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Medicaid in Crisis:

States look at life insurance policy conversions to save money

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Issue Brief

Over 10 million Americans require long term care annually and Medicaid is the primary payor of long term care services in the United States. For tax payers, this is an expensive proposition because the annual average cost of a nursing home is \$87,000, memory care is \$92,000, assisted living is \$42,000, and for home healthcare services it is \$43,000. These costs are rising ever year, and most people will drain all personal savings and assets paying for long term care within their first year.

Medicaid and state budgets have been impacted particularly hard by shrinking tax dollars and growing Medicaid enrollment brought on by the economic crisis and an aging population. States are legally required to operate with balanced budgets every year, and draconian cuts as well as federal assistance have become necessary to try to keep up. In 2009, Medicaid spent \$240 billion on long term care services, by 2011 that number had almost doubled to \$427 billion. States spend on average 16% of their annual budgets on Medicaid—making it the second biggest budget item behind only education. Medicaid covers 70% of nursing home costs, and to try to get costs under control the Center for Medicare and Medicaid Services (CMS) instituted an 11.1% reduction in long term care reimbursements starting in 2012.

“What is new is the concerted effort to integrate life insurance policies and long term care providers. This is a recent development involving – Life Care Funding. This new source of funds represents a potential alignment of long term care providers and state governments. Both state governments and the long term care industry are working to find a solution to the budgetary threat to Medicaid created as aging Baby Boomers impoverish themselves in order to have the state pay for long term care.”

Conning and Company, Strategic Research Series

As the pressure mount, States have begun looking for alternative ways to stimulate private dollars to help pay for the costs of long term care and reduce the pressure on Medicaid budgets. One example was the unanimous passage by the National Conference of Insurance Legislators (NCOIL) of the Life Insurance Consumer Disclosure Model Law requiring that life insurance companies inform policy owners they have a number of options to consider instead of abandoning an in-force policy. Among the options in the law is the right to convert a life insurance policy into a Long Term Care Benefit Plan.

“It is imperative that policy holders understand that they have alternatives to merely lapsing or surrendering their policy. The model would require a clear notice to consumers... including conversion to long term care.”

NCOIL President Rob Damron (KY)

This Model Law led to a flurry of legislative activity in 2103 resulting in eight states introducing legislation based on Life Care Funding’s program as a way to encourage more use of Private Pay for Homecare, Assisted Living, Skilled Nursing and Hospice through the conversion of a life insurance policy into a Medicaid Life Settlement funded Long Term Care Benefit Plan. Converting a life insurance policy to pay for Senior Care is already the legal right of every owner of a life insurance policy in the U.S.-but most don’t realize it and are too quick to abandon a policy to jump onto Medicaid. This consumer disclosure law grants authority to Medicaid Departments to inform and educate their citizens that an alternative to lapse or surrender of a life policy is to convert into a private market Long Term Care Benefit Plan which allows a policy owner to remain private pay longer before they would go onto Medicaid. Florida estimates that the annual savings from this law for the Florida Medicaid Department would be \$150 million. The states that have introduced this groundbreaking legislation in 2013 are *California, Florida, Kentucky, Louisiana, Maine, New Jersey, New York and Texas*. In June, 2013, Texas was

the first state in the nation to pass this consumer protection measure into law. What does this mean? It means that states are now passing laws endorsing the use of life insurance policies as a means to pay for long term care services because they are realizing the importance of unlocking the hidden value in life insurance policies before the owner allows it to lapse or surrender. The option to convert a policy to pay for long term care is available in all states, and these notification laws are being introduced and passed to make sure people are informed by their Medicaid Departments that this program is an accepted part of a Medicaid spend-down.

Statutory requirements of the Medicaid Qualified Long Term Care Benefit Plan include:

- A schedule evidencing the total amount payable, the number of payments and the amount of each payment required to be paid for long term care;
- All proceeds must be held in an irrevocable state or federally insured account;
- The lesser of five percent (5%) of the face amount of the life insurance or \$5,000 is reserved as death benefit payable to the estate or beneficiary;
- And, the balance of payments required under the contract unpaid at death of the must be paid to the estate or a named beneficiary.

