The Intersection of Long Term Care Costs, Estate Planning, Assets Preservation, and Ethics

Sandra M. Schildgen,
with contributions from Ben A. Neiburger

Generation Law
747 N. Church Road
Suite B4
Elmhurst, Illinois 60126

Illinois Medicaid Rules and Procedures Bootcamp
Thursday, October 12, 2017
ISBA Regional Office
20 S. Clark Street
Suite 900
Chicago, Illinois

Introduction

"I want to live in a nursing home." said no one, ever. Despite this desire, it often becomes the reality for many elders or persons with disabilities. There are a very lucky few that either have (1) family members with the ability and will to indefinitely care for the person at home for little to no pay or (2) enough assets to pay for in-home caretakers for life. Most Americans facing disabling conditions that require 24-hour skilled care are not so lucky and must transfer from their homes to a skilled nursing facility.

I. The State of Long-Term Care Costs

The overriding concern in the Elder Law practice for clients that need to enter a long-term care facility is how to pay for long-term care. This is an understandable concern with many long-term care facilities in the Chicago-Naperville, Elgin area charging between $4,050 and $10,650 per month for care (that's $48,600 to $127,800 per year) with a median annual rate of $82,125 ($6,843.75 per month) for a semi-private room.[1] A typical married couple in their 70's may have only $50,000 to $200,000 in life savings, plus a primary home. This means that if one spouse needs to spend enter a long-term care facility, he or she could burn through the couple's life savings in a year or two, if that.

The need for long-term care arises when a person begins to lose the ability to perform "activities of daily living." An activity of daily living is a basic task that a person does in everyday life, such as eating, bathing, dressing, toileting, and getting in and out of chairs and beds. As a person loses the ability to perform these activities of daily living, and their loved ones cannot help them restore or with these activities because of health issues or time commitments, the person must look outside the home for help. State-wide home healthcare costs are also high (between $150 and $264 per 8-hour day - or $4,500 to $7,920 per month) and Medicaid will only pay for a very limited amount in-home health care.[2] Thus, many elders are forced leave their home and enter a long-term care facility such as nursing home.

There are four ways to pay for long-term care: (1) long-term care insurance, (2) paying with your own savings (also called private pay), (3) Medicare, and (4) Medicaid.

Clients should obtain long-term care insurance if they can. It is one of the best ways to pay for care and may even enable the elder to receive long-term care in their home. Unfortunately, long-term care insurance has only started to become popular in the last few years and most people facing loss of activities of daily living or who need to live a nursing home do not have this coverage or cannot obtain it.

Although long-term care insurance is one of the most desirable options for paying for long-term care, long-term care insurance has some disadvantages. It is often purchased as a rider to a

[1] Genworth 2015 Cost of Care Survey, Illinois
[2] Id.

life insurance policy, but it can be so expensive that many seniors cannot afford to pay the premiums. Even if a senior has long-term care insurance, he or she may not have long-term care insurance with sufficient coverage. Elders may have a policy that pays $100 per day for care when their actual care costs are $135 to $355 per day. Some people cannot even purchase long-term care insurance even though they could afford the premiums. Many insurance companies that offer long-term care insurance policies apply very strict underwriting requirements. This means that, generally, the companies will not offer a long-term care policy to a senior who is not in good health. Moreover, many carriers no longer offer this type of coverage.

While most seniors do not have long-term care insurance, most are eligible for Medicare coverage. Medicare is the national health insurance program primarily for people 65 years of age and older. Medicare provides short-term assistance with facility costs but only for purposes of receiving rehabilitation services. The benefit will cover a stay up to 100 days.

A senior who needs to be in a skilled nursing facility for more than 100 days of rehabilitation must soon look for other financing sources when the Medicare rehabilitation benefit runs out. Frequently, this means using savings to pay for care and maybe selling the home to raise these funds. Unfortunately, few people can afford a long-term stay in a skilled nursing facility at a cost that can be as high as $127,800 per year.

The last option seniors have in paying for long-term care is enrolling in Medicaid. Medicaid pays for more than half of the long-term care costs in the U.S. Medicaid is a Federal- and State-funded and State-administered medical benefit program that can pay for the cost of the nursing home if a person meets certain strict asset and income tests. The Medicaid program is typically the program of last resort. However, with proper planning, it may be possible for a person to both qualify for Medicaid and conserve some of his or her assets for a spouse, children, or grandchildren.

Paying for long-term care is a major concern for seniors. It can potentially wipe out a couple's life savings in a year or two. With advanced planning, such as purchasing long-term care insurance or properly using the Medicaid program, a senior can receive the long-term care he or she needs at a cost that will not wipe out a life's worth of savings.

