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Basic Estate Planning Fact Sheet Series

Nursing Home Dilemma

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This fact sheet has an additional reference that can be ordered at no cost. The “Ohio Shopper’s Guide to Long-Term Care Insurance” is an excellent bulletin produced by The Ohio Department of Insurance. A copy can be obtained free of charge by calling 1-800-686-1526 or 1-800-686-1578 or online at www.ohioinsurance.gov/ConsumServ/Ocs/CompleteGuides/Complete_Guide_LTCare.pdf or <http://ohioinsurance.gov> (click on “Consumer Publications” under “Quick Links” then scroll through the shopper’s guides to Long Term Care Insurance). The Ohio Department of Insurance also has additional free consumer guides on automobile and home insurance, and numerous other insurance publications that you may also order by calling the above toll free number.

The nursing home dilemma is of concern to all, but not totally different from other concerns. For instance, we are concerned about being sued because we may be liable for damages we

cause in an automobile accident. Thus, most buy automobile liability insurance. We are also concerned about being disabled, loss of income, etc., but may or may not have insurance to cover those risks. Following are some things to consider concerning the nursing home dilemma, and if you should purchase long-term care insurance (nursing home insurance).

Medicaid and Medicare

Medicare pays about 10% of nursing home bills. In order for Medicare to provide coverage, you must be discharged directly from a hospital to the nursing home, require skilled nursing care, and show continued improvement to justify the skilled care. Even if you qualify for Medicare, Medicare pays the whole bill for 20 days and will pay the partial bill for generally no more than another 80 days.

Regrettably, personal savings and assets pay 40% and Medicaid (not Medicare) pays half of nursing home bills. Personal savings and assets

are depleted, then Medicaid takes over. Therefore, at the end of their stay, nearly two-thirds of nursing home patients have essentially no assets and are on Medicaid.

Medicaid eligibility requires a combination of low income and very low assets ... you can't make much or own much. To qualify for Medicaid for nursing home coverage, you must meet three eligibility tests: 1) older than 65 or disabled; 2) low income; 3) low assets or "resources."

Medicaid Income Limits

Let's consider first the income limitation. In general, to qualify for full Medicaid coverage, one must have monthly income less than \$556 if single or \$956 for a couple, not including medical insurance. If you are single and in a nursing home all but \$40 of unearned monthly income (except dollars used for medical insurance and other medical costs not covered by insurance, such as deductibles, copayments, and past medical bills) must be used to pay the nursing home bill. Anything over \$40 per month must be used to pay the nursing home, medical, or prescription expenses. If income is earned, a tad above \$100 per month (plus dollars used for medical insurance) may be retained by the nursing home resident.

If married and one spouse is in the nursing home, Medicaid calls that spouse the "institutionalized" spouse, and the spouse at home is called the "community spouse." If, and only if, the couple meets Medicaid's income and resource limits for a couple, the spouse in the nursing home is eligible for benefits. Once one qualifies for Medicaid, Medicaid allows the "institutionalized" spouse to keep only \$40 per month (plus dollars used for medical insurance). However the community spouse may keep their income. The community spouse

may even be able to keep all or a portion of the institutionalized spouse's income, depending on income of both spouses and household expenses. However, the amount of the institutionalized spouse's gross income that may go to the community spouse is \$2,610. The balance of the institutionalized spouse's income goes to pay nursing home bills and medical insurance. Medicaid then pays the rest of the nursing home bill. The County Department of Human Services determines eligibility and income to be kept by each spouse on an individual basis.

Medicaid Asset or Resource Limits

If you are single and in a nursing home, all but \$1,500 of "counted" or "non-exempt" resources or assets must be used to pay nursing home bills. Your vacant home is "safe" for six months, only if Human Services determines there is a chance you will be able to return home after the nursing home stay. If you qualify for Medicaid, Medicaid has paid your nursing home bill and you have not been able to return to your home for six months, you might have to sell the house and use the proceeds to pay the nursing home bill, until the proceeds are gone. The same could happen sooner if Human Services decides you will never be able to return to your home.

If married, the couple may have \$2,250 in combined counted or non-exempt assets in community property. If both are in the nursing home, each may have \$1,500 in those counted assets that are not "exempt." All other counted assets must be used to pay the bills Medicaid would otherwise cover or spent down in other permitted ways, such as prepaying funeral expenses. As with a single person, a couple's home is safe for six months, as long as it is possible that at least one of the couple may return to the home.