When a policy owner converts their life insurance when applying for Medicaid instead of abandoning it, they are able to choose the form of care they want because they remain private pay and in control of their own care decisions. Instead of immediately spending-down their assets to below the poverty level to qualify for Medicaid and become a ward of the state, they can decide if they want care provided by a nursing home, assisted living community or using home healthcare. Because the policy conversion is considered a “qualified Medicaid spend-down” of a life insurance policy asset, once the private pay Benefit has been spent-down, they will be able to seamlessly move over to Medicaid. This option also allows the owner to preserve a portion of the

death benefit throughout the spend-down period, protecting it from Medicaid Recovery legal action against the estate.

The policy conversion option benefits seniors and their families; providers of long term care services; and tax payers in every state:

- The policy owner and their family are able to convert a life insurance policy and use the proceeds in a Medicaid qualified spend-down to extend the time they are private pay before moving to government assistance. This allows freedom to choose the form of care they want, as well as financial control and dignity for themselves and their families.
- Providers of long-term care services benefit because they are operating under extremely thin margins and private pay dollars translate into higher quality services for everyone under their care.
- The longer a person can remain private pay before becoming Medicaid-eligible, the more budget/tax savings for the citizens of every state in America.

Sources:

Kaiser Family Foundation, Medicaid Fact Sheet, March 2011 and State Fiscal Condition and Medicaid Report, October 2010

National Conference of Insurance Legislators (NCOIL), Life Insurance Consumer Disclosure Model Law, November 2010

MetLife Mature Market Institute, Market Survey of Long Term Care Costs, 2010 and 2011

Florida State University-Center for Economic Forecasting and Analysis, Conversion of Life Insurance Policies to Long Term Care Benefit Plans in Florida, January 2013

Medicaid Eligibility Q&A

Q: Who Qualifies for Medicaid?

A: Eligibility for Medicaid's long-term care services is limited to persons who meet a state's functional level-of-care standards and certain financial standards (i.e., income and asset level tests). Persons qualify for Medicaid in one of the three ways: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus "spending down"; or (3) they divest of their assets to meet these income and asset standards sooner than they otherwise might if they first had to spend their income and assets on the cost of their care.

Q: What is the "Look Back" period to count assets for Medicaid Eligibility?

A: The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) or DRA lengthens the look-back period from three years to five years for all income and assets disposed of by the individual after enactment. It does not change the look-back period for certain trusts, which was already five years prior to DRA's enactment. Under this change, asset transfers for less than fair market value of all kinds made within five years of application to Medicaid would be subject to review by the state for the purpose of applying asset transfer penalties. The DRA expands the types of assets that are counted for the purpose of Medicaid eligibility and asset transfer penalties. Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed \$2,000 for an individual. Current law requires states to recover the private assets of the estates of deceased beneficiaries who have received certain long-term care services. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual, and includes only certain assets that remain in the estate of the beneficiary upon his or her death. For purposes of recovery, estates are defined as all real and personal property and other assets as defined in state probate law. At

the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death. In general, assets such as living trusts, life insurance policies, and certain annuities that may pass to heirs outside of probate would be subject to Medicaid recovery.

Q: Does ownership of a life insurance policy count against an applicant for Medicaid eligibility?

A: A life insurance policy is legally recognized as an asset of the policy owner and it counts against them when applying for Medicaid. If a policy has anything more than a minimal amount of cash value (usually in the range of \$1,500-\$2,000) it must be liquidated and that money spent towards cost of care before the owner will qualify for Medicaid. All Medicaid applications specifically ask if the applicant owns life insurance and full policy details. Failure to disclose and comply is fraud.

Some states allow for a final expense policy to be kept or transferred to a funeral home (but the funeral home would keep the entire death benefit). Medicaid recovery units have become much more forceful about looking for life insurance policy death benefits (declared and undeclared) that have paid out to families after the death of a Medicaid recipient. Medicaid budgets are now facing extreme pressure and asset recovery efforts can be very aggressive. Recovering the entire cost of care through legal actions against the estate and surviving family to claw back the death benefit payment is common

Q: Are Medicaid Guidelines and Asset Eligibility Rules Strictly Enforced?

A: Since the enactment of the Omnibus Budget Reconciliation Act of 1993, Medicaid's rules concerning eligibility, asset transfers, and estate recovery have been designed to restrict access to Medicaid's long-term care services to those individuals who are poor or have very high medical or long-term care expenses, and who apply their income and assets toward the cost of their care. In an attempt to discourage Medicaid estate planning, (a means by which some individuals divest

of their income and assets to qualify for Medicaid sooner than they would if they first had to spend their income and assets on the cost of their care), the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) contained a number of provisions designed to strengthen these rules. Medicaid beneficiaries are allowed to retain certain assets and still qualify for Medicaid. The Medicaid estate recovery program is intended to enable states to recoup these private assets (e.g., countable and non-countable assets held by recipients) upon a beneficiary's death to recover Medicaid's expenditures on behalf of these individuals. Since 1993, Medicaid law has required states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care, related services and other services at state option.

