Soaring costs and longer life expectancies pit the quality of care against the need to preserve wealth for future needs and goals. Conflicts can develop between healthy or surviving family members and those in need of costly care. Non-terminal care recipients can find their health restored but their finances decimated. Planning in advance may help maintain lifestyles and conserve assets for future needs. This article examines the availability, impact, and interplay of the three primary planning strategies for long-term care (LTC) and asset protection.

According to the American Association for Long-Term Care Insurance (2011) almost 70 percent of people age 65 and older will require some type of LTC.1 Taking this statistic further, 29 percent will require services for less than two years, 20 percent will require services for between two and five years, and another 20 percent will need care for more than five years. The study also concludes that women are three times more likely than men to need nursing-home care.

Long-term care refers to a wide range of health and support services for people who have lost some or all capacity for self-care. The goal is to allow individuals to enhance their quality of life. Such enhancements, however, aren’t cheap.2

Nationally, about 48.5 percent of today’s LTC costs are paid by Medicaid. Only about 6.6 percent is paid by private insurance, but this figure is growing. According to Long-Term Care: Financing Overview and Issues for Congress (2010),3 nearly 40 percent of the population is facing large and growing out-of-pocket payments for LTC costs.

Medicaid vs. Medicare
Medicaid and Medicare are two distinct programs. Medicaid is a safety net for the indigent and impoverished, and it is the only program that offers long-term nursing-home or at-home community care for the needy. Unlike Medicare, which has uniform federal guidelines and provides only 100 days of LTC coverage, Medicaid is administered by the individual states and varies considerably across the country.

Medicaid eligibility provides skilled care based on financial need. Medicare eligibility merely requires previous payment into the Social Security system or two years receipt of Social Security Disability Income (SSDI) payments. Medicare provides only five months of skilled (versus custodial) nursing-home coverage and requires a substantial co-payment after the first 100 days of care. Although Medicaid pays 100 percent of covered costs without time limitations, Alzheimer’s, Parkinson’s, and many other debilitating conditions do not always require skilled care and may not qualify for Medicaid absent other complications.

Medicaid’s financial qualification criteria generally limit nonexempt asset ownership to $2,000 ($3,000 total if married) per recipient. Exempt assets include a primary residence of any value, as the recipient’s spouse or another dependent relative may live there. If there is no such relative, the maximum value of a recipient’s home is $536,000, although states have the option to increase that limit to $802,000 if the Medicaid recipient either lives in the home or there is “reasonable evidence” that he or she will return to it. If there is no such relative, the maximum value of a recipient’s home is $536,000, although states have the option to increase that limit to $802,000 if the Medicaid recipient either lives in the home or there is “reasonable evidence” that he or she will return to it. After six months of hospital stay, a physician’s statement may be required to stay a state lien on the home. Exceptions to the requirement of “reasonable return” include a spouse or disabled child living in the residence.

An exception also exists for siblings who are part owners or non-disabled children who have been living in the residence for a two-year period before the nursing home or hospital stay. In this case, the state presumes that the co-habitation involved caring for the recipient and delayed the recipient’s entry into the outside facility, thereby reducing the overall drain on Medicaid.

Regardless of the residence exceptions, many states attach liens that become enforceable at the death of the recipient, giving rise to the exemption or failure of the reasonable evidence standard. Under
the “responsible relative” doctrine, the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) regulations require a lien recovery at death even if there is an at-home spouse. Note that creditor protection trusts are not exempt and even prenuptial agreements may fail against these liens.

Also exempt are modest personal property accumulations of the recipient (up to a maximum of $2,000 for individuals and $3,000 for couples), one car of any value, and a burial plot and pre-paid funeral expenses in an irrevocable funeral trust. Most states exempt heirloom jewelry, but some recognize only wedding and engagement rings. Medical necessities and medical appliances also are exempt, as are trade tools and insurance policies with a cash value of less than $1,500.

Spousal Impoverishment Act
Medicaid’s “spousal impoverishment” provisions include the standards for the Community Spouse Resource Allowance (CSRA) and the Community Spouse Maintenance Needs Allowance (CSMNA).

The specter of state legislation leaving a healthy spouse at home with meager exempt assets has been addressed as part of the Medicaid Catastrophic Coverage Act. This protection is determined by Medicaid, which provides upper and lower limits within which states must operate. It allows the non-Medicaid spouse to retain one-half of the jointly held nonexempt assets or assets in his or her name alone up to a 2015 maximum of $119,220 (subject to state-by-state reductions). Special income calculation rules may apply. For example, where certain basic household expenses are greater than 30 percent of the minimum MMNA, the at-home spouse may be entitled to keep more, known as the excess shelter amount (ESA). Rather than leaving the at-home spouse impoverished, the regulations permit states to allow retention of the minimum of (1) housing expenses greater than 30 percent of the floor amount or (2) up to 300 percent of the Social Security benefit amount. These examples are not meant to be comprehensive. Because of state-by-state variations and nuances in the income and expense regulations, an experienced practitioner should be consulted before embarking on any course of action.

