directives are your opportunity to ensure you will receive the type of care you desire in your aging years as well as make sure finances are managed by someone you trust.

When dealing with long-term care planning having an advance directive with gifting and transfer provisions is essential to being able to implement a plan.

What if I do not have Advance Directives?

If you have not executed advance directives and you lose capacity, it may be necessary to have a Court appoint someone to make decisions on your behalf. This process is called a guardianship or conservatorship proceeding. A guardianship is a legal proceeding through which a guardian is appointed to make personal care decisions for an individual. The individual subject to a guardianship is referred to as the "ward." A conservatorship is a legal proceeding where the court appoints a conservator to manage, preserve, and protect an individual's assets. The individual subject to a conservatorship is referred to as the "protected person." (*Note: see more detail on this process in Chapter 8.)*

Some courts are willing to assist in creating a long-term care plan for individuals who are incapacitated. Others are not. This is particularly so when gifting of an incapacitated persons' assets is involved. A financial power of attorney with gifting authority will help avoid the need of bringing the issue before a judge who must substitute his or her judgment for the incapacitated person when evidence of the incapacitated person's wishes is probably sketchy at best.

6.2 WHAT ARE SOME OF THE MOST COMMONLY ASKED QUESTIONS ABOUT ESTATE PLANNING?

When we meet with clients, they often ask similar questions. They want information to help them make the best estate planning decisions for themselves. Below are some of the more commonly asked questions.

What is a Will?

A will is a testamentary document which controls the disposition of an individual's probate assets at their death. Probate assets are any assets owned individually by an individual at their death. An asset with a payable on death designation, beneficiary designation or joint tenancy owner is not a probate asset and not controlled by a will. A will also appoints a Personal Representative to administer the will. For parents of minor children, the will can appoint a Guardian and Conservator for those minor children. A will is considered a testamentary document because it only becomes effective at an individual's death. Wills can be amended by executing a codicil or if there are significant changes to be made, by executing a new will.

What is a Trust?

A trust is an entity which holds assets for the benefit of the beneficiaries. A Trustee manages the assets and makes distributions pursuant to the terms of the trust. The most common type of trust is a revocable or living trust. This is a trust established by an individual or couple and funded by individual's assets and benefits the individual during his or

her lifetime. Upon the settlor's (person creating the trust) death, the trust is administered for the benefit of the named beneficiaries. Assets titled in the name of the trust are not probate assets at the death of the settlor, which means the disposition of the asset will be controlled by the terms of the trust rather than the terms of the will.

How often should I review my estate plan?

We recommend reviewing your estate plan every 3-5 years to make sure it remains consistent with your wishes. If a life event, birth, death, injury to a beneficiary or Agent occurs, you will want to review your estate plan at that time. Additionally, Federal and State laws change, which may directly affect your estate plan and necessitate reviewing and potentially making adjustments to your estate plan.

What does my net worth need to be to use a trust?

There is a common misconception that a trust estate plan is only for people with substantial assets. This misconception often precludes individuals from looking at the benefits of a trust, despite the size of their estate. If a trust is properly funded and remains funded with the individual's assets, at the individual's death there may not need to be a probate proceeding. Additionally, if an individual owns property in another state, using a trust can avoid a probate

proceeding in Colorado and an ancillary proceeding in the other state. Often clients like the privacy of trusts. Unlike wills, which may become public documents at an individual's death, trusts remain private and are only shared with the beneficiaries listed in the trusts. This can be advantageous in situations where beneficiaries are not treated equally or there is a disinherited individual. Finally, trusts can be used for incapacity planning. Along with an Agent under a Financial Power of Attorney, a Trustee can manage assets on behalf of an incapacitated individual.

What is Probate?

Probate is a general term for the court proceeding which commences at an individual's death. The purpose of the proceeding is to appoint a Personal Representative to administer the individual's estate for the benefit of creditors and beneficiaries. Colorado has adopted the Uniform Probate Code which streamlines our probate process, unlike other states where probate can be a long, arduous and expensive proceeding. The Personal Representative needs to meet certain statutory obligations such as filing an inventory, notifying creditors and keeping an accurate accounting of the estate assets. Typically, probate

proceedings take 6 months to a year or more to complete depending upon the complexities of the particular estate.