II. What is Medicaid?

Medicaid is a joint federal-state welfare program that provides health and long-term care assistance to low-income families, the disabled, and individuals over age 65. Each State has different Medicaid rules. In Illinois, Medicaid is about half funded by the Federal government and half funded by Illinois. The specific Medicaid program that is the subject of this discussion is the "Aid to the Aged, Blind, or Disabled" program, which pays for the beneficiary's medical costs, including long-term care costs. In these materials, this benefit is referred to as "Medicaid."

A. What is Medicaid Planning?

Medicaid planning is the process by which an elder rearranges assets in such a way as to qualify for the Medicaid program. Medicaid planning does not involve "hiding assets," as doing so is fraudulent. It involves the use of certain legal exceptions and exemptions under the Medicaid program that permits a Medicaid applicant to preserve assets. Once an elder becomes eligible for these benefits, Medicaid will then pay some or all of that senior's supportive living and/or skilled nursing facility expenses. Therefore, by engaging in Medicaid planning an elder is legally sheltering assets from long-term care costs by taking advantage of statutory exemptions and techniques and reporting to Medicaid the planning performed. In the end, the planning will result in Medicaid paying his or her long-term care costs without complete impoverishment but with full disclosure of the planning to Medicaid. But before we delve into the program's requirements and planning associated with Medicaid, I wish to pause to discuss some of the moral and ethical considerations a practitioner should examine prior to expanding his or her practice to include Medicaid Planning.

III. Ethical and Moral Questions and Your Professional Responsibility

A. To Plan or Not to Plan, that is the Moral Question

It is true that elders request Medicaid planning advice to ease the financial impact of long-term care. Since long-term care costs are so incredibly high, Medicaid is becoming the *de facto* long-term care insurance for the middle class, even for those who perform Medicaid planning or have long-term care insurance. Essentially, Medicaid planning shifts the burdens of paying for long-term care from private sources to the taxpayer. When someone uses taxpayer monies to pay for their long-term care when they still have some means to pay (and possibly completely deplete their assets in the process), it raises the question – is Medicaid planning morally appropriate? There are arguments for and against the morality of this planning. However, this planning does not violate any laws when done correctly.

The arguments against Medicaid planning use the premise that there is a limited amount of public money available to pay for long-term health care. Therefore, it is morally inappropriate for a person to use the taxpayer's money to pay for long-term care expenses while he or she still has the resources to pay for it -- even if it means impoverishing one's self and healthy spouse and leaving no legacy to one's descendants.

The arguments for Medicaid planning ignore the "limited resources" argument. Instead, these arguments focus on the fact that America's free-market health care system is amoral. This state of amorality justifies Medicaid planning. For example:

Medicaid and its better-known brother, Medicare, do not deliver health care; they simply finance health care services. If an elder develops an acute illness, such as a heart attack or a fast-developing cancer, Medicare will pay their health care bills regardless of how much they earn or

how much they have. However, if an elder develops a chronic illness such as Alzheimer's disease or Parkinson's syndrome that requires extended care, our health care system would force the elder to "spend down" his or her assets until they are low enough to qualify for Medicaid. Some would argue that it is inherently unfair (and, therefore, amoral) that the government will pay for the health care expenses of a person with an acute illness regardless of that person's assets and income but only pay the health care expenses of a person with a chronic illness only after they become impoverished. After all, no one intends to get sick, and no one chooses to develop a chronic or acute illness. Because no one chooses to develop an acute illness (that the government pays for) versus a chronic illness (which the government does not pay for), why should it be immoral for a family to engage in Medicaid planning to have the government minimize the financial impact of a chronic illness?

America has a free market health care system. This system will charge the highest prices that the market can bear. Likewise, health care patients, as purchasers of health care services, should be able to pay no more than the going rate for those services. However, the sick typically cannot bargain for their health care services and must pay whatever rate the free market health care systems charges. Accordingly, some would argue that since this removes the bargain element of the transaction, the price of health care services is artificially high. In addition, they argue, why should someone pay more than the minimum net cost to obtain health care services, merely because they have the resources to do so? Requiring someone to pay more than the minimum net cost is like saying that well-to-do people should not shop at a dollar store simply because they can pay more for products and services and the dollar stores are driving other merchants out of business. It follows that where the market permits planning that reduces the net price, one cannot tell a purchaser that paying a lower price for something is amoral. By this reason, using Medicaid planning to reduce the cost of health care is not amoral. Therefore, some would argue that until we acknowledge that everyone has a fundamental human right to health care and can have access to that health care; these arguments support the assertion that Medicaid planning is morally and ethically justified.

Although Medicaid planning is a legal avenue for people in need, there are strong reasons to engage in it and strong reasons not to. Medicaid planning is a highly morally charged issue and for attorneys. After careful consideration of the moral and ethical implications of engaging in Medicaid planning, if the practitioner is comfortable with performing this type of service, then the practitioner must begin with the basics of the program.[3] The author understands these concepts are discussed in prior sections of this course, so that the basic eligibility requirements are merely summarized in the following section.

