

**7. Personal and Financial Aspects of Disability:
*Qualifying for Public Assistance;
Long-Term Care Insurance***

Have you ever discussed the prospect of a disability with your spouse or children or parents? The reluctance to talk about this topic is sometimes even greater than discussing the possibility of death, or funeral plans, or Wills.

However, recent advances in medical technology and skills have increased the longevity of our population. As a result, your chances of being faced with the problems of caring for a substantially or totally disabled relative or friend are greater than ever. Clearly, a large number of elderly persons will be faced with a physical or mental disability. Younger persons can be disabled by birth defects, or injury, and may also require total care.

The best place to begin to plan for handling a disabled person is at home by discussing the possibility of disability with family members and by learning what resources are available. You can then discuss the various options and alternatives *before* the need to deal with a disabled relative arises. These include disability insurance and Social Security benefits described in other articles, and long-term care insurance, discussed later in this article.

The purpose of this article is to explore the basics of developing a plan to handle the care of a disabled relative or developing a plan for your relatives to handle your situation if you become disabled. This article will also review the general requirements to be eligible for public assistance. Additionally, it will review the types of assistance that are available for disabled persons, or relatives who must deal with a disabled person.

Considering Nursing Home Care

One of the most difficult decisions facing a family is when--and where--to place a disabled person who is no longer able to live independently. There may be alternatives to the drastic step of moving a person to a nursing home, but it can be a difficult task to try

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and determine not only what additional care is appropriate for the individual, but also how to locate the best care available.

Often, the initial recommendation for nursing home or home health care is made by the family doctor or hospital social worker. For the elderly patient, government organizations such as the King County Ombudsman (206-838-6810) and Senior Information and Assistance (206-448-3110) can provide guidance and assistance. There are also private agencies that assist families with finding the most suitable living arrangements for an elderly or disabled person. These agencies are often familiar with the quality of care offered in local nursing homes and can suggest alternatives to nursing

care when appropriate (e.g., in-home aides or group homes for the elderly and disabled). Many referrals to nursing homes and group homes are also made by friends whose family members are or have been patients.

The expense of nursing home care can range from \$3,000 to \$6,000 a month depending upon the facility's basic daily rate and any additional needs of the patient. Medicare insurance covers the cost of nursing home care in only very limited circumstances and for a very limited period of time (the maximum benefit period is 100 days with a large co-payment after 20). Many families are unable to pay or continue paying the cost of private nursing home care and, at some point, turn to the Medicaid program for financial assistance. It is important to remember that federal law prohibits nursing homes that accept government benefits from discriminating against residents on the basis that their care is paid for by the Medicaid program. More important, most of the care to nursing home residents is provided by nurses, nurses aides and food service staff, who typically do not know whether a particular resident is on the Medicaid program or paying privately for care.

The Medicaid Program for Nursing Home and In-Home Care

Unlike Medicare, the Medicaid program will pay for the cost of nursing home care of eligible persons. Washington State also has a Medicaid program called Community Options Entry System (COPES), which will pay for the cost of in-home care or other assisted care for people who need the nursing home level of care but want to stay in their home. The eligibility rules are the same for both programs. Medicaid is funded by the state and federal government and administered by the Department of Social and Health Services (DSHS). In King County, applications for Medicaid are processed by Holgate Home and Community Services Office of DSHS. The address is: P.O. Box 24847, N80-1, Seattle, WA 98124-0847 and the phone number for application (206) 626-5900.

To qualify for Medicaid for nursing home care, the applicant's resources must be below specified amounts (see below) and monthly income must be less than the private

pay rate for the nursing facility. To qualify for COPES benefits, the applicant's gross monthly income cannot exceed \$1,590 (this is the 2001 amount and increases in January of each year). Once a person is determined to be eligible for Medicaid, DSHS will specify how much of the person's monthly income must be paid to the nursing facility or the in-home aide and Medicaid will then pay the difference.

Qualifying for Medicaid Nursing Home or COPES Benefits

The eligibility rules for the Medicaid program are very different depending upon whether the applicant has a spouse. For a married couple the program looks at all resources of both spouses in determining eligibility. The following resources are disregarded in determining eligibility for married person:

- The home
- One car, regardless of value
- All household furnishings
- Certain prepaid burial arrangements plus a burial fund of \$1,500 for each spouse

For a married couple to qualify for COPES or nursing home Medicaid benefits, their non-exempt resources cannot exceed 89,000. This includes \$2,000 for the nursing home spouse and \$87,000 for the spouse at home.