If married and only one spouse is in the nursing home or applying for Medicaid coverage, when application is made, a resource assessment is done by the County Department of Human Services. The assessment will tell the couple the amount of resources the couple can keep. Special rules apply for the treatment of resources when only one spouse enters a nursing home. All resources or assets are combined for the couple, regardless of ownership. In addition to the assets not “counted” (listed below), in 2008 the couple with one spouse in the nursing home could keep in entirety \$20,880 of additional assets. The community spouse could keep a maximum of half of the assets valued between \$20,880 and nearly \$104,400 in 2008. All asset values of more than nearly \$104,400 and the institutionalized spouse’s half would then have to be liquidated and spent before becoming eligible for Medicaid. Historically, these asset limits are increased every year.

The following assets are not “counted,” so they are not figured into the above calculations. The following assets may be retained (in addition to the above) by the community spouse: 1) the home; 2) the car if any one of the following: a) it is the community spouse’s, b) if equipped for a disabled person, c) if used for employment, or d) if valued at \$4,500 or less; 3) wedding rings; 4) furniture; 5) certain other assets exempted by Medicaid.

However, if Medicaid pays your bills and you have the “uncounted” assets stated above, Medicaid may recover those bills up to the value of the remaining “uncounted” assets.

The bills may be recovered in two ways. First, if your spouse or dependent children are not living in the home, after Medicaid has paid for nursing home bills for six months or they determine you will not be able to return to

your home, the “uncounted” or “protected” assets may be sold and the cash used to pay nursing home bills. Second, Medicaid’s “estate recovery” program would have a claim against the proceeds of your estate for any expenses Medicaid paid for those 55 or older. Assets in an estate such as a home may have to be liquidated to cover the Medicaid claim.

That means your home is “protected” only for the use of you, your spouse, or your dependents. Your home is not protected from Medicaid for the purpose of passing it to heirs who are not dependents. It is protected for you or your spouse only as long as you live there or your spouse lives there, and for dependents only as long as they are dependents and live in the home.

Medicaid will have a claim against your estate when you and your spouse have both died and all taxes, funeral expenses and other estate settlement costs have been paid unless your heirs can persuade probate court that Medicaid recovery would work an “undue hardship” on them. For example, if your estate were a family business (farm) and Medicaid recovery would put the survivors out of work, or if the survivors are disabled or minors, assets may be passed on to heirs.

A prior “loophole” was closed on June 30, 2005, as part of the State Budget Bill. Previously, if a married couple owned property (real estate, bank accounts or other assets) in a form that avoided probate, such as joint tenants with right of survivorship (JTRS), the property passed directly to the person with survivorship rights. However, the change in the law now expands estate recovery to:

“any other real or personal property and other assets in which an individual

had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.”

Then comes the question, can I qualify for Medicaid if I put my assets into a trust where they are not available for my care, or can I give my assets to my children? Maybe, but the action must have been done a significant amount of time before making Medicaid application. If gifts were made too close to making application, Medicaid considers a portion of the assets gifted to be available and requires “spend down” of that portion of such gifts before making Medicaid payment. As a result of a change in the law on February 8, 2006, gifts must be made 60 months before Medicaid application to avert a portion being required to be spent down. Any gifts made during this lookback period create a period of disqualification that begins at the date of application under the new law. Under the old law, the disqualification began at the time of gift. Therefore, it may be even more important for the application for Medicaid to not occur until after the end of the 60 months or law applicable at date of application.

The terms of the trust will also make a difference for Medicaid eligibility. This is an area that changes often. With the new estate recovery applying to life estates and living trusts, it is easy to see the state trying to go after any retained interest in the trust. Ohio’s new Trust Code that took effect on January 1, 2007, also contains an exception for the State of Ohio to potentially reach interests of beneficiaries. However, a wholly discretionary trust may not

be considered an available resource. Ohio has also become more aggressive at putting liens on property. A number of issues are being addressed in court.

You should plan well before you have a need for Medicaid benefits, because the rules are getting more and more restrictive. As the proportion of the state’s budget spent on Medicaid continues to increase, this trend is likely to continue.

More on Medicare

Medicaid pays half of nursing home bills while Medicare pays 10% of the U.S. total nursing home bill. This is the case because Medicare pays only when you meet these very strict conditions:

- 1) hospitalized for at least four days in a row (counting the day of discharge)
- 2) your doctor has ordered daily skilled care
- 3) you enter a Medicare-approved, skilled nursing home within 30 days of leaving the hospital
- 4) you are admitted to the nursing home for the same thing for which you were in the hospital
- 5) you require daily skilled care that can only be provided in a skilled nursing home facility
- 6) you continue to make progress and respond to skilled care.