[3] Illinois Rules of Professional Conduct §1.1

IV. Medicaid Eligibility Requirements and Exceptions

A. General Requirements and Income

The applicant must be an Illinois resident and a U.S. citizen (or a non-citizen living in the U.S. with a specific type of immigration status) and must be age 65 or over, blind, or disabled. The applicant and his or her spouse must also contribute monthly income to toward the cost of care. The applicant can only keep $30 of income and the spouse is limited to $2,739. In addition, the applicant, and his or her spouse, must meet certain asset criteria. In the Medicaid world, assets are referred to as "resources."

B. Resource Requirements

In terms of resources the applicant must not have non-exempt assets over $2,000 and the spouse cannot have non-exempt assets exceeding $109,560. There is a myriad of assets that Medicaid considers exempt, the most commonly used exempt assets are the following: (1) homestead property,[4] (2) one motor vehicle owned by the applicant,[5] (3) one motor vehicle owned by the community spouse regardless of value, (4) personal effects and household goods, (5) life insurance up to a face value of $1,500. Term insurance is exempt because it has no cash surrender value, (6) burial plots, (7) Medicaid compliant prepaid funerals, (8) resources needed for self-support (that is, business assets). However, any income will be limited to $30 ($90 if the client is in a supportive living facility), (9) life estates, provided the life estate holder lives in the life estate for a year if the life estate, (10) certain irrevocable trusts, and (11) Medicaid compliant annuities.

C. Penalties and Using Gifting in the Medicaid Concept and Five-year Rule

In addition to determining whether an applicant or married couple do not exceed the resource limits, the Medicaid rules also look at any transfers that the applicant or the spouse made over the five-year period immediately before applying for Medicaid for less than fair market value ("non-allowed transfers"). If Medicaid finds that the applicant or the applicant's spouse made non-allowed transfers during the five-year review period, then Medicaid will compute a "penalty period" based on the aggregate dollar amount of transfers made during that five-year period. During the penalty period, Medicaid will not pay for an applicant's care. Medicaid assumes that if the applicant or the applicant's spouse made non-allowed transfers during the five-year look

[4] Homestead property is exempt as long as the owner who receives Medicaid benefits intends to return to the homestead. If there is no intent to return, the property is still exempt if it is occupied by the spouse, a sibling, a minor child of the recipient, or disabled child of the recipient

[5] The applicant's vehicle is exempt regardless of value if it is: necessary for employment; needed for medical transportation; modified for operation by or transportation of a handicapped person; OR needed to provide transportation for essential daily activities because of climate, terrain, remoteness or similar factors. If the vehicle is not exempt due to one of these factors, then the vehicle will only be exempt if its fair market value is less than $4,500.

back period, that the transfer was made for purposes of qualifying for Medicaid benefits unless the applicant or applicant's spouse proves otherwise with acceptable documentation.

Computing the length of the penalty period is simple. For example, assume that during the five years immediately before an applicant submits a Medicaid application, he transferred $20,000 to his granddaughter to pay for her college tuition. Medicaid would grant Medicaid benefits to pay for nursing home care once the applicant paid for $20,000 worth of care (or someone else paid for that care for him). Assuming a basic nursing home rate of $7,500 per month, this gift would create a penalty period of 2.67 months ($20,000/$7,500). So, if the applicant applied for Medicaid in July 2018, Medicaid would not pay for his care until sometime in late September 2018. Likewise, if the applicant gave away $100,000 during the five years immediately before applying for Medicaid, Medicaid would impose a penalty period equal to $100,000 of care before it pays for additional care (at $7,500 per month, this would create a 13.33-month penalty period). In the previous example, Medicaid would not pay for benefits until August 2019.

V. Additional Ethical Considerations when Incorporating Estate Planning

Once a practitioner is familiar with the basics of Medicaid, he or she is ready to begin representing clients in performing Medicaid planning. One of the most powerful tools in an elder law practitioner's tool kit is estate planning. So, when a client approaches a practitioner seeking Medicaid planning advice, the practitioner must stop to examine the situation from a professional responsibility perspective.

A. Capacity and Estate Planning

Estate planning, inclusive of advanced directives, often is the lynch-pin of Medicaid Planning. Unfortunately, many elders do not have an estate plan in place when they become disabled, sick, or injured. The question then becomes if the elder has retained sufficient capacity to execute valid documents once the senior seeks legal advice of an elder law attorney. Section 1.14(a) of the Illinois Rules of Professional responsibility states about clients with diminished capacity, "the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client."

Under Illinois Law, a person has mental capacity when he or she is capable of understanding, in a reasonable manner, the nature and effect of signing a document. The person does not have to be able to understand and explain every technical term used in the document. In other words, the person must understand that, by signing, for instance an advanced directive, he or she is giving his or her agent under that advanced directive the power to make decisions on his or her behalf. Of course, as a person develops dementia and that dementia progresses, it becomes more and more difficult to determine whether the person has capacity to sign documents. Eventually, the person's mental capacity declines to the point that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his or her person because of the progressing disability.