Note: All who may be eligible for long-term care Medicaid in the foreseeable future, may want to consider a will estate plan. Under the Medicaid rules, your home is an exempt asset as long as it its titled in your (or you and your spouse's) name. If it is in a trust, it will be considered an available asset which will most likely cause you to be

disqualified for long-term care Medicaid until the home is re-titled into your name. Re-titling a home is not a difficult process, but you are essentially undoing the trust planning, in part.

6.3 WHY THERE IS NO SUCH THING AS A SIMPLE WILL.

We often hear from clients they want to keep things simple. We understand this sentiment and strive to keep things simple in our own estate plans (if possible). So, what does "simple" really mean? Merriam-Webster defines simple as "not hard to understand or do; having few parts: not complex or fancy; not special or unusual." Applying this definition to an estate plan is inherently difficult. The law is complex. Families are unique. Life is unpredictable. So how do you accomplish keeping things simple during your life and after your death? Here are five things to think about.

1. Plan ahead: No one likes to think about death or incapacity, but it is important to plan for both. Creating an estate plan which passes your assets in accordance with your wishes is the only way to ensure your

family will know and follow your wishes. Similarly, loved ones trying to help you during a period of incapacity need the legal authority through powers of attorney to make medical and financial decisions for you.

2. Organization is key: Keep your original documents in one place and let your nominated Agent or Personal Representative know where you are keeping your documents. Keep an accurate description of your assets with your original documents so your Agent or Personal Representative knows what you own.

3. Assemble a good team of advisors: Financial advisors, accountants, and attorneys all contribute different expertise to your estate plan. It is important each know and understand what your wishes are so they can advise you accordingly. Your loved ones will also benefit from a well-established team of advisors they can rely on for assistance in the event of your incapacity or death.

4. Coordinate your assets: If you establish a trust,

   make sure you re-title assets into the name of the trust. Assets outside of a trust in your name individually will potentially trigger the need for a probate, which is one of the main reasons people choose to create trusts. If you have a will estate plan, do not add children or other individuals as

joint owners of the account or payable on death beneficiaries. Doing so will cause those assets to pass outside of the probate proceeding and consequently the will does not govern those assets. Titling assets is extremely important to ensure your estate plan will dispose of your assets the way you desire.

5. Protect vulnerable beneficiaries: It is appealing to clients to leave assets outright to beneficiaries. In many circumstances this is the appropriate distribution method for beneficiaries, however, creating a specialized trust for some beneficiaries is worth considering. Beneficiaries who are minors should have a trust established for them until they reach a certain age. Disabled beneficiaries would benefit from a special needs trust, so they do not lose their public benefits. Beneficiaries with a drug or alcohol problem or who are not good with money may benefit from a discretionary trust. We are also finding more and more clients interested in asset protection trusts for their beneficiaries. These are specialized trusts designed to cascade through generations while providing tax benefits and insulation from creditors of beneficiaries.

6.4 WHAT IF THE COMMUNITY SPOUSE DIES BEFORE THE INSTITUTIONALIZED SPOUSE?

It is important for the Community Spouse (the non-institutionalized spouse) to review his or her estate plan. Usually, we find the couple is likely to have an "I Love You" estate plan, which provides the assets of the first to die pass to the surviving spouse. This usually makes sense, except perhaps in the case of a second marriage, where there is a blended family.

If the Community Spouse dies with an "I Love You" will in place the assets will pass to the institutionalized spouse. In most cases this is not what should happen. First, if the institutionalized spouse is on Medicaid it simply exposes more assets to the estate recovery program and will likely disqualify the institutionalized spouse for Medicaid benefits.

Second, even if the institutionalized spouse is not on Medicaid, management of the assets is likely to be a problem. The assets should probably not pass to an individual who is not able to pay bills, write checks, make investment decision, etc. You get the point.

Instead, it likely makes the most sense for the Community Spouse to make changes to his or her estate plan. Perhaps the assets should be left in trust for the benefit of the

institutionalized spouse. Another option would be to consider making gifts of assets during lifetime. If the surviving institutionalized spouse is on Medicaid it may be necessary to place the assets in a special type of trust referred to as a "Spousal Election Trust" and then leave the balance of the assets into a trust, the assets of which are not going to be countable for purposes of Medicaid.