If you do qualify for Medicare, it will pay for 100 days of nursing home care. Medicare will pay the total bill for the first 20 days of care. For the next 80 days you pay up to the first \$128 per day and Medicare pays the rest. You pay the total bill after 100 days. Medicare generally fully covers medically necessary home health visits if you are homebound, if they are part-time or

intermittent skilled nursing services. However, full-time nursing care at home is not covered, nor are drugs or meals delivered to the home. You pay 20% of medical equipment costs, as well as personal care and housekeeping when cared for at home.

Those certified as terminally ill are eligible for hospice benefits from Medicare. In general, hospice services provided in your home are fully covered, except for needed drugs. If medical care is needed, but not for a condition related to the terminal illness, regular Medicare benefits are available.

Several words of caution are in order. First, the summaries of Medicaid and Medicare above are only that. Medicaid and Medicare are much more complicated than indicated above. Second, Medicare will be further discussed in the next fact sheet in this series. For more details contact your county Department of Human Services or call 1-800-324-8680, Ohio Department of Job and Family Services for assistance and various brochures.

Second caution, some plan to, have, or will qualify for Medicaid and plan to protect their assets by giving or putting in trust their assets to the heirs before the nursing home stay. Some plan to do this through a special kind of trust where they lose *all* control over the funds and some do this by outright gift. However, these transfers need to be made at least five years before application, and recent law changes in Ohio have made this very difficult. Also, gifting may eliminate the benefit of “stepped up basis.” Before implementing such a strategy, obtain the advice and council of a competent attorney. Also, call 1-800-282-1206 to get the free brochure “Understanding Estate Recovery” from the Ohio Department of Aging.

Should You Buy Insurance to Protect Your Assets from Nursing Home Bills?

The cost of nursing home insurance is substantial, but it is one tool to protect your assets from nursing home bills. The range of monthly premiums for nursing home coverage in 2005 for two year policies paying \$100/day for women with no elimination period (days in nursing home before pay) and no coverage withheld for pre-existing conditions but with Home, Day, Assisted Living, and Care Giver benefit was as follows:

Purchase Age	Cost/Month (with inflation protection)
55	32–80 (73–174)
65	62–147 (93–293)
75	165–433 (214–642)

The range of monthly premiums for home care plans for one year paying \$50/day for women with no elimination period (coverage starts immediately) and no restriction on pre-existing conditions but with respite and day care in 2005 was:

Purchase Age	Cost/Month (with inflation protection)
55	13–16 (21–31)
65	22–31 (34–58)
75	41–90 (56–140)

Of course, costs are higher now. The rates are lower for those who purchase at a younger age. This is true because the younger the purchaser, the more money the insurance company will likely receive before the nursing home expenses begin.

So, when considering the nursing home insurance dilemma, one needs to consider both

nursing home insurance cost and the possible benefits from nursing home insurance. When looking at only money considerations, the less your assets the less nursing home insurance is likely to benefit you and your heirs. There is less money to be lost from paying nursing home bills before Medicaid takes over.

So, how do you decide if you should purchase long term care insurance? Many financial advisors don't recommend long term care insurance unless the following are true:

- You have assets of at least \$75,000 not including your house or car unless you wish to pass those debt free to your heirs or
- You have individual retirement income of \$25,000 to \$35,000 or \$35,000 to \$50,000 for a couple that you wish to protect from being used to pay nursing home bills

And

- You are able to pay premiums without difficulty
- You have heirs to which you wish to leave a significant inheritance

Or

- Long term health insurance will significantly increase your peace of mind

How do the financial advisors arrive at the above figures? First, for those not in a nursing home, there is a 52% chance of going into a nursing home for a woman but only a 33%

chance for a man. So, half of women but only a third of men will get payment from nursing home insurance if they have the insurance when they enter and stay in the nursing home long enough. Half of women or a third of men will never get payment from nursing home insurance, even if they buy it.

Table 1 gives your odds of various lengths of nursing home stays and the approximate accompanying costs.

Odds are that those who purchase nursing home insurance will not get back the money they paid in, but those same odds are true with any insurance. However, those who end up staying long term in a nursing home will likely use up all their assets to pay for the nursing home bill. Forty percent (40%) of nursing home bills are paid by individuals, 40% by Medicaid, nearly 20% by Medicare, but only about 1% by insurance.