Once this occurs, the person can no longer sign estate plan documents and have them still be valid. If he or she does not have the requisite mental capacity, all hope to perform Medicaid planning is not lost, but the elder's family must proceed with the Medicaid Planning through a guardianship proceeding. Although proceeding with Medicaid Planning through a guardianship is more expensive, if the elder has lost capacity, it is the only legal and ethical manner of accomplishing a Medicaid Plan.

One of the best preventative techniques in catching dementia early so that one does not have to go through the murky process of determining capacity, is to have an annual checkup by a neuropsychologist. A neuropsychologist is a psychologist who specializes in studying brain behavior relationships. Neuropsychologists have extensive training in the anatomy, physiology, and pathology of the nervous system and they can diagnose dementia and the progress of it with specific scientific tests. However, alert the clients that Medicare will not pay for simply "diagnostic exams," but Medicare may pay for the most or all the cost of the annual exam.

It is recommended a healthy senior be evaluated by a neuropsychologist to obtain a "baseline" measurement. This baseline reading can be used later by doctors to measure any appreciable decline in mental abilities. A doctor can then evaluate whether the decline is a part of the normal aging process or is something else, like dementia. Once the senior and the family discover this decline, they can complete an estate plan that incorporates Medicaid Planning before there is not capacity, when it would be too late to execute.

The practitioner should also identify who the client is. Many elders become reliant on their adult children for care, transportation, and moral support. The practitioner must be absolutely clear as to who the client is. There should never be the expectation that the Medicaid planning is to save inheritances or legacies.

VI. Estate Planning and Medicaid

Provided the elder has capacity and who the practitioner represents is clear, estate planning for an elder expecting to need Medicaid long-term care benefits can range from the rather simple to the rather complex depending on the elder's asset level and wishes. For purposes of this discussion, the author assumes that the client has substantial resources and desires to perform rather complex Medicaid Planning through an estate plan.

Estate planning for our purposes includes executing documents that apply during life and at death and performing *inter vivos* transfers (gifts). The documentation typically involved in an estate plan that includes Medicaid Planning includes some or all the following: (1) irrevocable trusts, (2) revocable trusts, (3) wills, (4) Power of Attorney for Property, (5) Power of Attorney for Health Care.

A. Married Applicants

As previously discussed, Medicaid requires an applicant to disclose all transactions on all resources for five years prior to applicant's requested date of eligibility. Medicaid does not review any transaction beyond five years prior to the requested eligibility date. Accordingly, as part of an estate plan, an Elder Law practitioner can advise a married couple to transfer resources to arrange them in a fashion that legally protects the assets by transferring them and waiting five years.

If there is a spouse who lives in the community (the "Community Spouse"), this community spouse may keep up to a total of $109,560 of "countable assets."[6] (The spouse that is already in the nursing home or who is to receive Medicaid benefits is known as the "Institutionalized Spouse.") Any assets more than these minimum standards must be "spent down" until the remaining assets owned but the Community Spouse and the Institutionalized Spouse reach these maximum asset thresholds. There are two primary options in spending down excess property. The first is to convert "countable assets" into "non-countable assets" through both allowed and non-allowed transfers. The second is spending assets on needed items or services for fair market value.

B. Planned Spend-down vs. Required Spend-down

The Medicaid spend down is different depending on whether assets are spent down before or after submitting a Medicaid application. Before submitting the Medicaid application, assets may be spent on a wide variety of good and services. After a Medicaid application is submitted and approved with spend down, the options for spend down are severely limited since only medical expenses are eligible for spend down,[7] which in this outline is termed required spend down.

Accordingly, the first step in the planned spend-down is to take countable assets and spend them on items that are not countable. Therefore, one might advise the Community Spouse to fix up the house, purchase a new car or modify a car to be handicapped accessible, purchase a pre-paid funeral, etc. This conversion process could use up a large portion of the assets that must be spent down.

For the remaining funds that need to be spent down on fair market value payments, in most cases, those funds can be used to pay for any goods and services for the couple or the assets can be gifted to others (while paying attention to the penalty periods that the gifts create). Some ideas for spend down options include paying for (1) medical and nursing home expenses, (2) dentures, hearing aids, and vision care, (3) the balance of the mortgage, credit cards and other debt, (4) home improvements or to make the home handicapped accessible, (5) new household appliances and furniture, (6) real estate taxes that may be due soon, (7) pre-payments of homeowner's or other insurance and utility bills, (8) the hiring of someone to assist with care of the elder in the home, and (9) the hiring of chore services to help with house and yard work. Although complicated, the

[6] State of Illinois Policy Manual ("PM") § 07-02-22. This is the maximum inflation adjusted Federal spousal limit in 2009 when Illinois "froze" annual increases.
[7] PM § 15-08-05.