Once a spouse is approved for Medicaid, DSHS will determine how much of the couple's income must be paid to the nursing home. Income includes periodic payments such as pensions, wages, social security and VA benefits, interest and dividend earnings and rental or royalty payments. The spouse at home can keep all income paid in his or her name, no matter how high the amount. If the gross income of the spouse at home is less than \$1,452 (2001 amount), he or she can keep income of the nursing home spouse to bring his or her total income up to \$1,452 per month. The spouse at home may be able to keep even more of the nursing home spouse's income if housing expenses are high. Most of the remainder of the income paid to the spouse in the nursing home will go to pay for nursing home care and Medicaid will pay the difference.

If a Medicaid applicant has no spouse (or if both spouses are in a nursing home), the following property is exempt:

- the home, if the applicant states that he or she intends to return home
- all household furnishings
- a car with a Bluebook value of less than 5,000
- a \$1,500 burial fund plus certain prepaid burial arrangements
- \$2,000

One car, regardless of value, will be exempt if the car is necessary to get to medical treatment or if the car is modified for a handicapped person.

Transfers or Gifts Prior to Qualifying for Medicaid

Many people want to know whether they can transfer property to other family members or to a charity in order to come within the resource limits for the Medicaid program. The general rule is that, if a person or spouse makes gift of property in order to qualify for Medicaid, there will be a period of ineligibility for Medicaid benefits. The length of period ineligibility will depend upon the value of the resources transferred. Gifts made within three years of applying for Medicaid benefits will potentially affect eligibility. Gifts made more than three years before applying for Medicaid will have no effect on eligibility. This three-year limit is extended to five years for gifts made into a trust.

To determine the exact number of months of ineligibility for Medicaid benefits, you take the value of the gift and divide the amount by 4,689. (This divisor is the 2001 amount and is increased in October of each year.) The result is rounded down to the nearest whole number. This division will give you the exact number of months of ineligibility for Medicaid benefits. For example, if you transferred your home to your daughter and the value of the home was \$80,000, the transfer would disqualify you from Medicaid benefits for 19 month ($80,000 \div 4,689 = 17.06$).

Outright gifts made more than 36 months before the month in which you apply for Medicaid will have no effect on eligibility for benefits. So, in the above example, if you transferred your home to your daughter in January 1995, and you waited until at least the 37th month from January 1995 to apply for Medicaid benefits, the gift would have no effect on your eligibility for benefits, no matter the value of the home.

If you have made more than one gift in 36 months before applying for Medicaid, each period of ineligibility is calculated separately, using the mathematical formula discussed above. For example, if you made a gift of \$3,000 in January and \$8,000 in May, the gifts would have the following impact on eligibility:

1. If the gifts were made within 36 months before the month you apply for Medicaid, the gifts may have an effect on eligibility.
2. The \$3,000 gift will have no effect on eligibility
3. $(3,000 \div 4,689 = 0.63 \text{ or } 0)$.
4. The \$8,000 will disqualify you from receiving Medicaid for the month of May $(\$8,000 \div 4,689 = 1.70 \text{ or one month})$, which would be the month in which the gift was made.

The rules on how gifts can affect Medicaid eligibility are complicated and there are important exceptions that may apply. Before making any transfers of property in order to qualify for Medicaid, it is advisable to seek advice from a Medicaid counselor or an attorney.

Medicaid Liens

DSHS may recover benefits paid for nursing home care or under the COPES program by asserting a Medicaid lien. The following rules apply to Medicaid liens:

1. Medicaid liens only become effective when the Medicaid recipient dies.
2. The lien only applies to property owned by the Medicaid recipient.

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There is no lien against property owned by a spouse. For example, if the home is in the name of the spouse at home, there would be no Medicaid lien against the home when the spouse in the nursing home dies.

1. The lien only applies to Medicaid benefits paid after the age of 55.
2. The lien can be waived if it would cause an “undue hardship.”

Long-term Care Insurance

Over the last several years, the insurance industry has developed and marketed “long-term care” policies. This form of private insurance is intended to pay for at least some of the costs of long-term nursing home or at-home care and, therefore, protect the assets of persons who do not qualify for public assistance.

The best way to start your investigation of this area is with some careful planning. What is your current asset structure? How much income do you presently have that would continue in the event you become disabled? Which of your current living expenses would continue in the event of your disability? If you should need the full time care of a nursing home or assisted living facility, or the services of a home health care provider to allow you to remain in your home, would your income be sufficient to cover your continuing expenses *plus* the additional expenses of your care? Or, would you have to start using up your capital?