Q: What options do owners' of a life insurance policy have when attempting to qualify for Medicaid?

A: Medicaid rules are very clear that a life insurance policy is an unqualified asset and counts against Medicaid eligibility. The owner of one or more policies has a variety of options to consider:

- A policy with more than a minimal amount of cash value (usually \$1,500-\$2,000 depending on the state) must be liquidated with the proceeds spent down on care.
- A policy with no cash value does not need to be liquidated but the death benefit will be subject to federally mandated DRA Medicaid recovery efforts to "claw back" the amount of money spent on care.
- Many states will exempt a funeral or "final expense" policy if the full death benefit value is assigned to a funeral home.
- Assignment of a life insurance policy for less than its fair market value is a violation of asset transfer rules if done within the 60 month look back period.
- A policy owner has the legal right to convert a life insurance policy into a Long Term Care Benefit Plan at its fair market value and extend their spend-down period by covering cost of care while preserving a portion of the death benefit until exhausted.

Q: How does a policy conversion work?

A: A Long Term Care Benefit Plan is the conversion of an in-force life insurance policy into a pre-funded, irrevocable Benefit Account that is professionally administered with payments made monthly on behalf of the individual receiving care. This option extends the time a person would remain private pay and delays their entry onto Medicaid. By converting an existing life insurance policy into a Long Term Care Benefit plan, the owner is spending down the asset towards their cost of care in a Medicaid compliant manner while still preserving a portion of the death benefit. If the insured passes away while spending down their Benefit Account, any remaining death benefit would pay out to the designated account beneficiary without being subject to Medicaid recovery. By obtaining the fair market value for the life policy, and then at the direction of the policy owner putting the funds into an irrevocable bank account which can only be administered third-party to pay for Medicaid/Medicare qualified long term care services; the Long Term Care Benefit Plan is a regulated and Medicaid qualified financial vehicle to help cover the costs of long term care.

Converting a life insurance policy into a Long Term Care Benefit Plan provides multiple layers of consumer protections:

- The transfer of ownership of life insurance policies conforms to the rigorous regulatory standards that govern life settlements in each state.
- The irrevocable, FDIC insured Benefit Account is held by a nationally chartered bank & trust company and must conform to federal and state banking regulations.
- Because the account is irrevocable and can only be spent on long term care services, the Benefit Plan is administered as a Medicaid qualified spend-down.

Sources

Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS) (www.hhs.gov)
United States Government Accountability Office (GAO), Report to the United States Congress, "Medicaid Long Term Care" report, March 2007
Order Code RL33593, Congressional Research Service (CRS) Report, January 31 2008

Medicaid Eligibility Fact Sheet

What is Medicaid: Medicaid is a combined federal and state funded health care reimbursement program that helps many people who can't afford medical care pay for some or all of their medical bills. Medicaid is available only to children, people with limited income, disabilities and medical necessity. According to Medicaid guidelines, you must meet certain requirements in order to be eligible for Medicaid which will vary by state.

Who qualifies for Medicaid: Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These may include your age, whether you are pregnant, disabled, blind, or aged; your income and resources (like bank accounts, real property, life insurance, or other items that can be sold for cash); and whether you are a U.S. citizen or a lawfully admitted immigrant. The rules for counting your income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home.

Who qualifies for Long Term Care to be covered by Medicaid: In addition to financial eligibility, States determine if an individual meets the functional criteria by assessing the limitations in an individual's ability to carry out activities of daily living (ADL) and instrumental activities of daily living (IADL). The Medicaid statute requires states to use specific income and resource standards in determining eligibility; these standards differ based on whether an individual is married or single. If a state determines that an individual has transferred assets for less than "fair market value" (FMV), the individual may be ineligible for Medicaid coverage for long term care for a period of time.

Individuals who incur high medical costs may "spend-down" into Medicaid eligibility because these expenses are deducted from their income. Spending down may bring their income below the state determined income eligibility limit.