Medicaid spend down process provides many opportunities for an elder to use his or her assets to ensure that the Community Spouse is financially secure and the Institutionalized spouse has the goods and services he or she needs, before qualifying for Medicaid.

The spend down described here works well if the assets are moderate and the couple is within the five-year look back period. There are many other options for a planned spend down that will benefit the elder or the community spouse if the applicant is outside the five-year look back period and has significant assets.

C. Five Year Planning Irrevocable Trust Planning

Five-year planning through a full estate plan often involves transfers of resources to revocable trusts and irrevocable trusts, along with intense coordination with the applicant and the spouse if there is one.

1. Irrevocable Trust Terms and Availability of Trust Corpus of Income

As discussed, to qualify for Medicaid, a senior and the senior's spouse must not have more than a minimum amount of available resources. To protect a senior's assets from long-term healthcare costs, the assets that the senior would like to protect must not be an "available resource" for Medicaid purposes.

One method of ensuring that assets do not become an available resource is to transfer those assets that the applicant wishes to protect from the senior and/or his spouse to a Medicaid irrevocable trust. The type of irrevocable trust generally used in Medicaid planning is a so-called "grantor" trust under which the income tax attributes flow to the grantor elder who retains sufficient power over the trust so that the transfer of assets does not create a completed gift for tax purposes. However, the elder grantor will not have the legal right to demand distributions during his or her life.

The Medicaid rules consider an asset to be an available resource when the senior has the legal right to use that asset to pay for his or her healthcare or other expenses and the asset is not otherwise unavailable under certain exceptions to the resource rules.[8] However, the transfer to the trust is not allowed, thus the senior needs to wait to apply for Medicaid eligibility for five years. Accordingly, the senior and the spouse must create a budget for five years (as discussed in the revocable trust section) and reserve assets outside of the irrevocable trust to live on for the five years of wait time needed prior to applying.

When the senior applies for Medicaid he or she must still report the irrevocable trust's existence, as well as provide five years of trust account statements for review. Medicaid will review the trust terms to determine if any of the assets are available to the applicant or the

[8] 42 C.F.R.§ 435.845(a) and PM § 07-02-00 *et. seq.*

applicant's spouse. If drafted correctly, a Medicaid irrevocable trust's corpus is not available to the applicant.

The irrevocable trust's terms must restrict the senior and the senior's spouse's (if there is a spouse) access to income and principal. If either of them has access to the corpus or income of the trust, then those portions of the trust, whether principal or income, are available to pay for care and are subject to a required Medicaid spenddown.

Although the assets of an irrevocable trust are generally not considered to be available assets of the senior, the Medicaid law will consider the trust an available asset to the senior to the extent that any payment from the trust could be made to or paid on behalf of the individual[9]. Assets of an irrevocable trust are available to an individual "when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative."[10] These payments include any payment to another person or entity from which the individual may derive some benefit from the payment. These payments could include the purchase of items such as clothing, a television, or a radio which is given to the individual at some time. Payments could also include "payments for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual."[11]

Therefore, it is important that "[w]hen an individual establishes an irrevocable trust in which all or a portion of the trust cannot be disbursed to or on behalf of the individual, that portion"[12] will not be an available resource to the individual.[13]

a. Five Year Look-Bank and Avoiding Imposition of a Penalty Period

Even if the trust is drafted correctly and Medicaid deems it unavailable, if the transfers to the irrevocable trust occur within the five-year look back then there will be a penalty. Remember the transfer to the irrevocable trust itself is not an allowed transfer. Thus, the senior must wait five years to get the transfers past the five-year review period, else Medicaid will impose a penalty on the transfer of resources from the senior or the senior's spouse to the irrevocable trust. After five years pass, the transfer of assets to the irrevocable trust will not be penalized.

b. Important Cost Considerations of Funding the Irrevocable Trust

Taxes are often the biggest issue a practitioner guiding clients through an irrevocable trust funding process. Performing irrevocable Medicaid trust planning is not perfect, particularly for

[9] 42 U.S.C. § 1396p(d)(3)(B)(i).
[10] HCFA Transmittal No. 64, amending State Medicaid Manual § 3259.1(C).
[11] *Id.*
[12] HCFA Transmittal No. 64, amending State Medicaid Manual § 3528.4
[13] 42 U.S.C. § 1396p(d)(3)(B) and PM § 07-02-15-a.

clients with certain types of assets. Of special concern are clients with high value tax-deferred accounts, accounts that incur penalties or charges for liquidation, and the potential loss of senior exemptions and/or senior freezes on real property taxes for homesteads funded to the irrevocable trust.

i. Tax-Deferred Accounts

The irrevocable trust cannot own tax-deferred assets, such as IRA or a Simple IRA. Tax-deferred accounts must be individually owned. If an account is individually owned by either the applicant or the applicant's spouse, then the value of the account is counted against the applicant and the spouse's resource limits.