Keep in mind that the average cost for nursing home care in Washington in 1996 was \$156/day (\$4,680/month). Home health care providers will generally bill you by the hour with the rate based on the skill level required (nursing and therapy services cost more than personal and chore services). Home health care services can cost you less than a nursing home unless you need them on a continuing basis throughout the day, in which case they can actually cost more.

If your income is able to cover these costs, long-term care insurance may not be necessary. If your income is not able to cover these costs and capital would need to be consumed, then long-term care insurance might be very valuable.

As with any new insurance product, there has been a great deal of rapid evolution, and contractual provisions and costs have changed a lot over the past few years. Additionally, more and more insurance companies have entered the long-term care marketplace. The combination of these developments has made the choices of policies and insurance companies very complex.

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The Health Insurance Portability and Accountability Act of 1996, which became effective January 1, 1997, has increased the complexity of long-term care insurance planning by creating two classes of policies: those which are “tax qualified” and those which are “nontax qualified.” There are trade-offs between the two classes and the details are still subject to further clarification at this writing. Suffice it to say, if you are

considering long-term care insurance, you should ask for a current explanation of the two classes.

If you already have a long-term care policy, you should review it to see if it is up-to-date with your current expectations and compare it with what is available in the marketplace today. If it falls short, it may make sense to supplement or replace it.

You should consider your prospects for remaining in your home during a long-term disability. In other words, do you have family or others who can give you daily companionship and care if there is money available for outside help? If the answer is “yes” you should look into the new “pot of money” design of policies which do not limit the amount of benefits available for home health care. If the answer is “no,” you may choose instead to select from the lower cost, institutional care only, policy designs.

Long-term care insurance is usually subject to “medical underwriting.” This means you have to answer health history questions and the insurance company “underwriters” decide whether or not you will qualify for their policy. If your health is poor, you usually cannot get coverage, so it is wise to apply before health problem develop.

Your cost for this coverage will be substantially lower if you do not delay in applying. The rates most insurance companies charge are level, based on your age at the time you apply, rather than increasing each year as you get older. However, if you are already in your 70’s or 80’s, it is not too late. There are still quality plans available.

Once you decide you want to apply for a policy, where do you go? Some employers offer group long-term care plans. A few associations and retirement living facilities also offer access to long-term care insurance. For most of you, it will be necessary to find an insurance agent or broker who offers this kind of coverage to individuals.

Wherever you go, it may be helpful to apply the following set of criteria:

1. Look for an agent or a broker who is knowledgeable and experienced with this kind of coverage. This person should encourage you to take the time you need to make a decision and not put you under any pressure. At the same time, this person can be an invaluable source of information as you consider and make decisions regarding the many options that are available.
2. Ask your agent or broker for an explanation of the difference between “tax qualified” and “nontax qualified” plans. You may also wish to consult your tax advisor.
3. Look for an insurance company with high ratings with the A.M. Best Company, Standard & Poors Insurance Rating Services, Moody’s Investors Service and Duff & Phelps Credit Rating Company.
4. Make it a point to study three policies that have features and provisions that are appropriate for your situation. Carefully compare coverages and costs.
5. Examine the provisions and exclusions of each policy. Find out how “preexisting conditions” are treated. Each policy approved for sale in the State of Washington must meet certain minimum standards, such as covering a disability resulting from Alzheimer’s, senile dementia or other mental or nervous disorders. However there are some policies which just meet the minimum standards and there are others which offer better, more comprehensive coverage.
6. Last, but not least, if you have a family member, or somebody else, who will become responsible for your welfare during a disability, consider including that person in your discussions as you search for a plan.

The following changes are effective as of 2001:

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- The mailing address for Medicaid applications is:

Holgate Home and Community Services Office
P.O. Box 24847
Seattle, WA 98124-0847

- To qualify for COPES benefits, the applicant’s gross monthly

income cannot exceed \$1,590.

- For a married couple to qualify for COPES or nursing home Medicaid benefits, their non-exempt resources cannot exceed \$89,000. This includes \$2,000 for the nursing home spouse and \$87,000 for the spouse at home.
- If the gross income of the spouse at home is less than \$1,452, he or she can keep income of the nursing home spouse to bring his or her total income up to \$1,452 per month.
- The divisor to calculate the transfer penalty for Medicaid eligibility has been increased from 4,130 to 4,689.

The above figures change periodically. Consult your advisor for current information on the Medicaid eligibility rules