So, how much does nursing home care cost? A 2007 Genworth Financial survey found the following costs:

- \$60,250/year for a semi-private nursing home room (add \$6,800 for private)
- \$30,000/year for private, one bedroom assisted living facility
- \$51,700/year for a Medicare-certified 50 hour/week home health aide
- \$44,100/year for 50 hour/week homemaker services

Odds of Being in Nursing Home Women (Men)	Length of Stay	Approximate Cost for Private Room at \$180/day
52% (33%)	- 0 -	- 0 -
33% (22%)	3 months or less	\$16,200 or less
7% (5%)	6 months to 1 year	\$33,500 to \$67,000
5% (3%)	As long as 3 years	\$200,000 for 3 years

Many people “spend down” to Medicaid eligibility. That means that they pay their own bills until they run out of money and Medicaid then begins paying their bills. At some point in their stay, almost two-thirds of Ohio’s nursing home patients are covered by Medicaid.

A logical way to decide if nursing home or home care insurance should be purchased is to ask your heirs. Since your heirs are the ones who will get the money if not used for nursing or home care bills, they are the best ones to decide.

Ohio also has created a long-term care partnership program that helps you protect additional assets when you purchase new qualified policies. For example, if you buy a qualified policy and receive \$50,000 in benefits under the policy coverage, the Medicaid program will allow you to retain \$50,000 of other assets and still apply for Medicaid. Normally, you would be required to spend down the \$50,000 before Medicaid would provide any benefits.

Will You Need Long Term Care and Who Will Pay?

The above are averages, but no one is average. Will you beat the averages? No one knows, but if your family has lived long, you too may live longer. The longer you live, the more likely you will need nursing home care. If your family has a history of senility or Alzheimer’s in their old age, the more likely nursing home care will be needed for you, and it will be more likely to be long term. If you have had a history of health problems, have been a heavy smoker, have high blood pressure or diabetes, or other conditions or habits that result in chronic health problems, your chances of being in a nursing home are higher. But, if you are and have been healthy, nursing home care is less likely. Also, if rela-

tives or friends will be willing and able to care for you in the event you can’t, then a nursing home stay is less likely.

Shopping for Nursing Home Insurance

The bulletin that you can order at the 800 number below is excellent in assisting you if you choose to purchase nursing home insurance. If you won’t be purchasing nursing home insurance, ignore the rest of this fact sheet. If you attempt to compare policies, you will be confused. But this is the case when attempting to compare any insurance policy. If you choose to shop around, use the outline of coverage (required to be given to you by the insurance agent) to compare policies and get the updated version of the bulletin before you begin shopping and definitely before purchase by calling 1-800-686-1526. Also, Consumer Report has excellent articles on nursing home insurance. It is available at your public library.

If you change your mind after you have purchased a policy, you have 30 days to get your money back. Never pay for a policy with cash. You should always buy from a reputable company. If a licensed company goes bankrupt, your insurance is protected (up to \$100,000 by the Ohio Life & Health Guaranty Association). If you are approached by a company not listed in the bulletin, call 1-800-686-1526 to see if the company is licensed in Ohio, or if you become confused, call 1-800-686-1578 to speak with a counselor.

Perhaps the most important feature of the bulletin is the chart of premiums and benefits. The chart compares policies that will pay for benefits for two or four years. Again, to get the bulletin and chart call either of the above toll-free numbers.

The following is an explanation of some features of nursing home insurance:

DAILY BENEFIT: The average cost of nursing home care in Ohio is about \$180 per day, so policies generally provide daily benefits of at least \$100 per day.

ELIMINATION DAYS: Elimination days are similar to a deductible in car insurance. The more money you have to pay before your car insurance will pay, the lower the premium. The more days of nursing home stay you have to pay before the insurance pays, the lower your premium for nursing home care or the longer the “waiting” period before your insurance pays. Most policies in the bulletin chart require you to pay between no days to 100 days before they will pay. Assuming a cost in a nursing home of \$180 per day, a 20 day waiting period would require you to first pay \$3,600 before the insurance would pay. A 60 day waiting period would require you to pay \$10,800 before the insurance would take effect, but a 100 day waiting period would require you to pay \$180,000 before the insurance would pay anything.

HOME CARE: In addition to nursing home care, some policies also offer home care benefits, generally with a higher premium cost. Where this benefit is included, the payment amount for home health care is often only about one-half the amount the policy pays for nursing home care. Some policies only offer home care benefits and do not offer nursing home care benefits.

INFLATION PROTECTION: Most policies add 5% inflation protection to the daily benefit amount each year. The cost of nursing home care increases at about that rate each year. If the benefit is compounded, it increases more than if simple interest is used to increase the

benefit. So a compounded benefit on your policy is better than simple rate increase. If the policy doesn't increase benefit, but allows you to add to benefits at specified times, (GPO or Guaranteed Purchase Option), the premium may be lower at first, but will likely catch up with the other policies as you add to your daily benefit in the future.