If couple has tax-deferred accounts with minimal to moderate value, then the couple should reserve the tax-deferred accounts to pay for living expenses for the five years prior to applying for Medicaid. By distributing assets from tax-deferred accounts over the course of five years to pay for living expenses the tax liability is spread over multiple years. As the years progress the diagnosed spouse, or even the non-diagnosed spouse, may incur medical expenses that may qualify for Medical payment tax credits. The alternative would be for the couple to liquidate the tax-deferred account immediately, which would incur ordinary taxes on the amount distributed from the tax-deferred account in single tax year.

Unfortunately, immediate liquidation is sometimes the only option; the practitioner must inform the client of the risks. Tax-deferred assets are more problematic when these are most of the clients' assets. To fund tax-deferred assets into an irrevocable trust, the couple must distribute the assets from the tax-deferred accounts, incur the large and immediate taxation and penalties if the owner of the account is under 55 and affect the taxation of Social Security benefits for seniors already receiving then. The clients must be advised of the possibility that they will incur a tax liability that is far greater than any Medicaid benefit they hope to receive in the future. For instance, both spouses may pass away prior to the five years elapsing without either ever needing to enter a facility. It is key that the elder law practitioner review the risk that the planning may cost more than the benefits they may ultimately receive when the majority or even just a large portion of the couple's combined assets are in tax-deferred accounts.

Moreover, the couple may have other assets, such as annuities with surrender charges or tax consequences for liquidation or for transferring the ownership from the individual to the irrevocable trust. Certificates of deposit may incur penalties. In short, the practitioner must take a careful inventory of the client's assets and coordinate the funding that the funds chosen to be funded into the irrevocable trust are the funds that will incur the least cost in the form of taxes, penalties or fees.

ii. Real Estate Tax Exemptions

Generally, when planning for a married couple, it is not necessary to transfer the homestead to the irrevocable trust. Due to the Medicaid homestead exemptions and allowed transfers, this asset

can be held either jointly or funded in equal shares between the spouses' respective revocable trusts. If there is no spouse, there is a chance that both spouses would enter a facility in the future, then it may be prudent to fund the homestead into the irrevocable trust.

If this transfer occurs, then the planning must include a leasehold between the spouses and the trust wherein the couple is made responsible for the payment of real property taxes as rent. Illinois extends the real estate senior exemptions and freezes (if the couple qualifies) to persons over 65 who are responsible for the real property taxes through a leasehold or if the elder has an equity interest in the real property. Moreover, to avoid higher taxation of capital gains taxes on real estate. The practitioner may wish to include provisions in the trust that allows him or her to decide whether to pass through income. This allows for the any capital gains on the real estate upon its sale be passed through to the individual grantors and be taxed and the individual rate.

c. Control and Protection

A practitioner must stress to the elder couple that they must implicitly trust the trustee. The trustee will have full control over the substantial portion of their life's savings in the irrevocable trust. Despite the implicit trust in the named trustee, the irrevocable trust should have a so-called trust protector. The function of the trust protector is to monitor the trustee's administration of the trust. Generally, the trust terms grant the trust protector the ability to remove the trustee if he or she is mismanaging the trust and to appoint a new trustee.

Practitioners often include a safety valve in case the funds reserved outside of the irrevocable trust are insufficient to pay for living and/or care expenses for five years. Accordingly, another function of the trust protector is to manage the safety valve of the irrevocable trust. The terms of the safety value generally allow the trustee, with the trust protector's approval, to distribute either income or principal to persons, normally the couple's children. The children upon receipt of the trust distribution are the legal owners of the funds and may choose, but are not required, to pay for the parent's expenses until the five years are over. It is the intent that the safety valve never be used and is a doomsday last resort proposition.

One could also argue that the safety value should not be incorporated into the irrevocable trust. Its use is subject to interpretation and the issue must be approached with the utmost care.

2. Revocable Trust

The practitioner must help the couple carefully coordinate the resources funded to the irrevocable trust because it must work in concert with revocable trusts set up for each of the spouses. While the irrevocable trust will hold the assets that the elder couple wishes to protect, the revocable trusts will hold at least part of the resources the couple budgeted to live on for five years, plus the Community Spouse Resource Allowance.

It is important to stress that Medicaid considers the corpus of the revocable trust to be an available resource to the individual or the individual's spouse[14]. Accordingly, the practitioner must work closely with the applicant and his or her spouse to inventory all the couple's collective resources and income, and establish an annual budget. It is vital that the practitioner help the couple carefully estimate the amount of resources that the couple will need to reserve in the revocable trust. The plan involves calculating the expected income for five years, investment income, taxes, inflation and possible increased medical costs for both, since both will decline in health as the five years elapse. It is wise that once the couple calculates the expected budged, that the couple fund additional resources over and above the expected budget to account for emergencies and other unexpected costs.