What type of assets count against Medicaid eligibility: Income and Assets are both calculated to determine Medicaid eligibility as part of a Medicaid application. Income from work, investments,

and entitlements such as Social Security all need to be reported by the applicant. Assets such as cash, stocks, bonds, trusts, annuities, real estate, vehicles and life insurance all must be reported and are calculated for eligibility. States determine their own specific eligibility standards within federally mandated parameters.

How does Medicaid view "Asset Transfer" and Asset Recovery" inside the Look Back Period:

According to the Center for Medicare and Medicaid Services (CMS)—Transfers of Assets for Less Than Fair Market Value: This practice is prohibited for purposes of establishing Medicaid eligibility. Applies when assets are transferred, sold, or gifted for less than they are worth by individuals in long-term care facilities or receiving home and community-based waiver services, by their spouses, or by someone else acting on their behalf.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Estate-Recovery.html>

Estate Recovery: State Medicaid programs must recover from a Medicaid enrollee's estate the cost of certain benefits paid on behalf of the enrollee, including nursing facility services, home and community-based services, and related hospital and prescription drug services. State Medicaid programs may recover for other Medicaid benefits, except for Medicare cost-sharing benefits paid on behalf of Medicare Savings Program beneficiaries.

How is life insurance counted as an unqualified asset: Ownership of any in-force life insurance policies must be reported by the applicant when determining eligibility for Medicaid and failure to report is fraudulent. Specific limitations vary by state, but any policy with cash value in the range of \$1,500 to \$2,500 must be liquidated and the proceeds spent down on care before eligibility is approved. Exemptions are allowed for final expense policies if the entire policy is assigned to a funeral home. Term policies that do not have cash value are also exempt, but the death benefit

and estate is subject to legal action and liens by the Medicaid department to recover all money spent on care for the deceased.

Life insurance is an unqualified asset and counts against the Medicaid applicant's eligibility to qualify. Any amount of money derived from ownership of a life insurance policy must be either spent down on care (cash value or monetary value available while alive) or the death benefit is subject to legal action against the estate as part of Medicaid's required asset recovery procedures.

What are the rules for Medicaid Recovery actions: The Omnibus Budget Reconciliation Act (OBRA) of 1993 defines estate and requires each state to seek adjustment or recovery of amounts correctly paid by the state for certain people with Medicaid. The state must, at a minimum, seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution. The State may at its option recover amounts up to the total amount spent on the individual's behalf for medical assistance for other services under the state's plan. For individuals age 55 or older, States are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals.

People with Medicare are notified of the Medicaid estate recovery program during their initial application for Medicaid eligibility and annual redetermination process. Individuals in medical facilities (who do not return home) are sent a notice of action by their county Department of Social Services informing them of any intent to place a lien/claim on their real property. The notice also informs them of their appeal rights. Estate recovery procedures are initiated after the beneficiary's death.

Can ownership of a life insurance policy be transferred to keep the policy in the family: When an individual applies for Medicaid, the State conducts a "look back" to find transfers of assets for 60 months prior to the date the individual

is institutionalized or, if later, the date he or she applies for Medicaid. All transfers made by the applicant or the applicant's spouse subsequent to January 1, 2010, whether from an individual or to an individual or from a trust or to a trust, have a five year look-back period.

These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf. At state option, these provisions can also apply to various other eligibility groups.

Transferring ownership of a life insurance policy for less than its fair market value would be a violation of Medicaid's asset transfer and look back requirements. A policy can be surrendered for its cash value to be spent down on care or a policy can be converted for its market value and the benefit of that conversion can be used to pay for long term care as a qualified spend-down.

Are there penalties or delays to qualify for Medicaid based on violations of asset transfers and reporting: If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the State. Example: A transferred asset worth \$90,000, divided by a \$3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period.

(Section 1917(c) of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396p(c))

Sources

Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS) (www.hhs.gov)

United States Government Accountability Office (GAO), Report to the United States Congress, "Medicaid Long Term Care" report, March 2007

United States Social Security Act

What is a Long Term Care Benefit Plan

A Long Term Care Benefit Plan is the conversion of an in-force life insurance policy into a pre-funded, irrevocable Benefit Account that is professionally administered with payments made monthly on behalf of the individual receiving care. This option extends the time a person would remain private pay and delays their entry onto Medicaid. It is a unique financial option for seniors because all health conditions are accepted, and there are no wait periods, no care limitations, no costs to apply, no requirement to be terminally ill, and there are no premium payments. Policy owners use their legal right to convert an in-force life insurance policy to enroll in the benefit plan, and are able to immediately direct payments to cover their senior housing and long term care costs.

