Four Myths about Paying for Long-Term Care

Long-term care is scary! Most of us don't want to think about the time when our loved ones, let alone ourselves, will need help with the basic personal tasks we all take for granted. Yet we can't escape reality. According to at least one statistic from the Henry J. Kaiser Family Foundation, 1 in 3 people turning 65 will require nursing home care at some point.

Even scarier is the cost. The most recent Genworth Cost of Care study reports the national median cost of nursing home care in a semi-private room was over $84,000, **well over** the annual income of most seniors. And the reality is that most people can't adequately prepare for this large of an expense because they have insufficient resources to do so, and those who likely can prepare, often don't. One reason for the lack of planning may be the myth that Medicare will cover much of the cost. Another may be the myth that one can simply transfer assets to family members and immediately qualify for Medicaid.

Let's take a look at 4 myths related to paying for long-term expenses.

Myth 1: Medicare pays for long-term care expenses

Medicare will cover a portion of the costs for a **limited** stay in a skilled nursing facility or for home health care if ALL of the following conditions are met:

- A recent prior hospital stay of at least three days;
- Admittance to a Medicare-certified nursing facility within 30 days of a prior hospital stay (not all facilities are Medicare-certified); and
- Care such as physical therapy or skilled nursing services is needed for the condition that caused the hospital stay. The care must be considered rehabilitative (meaning it is expected the individual's condition will improve). Generally, Medicare does not cover ongoing care for chronic illnesses.

The amount covered is as follows:

- 100% of the cost for the first 20 days of care; and
- The balance above the patient's responsibility of $167.50/day for the next 80 days of care.

To be clear, after 100 days, Medicare **does not pay anything even if the individual clearly still needs care.**

Myth 2: Medicaid pays for long-term care expenses once someone is completely broke

In order to receive Medicaid benefits (room, board, and medical services in a skilled nursing facility or a supportive living facility, but not an assisted living facility), individuals must qualify both medically and financially.

While financial eligibility requirements vary by state, there are some general guidelines:

- Asset Limits
    - In general, a Medicaid applicant can have no more than $2,000 of countable assets, although the number varies by state. Note that countable assets include savings, retirement, and investment accounts as well as most cash-value life insurance. While

neither a home (if the applicant intends to or, in some states, is likely to return to the home, or a spouse or dependent lives in the home) nor a car count as includible assets, there is a cap on the home equity that varies by state (unless a spouse or dependent lives in the home).

- The asset limits for married couples are higher. In most states, the "community spouse," also known as the spouse not applying for Medicaid, is allowed to keep $123,600 of assets for 2018.

Keep in mind that some states require that the home be used to pay back Medicaid (once the individual and the individual's spouse are no longer in the home), and they reserve the right to file a Medicaid-lien against the property.

- Income Limits

  - States that are referred to as "income cap states" set a hard income maximum of 3 times the government's Supplemental Security Income (SSI). In 2018, this limit is $2,250 per month, although in some cases lower income limits may apply.

  - States that are referred to as "non-income cap or spend-down states" consider an individual's income relative to the cost of care. The amount by which the individual's income exceeds the state's limit is considered excess income. In order to qualify for Medicaid benefits, the individual is required to spend the excess income every month on her own care before Medicaid will pay the balance.

Myth 3: To qualify for Medicaid, you may transfer assets to your family members

With very few exceptions, individuals may not give all of their assets away on Friday and then apply and qualify for Medicaid on Monday. To prevent this from taking place, there is a "look-back period," and individuals who transfer assets without receiving fair value during this period will be subject to a penalty. This period is for a set amount of time from the date of application, currently 5 years for all states except California. All financial transactions made during this period must be disclosed to, and will be reviewed by, Medicaid. The penalty for transferring assets during this time is the number of months Medicaid will not cover the costs even though the person is otherwise eligible.

Here's how the penalty period is calculated. The amount that was transferred during the look-back period is divided by average cost of a nursing home stay in the state of residence. If the amount transferred during the period was $60,000 and the average cost of care in the state is $6,000, the penalty period would be 10 months. This means that although the person is medically eligible and out of money, there would be no Medicaid coverage during the penalty period. This is clearly a problematic situation. The good news is that if the recipient still has the asset that was transferred, the penalty can be "cured" if the transferred asset is returned.

For more information on the look-back period, visit Paying for Senior Care.com.

Myth 4: It is illegal to plan for Medicaid eligibility

As contrary as it sounds, it is currently legal (although by no means simple) for individuals to plan in advance for Medicaid eligibility. Whether "Medicaid planning" is ethical has been debated for years. On one side are those who think that the program should be for those who are truly in need. On the other side are those who believe they worked hard, scrimped and saved, and paid their fair share of taxes and why

shouldn't the government pay for their care. In the middle are people who understand that the Medicaid program cannot possibly cover care for everyone (and as taxpayers, none of us would be too happy about paying the taxes needed to fund such a program) but are concerned that the costs will wipe out their savings and unduly burden their families.

If you are interested in exploring how to plan for Medicaid, below are a few tips:

1. Don't wait for a crisis as planning, to be effective, often must occur well in advance of the need for care. Seek out an experienced elder law attorney (a great resource is the National Academy of Elder Law Attorneys) or benefits planner immediately.

2. Planning for Medicaid eligibility may be inconsistent with other tax and financial planning you have done. If you work with an accountant and/or financial planner, make sure to keep them in the loop and seek their advice.

3. Understand that not all nursing homes accept Medicaid. Some accept Medicaid but they have a limited number of "Medicaid" beds and a private pay requirement before an individual may be added to the Medicaid-bed list. Other facilities are 100% Medicaid funded (and are generally not as desirable). If you have identified the facility where you or a loved one hope to stay, if needed, make sure to understand their policies (and realize they may change before care is actually needed).

The key takeaways? Dealing with long-term care needs is emotional and expensive and the rules and requirements of Medicare and Medicaid are confusing. The more knowledgeable and prepared you are, the better positioned you will be to manage it all.

About the author: Tammy Wener, CFP®, MBA is the co-founder of RW Financial Planning, LLC in Lincolnshire, IL, a financial planning firm dedicated to providing objective, thoughtful, and candid advice on an hourly or project basis.

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Tammy Wener, CFP®, MBA
RW Financial Planning, LLC
475 Half Day Rd., Suite 100
Lincolnshire, IL 60069
twener@rwfinancialplanning.com
(847) 777-0272 (tel)