3. Wills

Generally, an estate plan with a revocable trust will include a pour over will. However, an elder law practitioner must carefully coordinate inheritances to a diagnosed spouse or one that is already in a facility.

When performing this type of planning using revocable trusts, the practitioner should account for the possibility that the healthy spouse may predecease the diagnosed spouse. If the diagnosed spouse were to inherit from a deceased spouse, then the inheritance would be subject to a Medicaid required spend down once the diagnosed spouse receives the inheritance from the deceased spouse's estate. If the diagnosed spouse has not applied for Medicaid yet, then that inherited amount would need to be spent down prior to applying by either paying for care or by additional Medicaid planning. If the diagnosed spouse is already institutionalized, then Medicaid will suspend benefits for the Institutionalized Spouse. In other words, the State would stop paying for the Institutionalized Spouse's long-term care costs and not begin payments until the Institutionalized Spouse proves to Medicaid that he or she has spent the inheritance back down to $2,000.

The temptation might be to completely disinherit the diagnosed spouse, perhaps by utilizing the healthy spouse's revocable trust, but Illinois probate law protects a spouse from being completed disinherited by a deceased spouse. If a spouse were to be disinherited, then he or she must act and disclaim the will in probate court. By disclaiming, the spouse will receive one-third of the probate estate. If the surviving spouse fails to disclaim the will and the failure to do so is within the five-year look back period, then Medicaid will deem the failure to disclaim as a non-allowed transfer and impose a penalty.

To prevent a Medicaid required spend down vs. a planned spend down should the healthy spouse predecease the Institutionalized/Diagnosed Spouse, the practitioner should include

[14] 42 U.S.C. § 1396p(d)(3)(A) and PM § 07-02-15-a.

provisions that direct the trustee to distribute assets to the in a Supplemental Needs Trust established by the Community Spouse's will.

Medicaid exempts inheritances that a spouse leaves to an applicant or recipient, provided that the assets are left in a supplemental needs trust established by the deceased spouse's will- in other words, a testamentary supplemental (special) needs trust. The spouse's failure to leave the assets through a testamentary supplemental needs trust will produce either a spend down or create the imposition of a penalty.

a. Testamentary Supplemental (Special) Needs Trust

A testamentary supplemental needs trust is established by will at the testator's death. The law specifically exempts a testamentary supplemental needs trust from availability and from spend down.

The terms of a testamentary supplemental needs trust protect the surviving spouse's Medicaid eligibility by restricting the trustee's ability to make distributions to the diagnosed/institutionalized spouse. A supplemental needs trust (testamentary or not) will include terms that only allow the trustee to supplement, rather than substitute, Medicaid or other public aid payments. Thus, the trust restricts the trustee to making payments only for goods and services that Medicaid will not pay. The terms leave the decision of whether to make a distribution up to the trustee's sole discretion. The discretionary standard is what makes the supplemental needs trust unavailable. If the terms of the supplemental needs trust allow for distribution of trust corpus for any reason, then the entire trust is available.

4. Advanced Directives

Illinois Law provides for several types of advanced directives including: health care powers of attorney, financial powers of attorney, living wills and mental health treatment preference declarations, and POLST.

When a senior executes a power of attorney he or she names an agent and grants the agent the legal authority to make decisions for him or her. There are two types of powers of attorney in Illinois, the power of attorney for property and the power of attorney for health care. The power of attorney for property permits an agent to make financial decisions for the senior for any asset that he or she has. The agent under the health care power of attorney will control your healthcare decisions. The discussion for our purposes will be limited to powers of attorney for property.

Although the powers of attorney are rather broad, there are plenty of actions that the agent under of attorney has no authority to perform unless the power of attorney specifically grants it to the agent. Examples of authority that must be enumerated in the power of attorney for property are as follows: (1) transfer ownership of real estate; (2) gift property to others or to the agent

him/herself to avoid the presumption of fraud; (3) the ability to create, amend, and/or fund trusts; and (4) to perform Medicaid Planning.

It is often the case that the elder has already signed power of attorney and a great deal, if not all, of the planning is completed by one elder's power of attorney for property. In these instances, the practitioner should be very mindful of the steps taken making a Medicaid plan to ensure that the attorney in fact is meeting his or her fiduciary obligations. [15]

Moreover, the practitioner should carefully review existing powers of attorney to confirm the attorney in fact has the authority to make the planned transfers. If there is no authority to perform Medicaid planning then the elder's family or attorney in fact must consider opening a guardianship to obtain an order.

5. Gifting to Others Outside of the Five-Year Look Back Period

Estate planning also includes gifts during life. It is heartbreaking to a senior facing a degenerative disease that he or she will be unable to help with a grandchild's college tuition. This is especially the case, if the senior has contributed toward the college costs of older grandchildren. While, most clients do not have the time or resource levels to perform the planning described in this section, it is useful for clients when it available to them.