Bottom line: The Community Spouse needs to review his or her estate plan when the institutionalized spouse is placed in a skilled facility. It is actually best to anticipate the placement and get the planning wrapped up well in advance of placement.

Keeping all of these things in mind might not make planning seem so simple right now but will make things easier for you and your family in the years to come.

CHAPTER 7

NURSING HOME RESIDENT RIGHTS

WHAT ARE MY RIGHTS AS A NURSING HOME RESIDENT?

If you are a resident at a skilled nursing facility, the U.S. government has enacted guidelines for your health, safety and security. According to the U.S. Department of Health and Human Services website, your rights include:

- Respect: You have the right to be treated with dignity and respect.
- Services and Fees: You must be informed in writing about services and fees before you enter the nursing home.
- Money: You have the right to manage your own money or to choose someone else you trust to do this for you.
- Privacy: You have the right to privacy, and to keep and use your personal belongings and property as long as it doesn't interfere with the rights, health, or safety of others.
- Medical Care: You have the right to be informed

about your medical condition, medications, and to see your doctor. You also have the right to refuse medications and treatments.

Ombudsman Program

The Colorado Department of Human Services offers an Ombudsman program designed to protect the health, safety, welfare and rights of residents in licensed long-term care. Ombudsmen are advocates who work to resolve individual resident issues and to bring about changes at the local, state, and national level to improve long-term care.

Current ombudsman contacts:

- Region 11: Mesa, Garfield, Moffat and Rio Blanco & Routt counties. Contact Heather Jones (970) 248-2717, heather.jones@mesacounty.usRegion 10: Gunnison, Hinsdale, Ouray, Montrose, San Miguel and Delta counties. The contact person is Sandy Walker at (970) 765-3131, sandy@region10.netFor Mesa County specifically, contact Robb Huff 970-243-7940 ext. 4, rhuff@colegalserv.org; Heather Jones 970-248-2717, heather.jones@mesacounty.us; and/or Marilyn Richardson 970-243-7940 ext. 5, mrichardson@colegalserv.org

Watch out for Financial Exploitation!

The elderly are often victims of financial exploitation and the perpetrator is frequently a family member or close friend. If you suspect something is going on, get to an attorney quickly before the damage becomes irreparable.

You can also report suspected exploitation to your county Adult Protective Services.

CHAPTER 8

CONSERVATORSHIP AND GUARDIANSHIP PROCEEDINGS

In Colorado, a guardianship is a legal proceeding by which a guardian is appointed to make medical and other personal care decisions for an individual. The individual subject to a guardianship is referred to as the "ward." A guardian may be called upon to decide if the ward needs to reside in some form of assisted living facility.

A conservatorship is a legal proceeding where the court appoints a conservator to manage, preserve, and protect an individual's assets. The individual subject to a conservatorship is referred to as the "protected person." A conservator may also have responsibility for the legal affairs of the protected person.

Prior to the appointment of a guardian or conservator, the individual is called the "respondent." The individual seeking to be appointed as guardian and/or conservator is referred to as the "petitioner."

Legal Process

The guardianship and conservatorship procedures in Colorado are similar, and oftentimes both are requested at the same time by the petitioner.

Guardianships and conservatorships are both initiated through the filing of a petition for appointment of a guardian and/or conservator. These cases typically must be

filed with the Colorado district court in the county where the respondent resides. The petition may request the appointment of either a limited or unlimited guardian or conservator. A limited appointment typically requests a narrow scope of authority. For example, one could petition the court to be appointed as a limited conservator for purposes of selling real estate. Most often, however, petitioners are seeking unlimited appointments.

Furthermore, a petition could also seek the appointment of an emergency guardian or special conservator when exigent circumstances exist, for example, when the respondent may suffer significant personal or financial harm without prompt intervention by the court. The petitions require specific inclusion of certain information, including a description of why a guardianship or conservatorship is necessary. In addition, petitions typically require a letter from the respondent's physician or other medical evidence supporting the appointment of a guardian or conservator.