The policy transaction is specifically designed to conform to the secondary market regulations that govern life settlement/viaticals, and the Benefit is administered specifically to be a Medicaid qualified spend-down of the asset proceeds. By obtaining the fair market value for the life policy, and then at the direction of the policy owner putting the funds into an irrevocable bank account which can only be administered third-party to pay for Medicaid/Medicare qualified long term care services; the Long Term Care Benefit Plan is a regulated and Medicaid qualified financial vehicle to help cover the costs of long term care.

Q: What types of life insurance qualify for conversion into a Long Term Care Benefit Plan?

A: The conversion option applies to any form of life insurance: Universal, Whole, Term, and Group. The value of the conversion is based solely on the

death benefit, and cash value is not a factor in determining the conversion value of a life insurance policy.

Q: What forms of long term care qualify?

A: The Benefit Plan will pay the following monthly expenses directly to the health care provider:

- **Homecare**
- **Assisted Living**
- **Skilled Nursing Home and Memory Care**
- **Hospice Care**

Q: Is there a Funeral Benefit?

A: Yes, all Benefit Accounts reserve 5% of the death benefit or \$5,000, whichever is the lesser, to provide a funeral benefit payment to the Account's named beneficiary.

Q: Are there any fees or obligations to apply?

A: No, there are no application fees and no obligations to apply. Once a policy is converted by the owner, the Long Term Care Benefit payments begin immediately and the enrollee is relieved of any responsibility to pay any more premiums.

Q: How long does the enrollment process take?

A: The typical enrollment time is 30 days. The actual time to complete the process will vary on the applicant's ability to provide the necessary requirements for review such as: signed application and authorizations, copy of life insurance policy, last two years of medical records, and offer/enrollment packet.

Q: What happens if the enrollee dies before all of the Long Term Care Benefit is paid out?

A: Should the enrollee pass away with additional funds remaining in their Benefit Account, the remaining balance is paid directly to the enrollee's named beneficiaries. Enrollees and/or their ben-

eficiaries are assured to receive the full Benefit amount even if the client dies before all monthly payments have been made.

Q: Is the enrollee actually transferring the ownership of the life insurance policy?

A: Yes, the enrollee will transfer all ownership and beneficiary rights to the life insurance policy to enroll in the Long Term Care Benefit Plan. From the moment the Benefit Plan is established, the Benefits Administrator will begin making monthly payments to the appropriate health care provider as well as all future premium payments on the life insurance policy. The enrollee is no longer responsible for premium payments and the policy is no longer considered an asset that will count against them for future Medicaid eligibility.

Q: Which states can a policy be converted?

A: A life insurance policy owner has the legal property ownership right to convert their policy into a Long Term Care Benefit Plan in every state in America.

Q: How is a Long Term Care Benefit Plan regulated?

A: The policy transaction is specifically designed to conform to the secondary market regulations that govern life settlement/viaticals; and the Benefit is administered specifically to be a Medicaid qualified spend-down of the asset proceeds. By obtaining the fair market value for the life policy, and then at the direction of the policy owner putting the funds into an irrevocable, FDIC insured bank account which can only be administered third-party to pay for Medicaid/Medicare qualified long term care services; the Long Term Care Benefit Plan is a regulated and Medicaid qualified financial vehicle to help cover the costs of long term care.

Q: How is the Long Term Care Benefit Account safe-guarded?

A: The Benefit Plan is an irrevocable; FDIC insured Long Term Care Benefit account held by a nationally chartered Bank & Trust and then administered by a licensed, third party benefit administration company ensuring that the funds are protected and only used for the recipient of care. The account also has the added protection for the enrollee of paying any remaining balance to a named account beneficiary and/or providing a final expense benefit to help cover funeral expenses.

Q: How is the Long Term Care Benefit Plan administered?

A: The Benefit Plan is held as an irrevocable account by an FDIC insured, nationally chartered Bank & Trust company, and the monthly benefit is administered third-party by a licensed Benefit Administration company.

First, the policy owner voluntarily directs a licensed Provider that the entirety of the proceeds from their policy conversion is moved from an escrow account and into their irrevocable, Benefit Account held by an FDIC insured, Chartered Bank & Trust Company.

Second, the enrollee provides specific instructions that the irrevocable account be used only to make monthly payments directly to their choice of long term care provider (home health, assisted living, and nursing home) and monthly payments are administered third-party by a licensed Benefit Administrator.