Under the law, each person has a $5.49 million gift exemption (for 2017). In addition to the extent a person makes a gift to a single recipient of $14,000 or less in a year, the first $14,000 of the gift does not count against the lifetime gift exemption. This $14,000 gift can be made to multiple recipients within a single year. To the extent you use portions of your $5.49 million lifetime exemption limit, you will also use up the same proportion of your $5.49 million lifetime exemption. The practitioner must advise clients not to confuse the estate and gift tax exemptions with Medicaid exemptions. Medicaid will not exempt gifts simply because the IRS does not exact consequences for the gift. If there is a gift transaction, Medicaid will exact a penalty in benefit coverage, while the IRS will simply not exert a tax consequence.

a. 529 Plans

Under law, any contributions an applicant makes to a 529 Plan in excess of $14,000 counts against the gift exemption. An applicant and the spouse can each contribute up to $70,000 in a single year for each 529 Plan she establishes using the five-year carry-forward option. This option allows an applicant to make five years of contributions in one year to each beneficiary without it counting against the gift exemption. However, the will not be able to make 529 Plan contributions or other gifts to each beneficiary for five years afterwards without the contribution or gift counting against the gift tax exemption or causing a penalty period once the applicant applies for Medicaid.

[15] Comment 4 for §1.14 of the Illinois Rules of Professional Conduct

The drawback to this estate planning tool is that the elder cannot be the custodian of the 529 Plan account for the child/grandchild. Medicaid considers any 529 Plan over which the elder has any sort of authority as an asset that can be liquidated and this is available to pay for the elder's long-term care benefits. Accordingly, if the elder wishes to engage in a five-year 529 Plan gifting plan, the elder must choose a trusted family member to take charge of the account the senior funded. This loss of control may not be palatable to the senior.

b. Medical Expenses

In addition to the $14,000 annual (per donee) exclusion, there is an unlimited exclusion from gift tax for qualified transfers of property by gift for payments for medical care (or tuition). This exclusion is available without regard to the relationship between the person making the gift and the one benefiting from the payment. Monetary gifts to an individual for medical expenses can be excluded from the gift tax only if the payments are made directly to the provider of medical services (as defined by the IRS) or if the payments are made for medical insurance. There is no tax exclusion for funds an elder gives directly to the individual for medical expenses, for reimbursing an individual for medical expenses he/she has paid, or for payments that were reimbursed by medical insurance.

VII. Liens and Estate Claims

A. Liens

If the elder applies for Medicaid and cannot or will not transfer his or her ownership interest in his or her homestead, then Medicaid will record a lien against the real estate property provided that no qualifying person, such as a spouse, child under 21, disabled child or sibling with an equity interest resides in the homestead. Generally, Medicaid liens are only recorded against real property solely owned by the applicant or is non-homestead property with a value over the asset limit(s).

Upon sale of the real property, Medicaid, upon the real estate attorney's request, will produce a pay-off statement of all payments Medicaid made on behalf of the recipient to date. The practitioner should carefully review the pay-off with the client or the client's family to ensure accuracy of the statement. If there are assets left over after the Medicaid lien is paid off from the real estate proceeds, Medicaid will require a spend down as discussed above or the recipient must perform some Medicaid annuity planning that is the subject of a prior section.

B. Probate Estate

If a Medicaid recipient dies with a probate estate, meaning assets in his or her name only with no named beneficiary, then Medicaid can make a claim against the person's probate estate up to the amount that Medicaid paid on the person's behalf. Generally, when a Medicaid beneficiary passes away, Medicaid sends a form to the deceased beneficiary's power of attorney or representative on file seeking to assess the value of the deceased person's probate estate. If there

are any assets in the probate estate, Medicaid can make a claim against the estate. However, Medicaid's claim is a sixth-class claim, so it will only get paid after the first five classes of claims are satisfied. In addition, Medicaid must file a claim within a six-month period, and its failure to do so will prevent recovery.

1. Small Estate Affidavit

There may be a situation where the deceased Medicaid recipient has probate assets, but the person passed away without owning real estate and the value of the non-real estate assets are under $100,000. In this situation, the deceased Medicaid recipient's personal representative can distribute the probate assets via small estate affidavit, thus avoiding the probate court process. Nevertheless, the practitioner must advise the Medicaid recipient's personal representative that he or she must pay all creditors prior to distributing to heirs at law or the will's legatees. The Small Estate Affidavit is intended to be an abbreviated version of a probate court case, not a means through which an estate avoids paying claims. If the affiant signing the small estate affidavit fails to pay creditors, then he or she is personally liable for the debts out of his or her own funds, even if the distributed funds did not go to him or her.

Conclusion

Medicaid Planning incorporates multiple areas of law: Medicaid law, estate planning, probate or estate administration, and some tax. However, once a practitioner familiarizes him/herself with Medicaid requirements, professional responsibility obligations, and how Medicaid requirements work with other areas of law, he or she can assist elders with the appropriate legal and ethical plans.