After the appropriate petitions are filed, the court will appoint a court visitor to investigate the allegations within the petitions. The court visitor is typically a social worker or an attorney, depending on the county in which the

petition is filed. The court visitor will interview the respondent as well as family members and may obtain medical information from the respondent's healthcare providers. After this investigation, the visitor will prepare a report to the court giving recommendations as to whether a guardian and/or conservator is necessary and whether the petitioner is the appropriate party to serve as guardian and/or conservator. A court hearing is required prior to the court appointing a guardian or conservator. The respondent is required to attend the hearing unless excused for good cause by the court. The nature of the hearing depends upon whether the guardianship or conservatorship is contested or uncontested. The hearing could be contested by the respondent objecting to the appointment of a guardian or conservator, or there could be individuals competing to be appointed as the respondent's guardian or conservator (e.g., different siblings battling to be appointed as Mom's guardian and conservator).

In either case, in order for a court to appoint a guardian, the court must find by clear and convincing evidence that the respondent is an "incapacitated person." Incapacitated person is defined in Colorado as an individual other than a minor, who is unable to effectively receive or evaluate information or both or make or communicate decisions to such an extent that the individual lacks the ability to satisfy essential requirements for physical health, safety, or self-care, even with appropriate and reasonably available technological assistance.

The courts rely heavily on medical or psychological evidence to determine whether the respondent is an incapacitated person. Prior to appointing a guardian, the

court must also find, again by clear and convincing evidence, that the respondent's identified needs cannot be

met by less restrictive means, including use of appropriate and reasonably available technological assistance.

With respect to the appointment of a conservator, the court must make the following findings: (1) by clear and convincing evidence, the individual is unable to manage property and business affairs because the individual is unable to effectively receive or evaluation information or both or to make or communicate decisions, even with the use of appropriate and reasonably available technological assistance; and (2) by a preponderance of evidence, the individual has property that will be wasted or dissipated unless management is provided.

Once a guardian or conservator is appointed, the individual's authority to act is evidenced by documents entitled: "Letters of Guardianship," "Letters of Conservatorship," and "Order Appointing Guardian (or Conservator)." The conservator will utilize these documents at the outset to establish a conservatorship account(s) with a financial institution. Within sixty days of appointment, the guardian is required to file an initial Guardian's Report. Thereafter, the guardian is required to file annual reports with the court. No later than ninety days

after appointment, a conservator must file an initial Conservator's Inventory with Financial Plan. Annual Conservator's Reports must be filed with the court after this initial filing. The court may impose a bond requirement on the Conservator unless the court finds the bond is not warranted under the circumstances (e.g., minimal liquid assets).

Both the guardianship and conservatorship statutes in Colorado specify the powers of the guardian and conservator as well specific actions that require court approval. Accordingly, it is important for guardians and conservators to understand the authority they have and to conduct their duties withing the authority they have been granted by the court and Colorado law. Guardians and Conservators must also be sure to fully comply with their reporting requirements.

Disclaimer (Again)

I know this book is written by lawyers. Notwithstanding, you should not read it and then rely on it for legal advice. It is not intended to be legal advice, nor create any type of attorney client relationship and is only a discussion of legal issues by the authors.

If you have questions about any of the items discussed in the book, please go see an attorney well versed in these issues. Laws and regulations surrounding these issues are constantly changing and you need to consult with an attorney who is current on the law in this area.

Where the law and regulations intersect with reality you will find the interpretation and the implementation of the laws vary from county to county in Colorado. They shouldn't vary as they should all be applied the same. The fact of the matter is the different counties interpret the laws differently from time to time.

If this isn't frustrating enough, keep in mind there is further implementation of the law and regulations from one technician to another in any given county. So, keep this in mind when trying to figure out to navigate through this complex area of the law.

About the Authors

BAIRD B. BROWN, ESQ.

Baird has over 46 years of experience in family wealth preservation, focusing his practice on tax, estate planning and administration, long term care and special needs planning. He graduated from the University of Colorado with a Bachelor of Arts degree in Economics in 1972 and received his law degree from Willamette University in 1975. He founded the law firm of Brown & Brown, P.C. and has practiced in the Western Slope since 1975.

Baird is actively involved in the legal industry:

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Baird also has been a guest speaker at various legal continuing education events periodically throughout the United States.

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