At-Home Maintenance Allowance
The at-home spouse is entitled to retain monthly income subject to the 2015 maximum ceiling of $2,980.50 (subject to state-by-state reductions). Special income calculation rules may apply. For example, where certain basic household expenses are greater than 30 percent of the minimum MMNA, the at-home spouse may be entitled to keep more, known as the excess shelter amount (ESA). Rather than leaving the at-home spouse impoverished, the regulations permit states to allow retention of the minimum of (1) housing expenses greater than 30 percent of the floor amount or (2) up to 300 percent of the Social Security benefit amount. These examples are not meant to be comprehensive. Because of state-by-state variations and nuances in the income and expense regulations, an experienced practitioner should be consulted before embarking on any course of action.

New Asset Transfer Rules
Under OBRA ’93, the old Medicaid Qualified Trust has become subject to an extended “lookback” period. The new lookback rules are three years for outright gifts and five years for transfers to trusts. The five-year period begins at the latest transfer to the trust. This means that clients who wish to do trust planning must now have enough individual money or LTC insurance coverage to pay for five years of private nursing-home care, versus the old two-and-one-half-year standard.

If a Medicaid applicant has made gifts within 36 months of application, the amount of the transfers up to three years back is summed and, if the amount of the transfers would have paid for the equivalent of 50 months of nursing care, the applicant is disqualified for a period of 50 months hence. This overrides the old rules, which allowed for a maximum of 30 months of disqualification. Under the Kennedy Kassebaum Act, effective January 1, 1997, botched planning may subject a Medicaid applicant to criminal penalties if he or she applies too soon for Medicaid.

OBRA Trust Exceptions
The OBRA ’93 regulations permit trusts that protect the assets of the Medicaid recipient. Three exceptions exist to the trust five-year transfer rules. The first, which is available only in about a dozen states where eligibility is contingent on a low-income threshold, including Colorado, Florida, and Texas, provides exemptions that take the allowable amount over the threshold and places the corpus in trust for the state until the death of the special-needs beneficiary.

Second, in most states, parents who need nursing-home care and have a handicapped child (up to age 65) can transfer their entire estates into special needs trusts for the benefit of the handicapped child. Precise language is required to avoid interpretation as a support trust. Special needs trusts are specifically not designed for basic care and support, and they must be properly drafted to remain outside the reach of the beneficiary’s creditors. At the beneficiary’s death, the state is reimbursed from the remaining corpus. An OBRA ’93 special needs trust allows eligibility on the day following transfer to the trust.

This type of asset-protection trust requires an irrevocable assignment outside the reach of the grantor and the beneficiary. The reluctance to relinquish control causes many couples to hesitate, but this technique can be a true financial life saver. It can work especially well where the institutionalized beneficiary transfers assets to a well spouse, who then transfers those assets to the special needs trust. If the well spouse predeceases the institutionalized spouse, the...
special needs trust will prevent asset dissipation in favor of state liens. Remember, if the well spouse dies within three years, the three-year lookback rule may be invoked.

Third, pooled trusts, such as the Arc (formerly the Association of Retarded Citizens) of Indiana, allow individuals who are handicapped and younger than 65 years of age to transfer funds to pooled trusts for their benefit with the corpus reverting to the state at death.

Need for Private Pay
Many nursing homes will not accept a new Medicaid patient who hasn’t been a privately paid resident for the prior two or more years. Therefore, wise planning dictates that upon entering a nursing home, people have enough savings or private insurance to cover a couple years of expenses. Because of state-regulated limits on Medicaid bed allocations, it is wise to obtain a written commitment letter from the nursing-home operator acknowledging acceptance of Medicaid benefits when private resources run out.

With a written agreement, as the institution becomes aware of private funds depletion, it will be more likely to reserve a bed or provide notice that an accelerated paydown is in order. Case law is sparse but it is clear that, fair or not, nursing homes with commitments to honor are more likely to communicate with the client.

Long-Term Care Insurance
In response to concerns about the rising cost of long-term care, Congress has developed new tax incentives for private insurance. Beginning in 1997, eligible premium payments on LTC insurance may be deductible expenses. In addition, LTC policy benefits are received tax-free for all taxpayers. Deductions are based on a sliding scale and start at $360 per year for those under 40 rising to $4,550 per year for policy holders over age 70. Unfortunately, the deduction can be used only if uninsured medical expenses exceed a certain percentage of adjusted gross income (AGI). Premiums for qualified LTC insurance policies are tax-deductible to the extent that they, along with other unreimbursed medical expenses (including Medicare premiums), exceed a certain percentage of the insured’s AGI. This threshold rose to 10 percent on January 1, 2013, although it will remain at 7.5 percent for taxpayers 65 and older through 2016.