RESPIRE: Respite care benefits pay for a temporary substitute if relatives or friends are caring for you at home. Those families who plan to provide the care for their aging members should pay special attention to respite care.

ACCIDENTAL LAPSE PROTECTION: This provision is required in all policies sold in Ohio since 1994. When you buy a policy, you are asked to designate another person who will receive a copy of all cancellation notices. Then, even if the policy is canceled for late payment, you can reinstate it within 5 months, *if* your doctor certifies that you had mental disability during that time.

Outline of Coverage and Shopping List

To help you compare the provisions of different policies, all long term care insurance policies in Ohio are required to provide you with an outline of coverage. The first page of the outline must follow a standard format, which is provided to you in the bulletin. Call the toll free number to get the bulletin and look for this outline of coverage. It will help you to compare policies.

The bulletin also contains a form to help you compare 4 different policies. The most important features of policies are listed on this form. If you have trouble using the form, call 1-800-686-1578 and they will refer you to a counselor located near your home.

Ohio Senior Health Insurance Information Program

The Ohio Department of Insurance coordinates a program to personally assist seniors. The Ohio Senior Health Insurance Information Program, accessed by the same toll free numbers above, has volunteer counselors throughout Ohio to help you 1) decide if your insurance coverage is adequate, 2) select the appropriate insurance program, 3) deal with and make sense of the medical bills and statements you receive, 4) make sure you get the benefits you are entitled to, and 5) better understand insurance and Medicare.

These fact sheets should in no manner be considered as a replacement for consulting with estate planning professionals, nor should the general principles in these fact sheets be applied to specific situations without consulting with an attorney.

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TDD No. 800-589-8292 (Ohio only) or 614-292-1868

Your Response

Fact Sheet 10

1. Assuming you hit the averages:

- a. What are your chances of *never being* in a nursing home? _____
- b. What are your chances of *being* in a nursing home? _____

2. Assuming you hit the averages:

What are your chances	
a. of being in a nursing home 3 months or less	
b. of being in a nursing home 6 months to 1 year?	
c. of being in a nursing home as long as 3 years?	

3. Who pays the nursing home bill in the United States? Assuming all nursing home bills are combined and lumped together, the percent paid by Medicaid and the percent paid by the resident or his or her family are the same. What is that percent?

- _____ 10%
- _____ 40%
- _____ 80%

4. Do you plan to investigate nursing home insurance?

Yes _____ No _____

Only you can decide if you need a policy. Only you can decide which policy is best for you. This fact sheet will help you to decide if you should buy a policy. But, if you decide to buy, call 1-800-686-1526 and/or use the bulletin to shop for your policy. At that number also you can ask to talk to a counselor at the Ohio Department of Insurance.

Answers

Fact Sheet 10

1. Assuming you hit the averages:

- a. What are your chances of *never being* in a nursing home? 48% for women; 67% for men
- b. What are your chances of *being* in a nursing home? 52% for women; 33% for men

Women are more likely to go into a nursing home because they live longer and are more likely to become feeble.

2. Assuming you hit the averages:

What are your chances	
a. of being in a nursing home 3 months or less	33% women, 22% men
b. of being in a nursing home 6 months to 1 year?	7% women, 5% men
c. of being in a nursing home as long as 3 years?	5% women, 3% men

3. Who pays the nursing home bill in the United States? Assuming all nursing home bills are combined and lumped together, the percent paid by Medicaid and the percent paid by the resident or his or her family are the same. What is that percent?

- _____ 10%
- _____ 40%
- _____ 80%

Forty percent of nursing home bills are paid by Medicaid. Two-thirds of those in a nursing home “spend down” their assets and savings so Medicaid pays the remainder of their nursing home bill.

4. Do you plan to investigate nursing home insurance?

Yes _____ No _____

Only you can decide if you need a policy. Only you can decide which policy is best for you. This fact sheet will help you to decide if you should buy a policy. But, if you decide to buy, call 1-800-686-1526 and/or use the bulletin to shop for your policy. At that number also you can ask to talk to a counselor at the Ohio Department of Insurance.

For those that wish to purchase nursing home insurance, we hope you can afford the policy you desire. If so, you will likely take the next step and purchase nursing home insurance. Then your shopping begins. We suggest that your shopping start with this bulletin.

If the answer is no, you are the majority. This is not the end of the world, as most don't and won't have nursing home insurance. Remember that only 1% of nursing home bills are paid by insurance, and that the chance of getting any payment from a policy with a 100 day waiting period is 33% for women and 22% for men.