Bonus for the Self-Employed
Further Congressional encouragement of LTC programs is directed at the rising tide of self-employed taxpayers. LTC premiums up to 100 percent of the eligible premium amounts (including spousal and dependent premiums) may be deductible for the owner without meeting the AGI threshold, as long as there is a net profit to the owner from the venture. However, no deduction is allowed during a month where the spouse or self-employed individual is eligible to participate in (another) employer-subsidized LTC plan.

Partnerships
Partnership members and shareholder/employees of Subchapter S corporations with more than 2 percent ownership also may qualify for deductibility. Although the LTC premium paid by the entity is included in the AGI, a deduction is allowed up to the amount of the eligible premium amounts. Again, so long as there is a net profit from the venture, the AGI threshold does not apply.

Planning Opportunity
Where a spouse is employed in a sole proprietorship or partnership, the owner/partner may be able deduct the full premium for the spouse’s policy. This is the case even if that spouse’s policy had a shared benefit rider and/or an accelerated payment schedule.

Subchapter C Corporations
LTC premiums are generally 100-percent deductible as business expenses when purchased for employees, spouses, or dependents without limitation to the age-based ceilings. Because there are no anti-discrimination rules, the employer can be selective in the class of employees that it chooses to cover and should seek advice from legal and tax counsel. Again, an accelerated payment policy may provide advantages in this area.

Traditional LTC Policies
Option 1: Pay-As-You-Go
Depending on the needs and financial resources of the LTC client, there are two main types of policies. They provide similar LTC benefits and mainly differ in (1) the premium payment mode and (2) the availability (or not) of your money for nonpolicy uses.

This typical payment plan balances expected care needs with the buyer’s ability to pay. Much like a common term life insurance policy, this payment feature may be attractive to those who could be financially devastated by nursing-home costs and perhaps forced to seek less-expensive care. Like term life insurance, there is no cash build up and no surrender value.

With traditional long-term care, your annual premium rate is guaranteed and cannot be raised by the LTC provider unless the same cost increase is applied uniformly to the entire class of insureds in which you belong. This means that you cannot be singled out for a premium increase.

Option 2: Lump-Sum and Single-Premium Life/LTC Hybrid
For many people, however, passing assets to heirs is an important consideration. These people often wrestle with statistics and wonder if they might beat the system and avoid long-term care altogether. Others examine the coverage opportunities and either can’t afford it or opt to pay care costs out of pocket, hoping to come out money ahead versus paying for a policy, hoping they can pass more money to their kids. Unfortunately, the children often are more concerned about the financial strain and costs of care for aging parents.

The second LTC product addresses these concerns directly. Although somewhat more expensive, ready access to your funds means that if LTC coverage is not needed, your nest egg can remain intact, insuring against the risk of high care costs. Given these types of options, it is no wonder that the children of older parents are large buyers of traditional LTC and Life/LTC Hybrid policies.
This increasingly popular LTC product accepts a single deposit or a redeployment of a less productive financial asset such as a maturing certificate of deposit. For those desiring to pass assets to heirs, these policies provide a death benefit (potentially income-tax and probate free) if LTC services are not needed during life. For those who are concerned that they may need the money back one day, issuers guarantee 100-percent return of principal, reduced by any loans, withdrawals, and benefits paid, provided all plan premiums are paid. This option may be subject to a holding period and may be taxable. This assures easy access and quick liquidity of unused payments along with potential tax-deferred growth.

Summary
Safeguarding against devastating risk can be as important as properly diversifying an investment portfolio. Whether these risk-shifting programs are right for an individual client depends largely upon the client’s special needs and resources. Only by looking at your family’s situation can a meaningful LTC strategy be developed. In that regard, there is never a substitute for a personal review with a competent counselor.

Long-term care planning is fraught with subtle nuances, lack of interstate conformity, changing regulations, and legal intricacies. Qualified counsel should be consulted before entering into any plan of action that may have tax or legal consequences.

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Endnotes
5. Since life insurance and long-term care insurance are medically underwritten, you should not cancel your current policy until your new policy is in force. A change to your current policy may incur charges, fees, and costs. A new policy will require a medical exam. Surrender charges may be imposed and the period of time for which the surrender charges apply may increase with a new policy. You should consult with your own tax advisors regarding your potential tax liability on surrenders or (withdrawals).

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