Long Term Care Solutions !

How Will You Pay For The Devastating Costs Of Long Term Care . . . That Will Ultimately Hurt Most Of Us At The Worst Time Of Our Lives ?

Dave Nute

RICP®, ChFC®, CLU®,

Retirement Income Certified Professional™

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This publication contains the author's opinions and is designed to provide accurate and authoritative information. It is given with the understanding, the author is not engaged by the reader in rendering legal, accounting, investment or insurance planning, or other professional advice.

Please be advised that before any professional advice can be given responsibly, it is necessary to invest our time together and have a meaningful dialogue and share information that is relevant to determine which, if any, of the solutions outlined in this book are recommended for your situation !

Dave Nute, RICP®, ChFC®, CLU®,
Retirement Income Certified Professional™

Assisting with Financial, Long Term Care, Retirement and Estate Planning Solutions since 1984

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Company Disclosure

My name is Dave Nute and our company is Creative Retirement Planning, Inc.

All of our contact information is detailed for you on ***Page 3*** *and also on the last page of this book.*

I have helped our clients with Long Term Care insurance and planning since 1984.

I have been a licensed insurance agent since 1984, a licensed Registered Investment Advisor since 2005, a licensed ChFC® (Chartered Financial Consultant™) since 2006, a licensed Mortgage Loan Originator since 2008, a licensed CLU® (Chartered Life Underwriter™) since 2010, a licensed RICP® (Retirement Income Certified Professional™) since early 2013 and a licensed CFP® (Certified Financial Planner™), from early 1993, retiring this one license in February 2022.

It is my goal to help each of my clients to make their best decisions, working with what they have available, for their retirement.

If you have any further questions, please call our Sequim office at . . .

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The RICP® educational curricula is the most complete and comprehensive program that is available to professional financial advisors who strive to help their clients create sustainable retirement income.

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is pleased to announce that

David R. Nute, CFP®, ChFC®, CLU®, RICP®

has been awarded the

Retirement Income Certified Professional®

professional designation

May 1, 2013

Dave's Comments About Long Term Care

70 % *of us will need Long Term Care during the rest of our lifetime and one of four of us will need Long Term Care for two years and more.*

BUT ONLY 20 % OF US . . . BELIEVE WE WILL PERSONALLY NEED IT . . . AND THIS IS OUR FIRST PROBLEM !

The challenge of planning ahead for Long Term Care is truly one of the most difficult and expensive unknown costs for each of us.

This book is about the planning choices that many of us will have to choose from.

There are different solutions for different situations and it's often wise to implement a ***COMBINATION*** *of these choices, working with what we have available, to help minimize the extra stress and costs for our family caregivers and help provide us with our most preferable and effective care.*

Many insurance agents, other financial planners and attorneys will typically only have one point of view and only one option to offer. All too often they are ***"peddling a product or a limited service"****.*

This may not be your personal ***BEST CHOICE****.*

A knowledgeable professional can be a positive asset and provide extra value to help you wade through the distractions.

This book is a good place for both of us to start. It will help you to understand many of the various positive solutions available to some of us.

It will help us to introduce the work I do and share what I've learned over the past thirty five years, helping others to make life a little easier for their families and themselves when life takes a turn and they need to pay for their Long Term Care assistance . . . this eventually happens to ***70 %*** *of us.*

Please feel free to call our office and we can set a time to discuss your questions and your situation further.

What Are "THE ODDS" We'll Need LTC ?

Our Need For Long Term Care Assistance

I've been assisting my clients with Long Term Care planning since 1984 and I've been a part of many claims for this over three decades.

THIS IS A DIFFICULT SUBJECT FOR ALL OF US.

BUT IT IS IMPORTANT !

HERE ARE THE FACTS.

*Ladies, if you are fortunate enough to live to the age of 65 . . . about **79 %** of you will need some type of Long Term Care assistance at some point during the rest of your lifetime !*

*This is about eight out of ten or **FOUR OUT OF EVERY FIVE WOMEN**.*

*Men, if we live to the age of 65 . . . about **58 %** of us will need Long Term Care . . . about **THREE OUT OF EVERY FIVE MEN**.*

*On average, this is going to happen to about **70 %** of us who have reached the age of 65 !*

*And for Couples, there's about a **45 %** chance that **BOTH SPOUSES** will need long term care.*

*Ladies, if you need care . . . you're going to need assistance for an average of about **3.7 YEARS !***

*Men, for those of us who need care . . . we'll need it for an average of about **2.2 YEARS**.*

But speaking as a Financial Planner . . .

BE CAREFUL !

IT'S ALWAYS RISKY . . . TO PLAN AROUND THE "AVERAGES" !

WHAT IF YOU NEED MORE CARE THAN THE "AVERAGE" ?

More and more, planning ahead for our future Long Term Care is less and less about ***"Planning for the Nursing Home"*** *!*

Of all insurance claims, about ***HALF*** *are for home care. About* ***19 %*** *are for assisted living and only* ***31 %*** *ever get to a nursing home.*

I understand there is not one of us who wants to think about this, especially when we are younger and healthy !

And studies have shown us that only about ***20 %*** *of us even believe we will need Long Term Care ! (It's always someone else, isn't this true ?)*

Because you have requested this book, I am going to assume you are more aware of this problem and this higher awareness creates more concern and motivation to plan ahead !

PLANNING AHEAD FOR LONG TERM CARE

HELPS US RETAIN OUR "INDEPENDENCE".

IT HELPS US TO RETAIN OUR "DIGNITY".

AND IT HELPS TO PROVIDE THE CARE WE'LL NEED IN THE MOST PREFERABLE SETTING !

LONG TERM CARE PLANNING

WILL HELP MANY OF US

TO STAY OUT OF THE NURSING HOMES

THAT NONE OF US WANT TO EVER NEED !

Who Will Pay For Our Lack Of Planning ?

So how are you going to pay for this ?

Someone always pays a price for our Long Term Care needs and most of the time it's ***OUR LOVED ONES****.*

About ***80 %*** *of us who need Long Term Care will receive the care we need in our homes (including the "Uninsured") and this care is mostly provided by our family caregivers who rarely get paid for their efforts.*

(Remember earlier, only about 50 % of the "Insured Claims" are for home care. This extra planning often protects other options for our families.)

As stated earlier, about ***70 %*** *of us will need some type of Long Term Care assistance during our lifetimes.*

I want to make a point.

Do you have homeowner's insurance ?

Do you have auto insurance ?

Most of us do. Here's my message.

We can see on ***Page 12****, the probability of losing our home to a fire is only about* ***ONE OUT OF 1,200 !***

And the chance of having a serious car accident is only about ***ONE IN 240 !***

Of course these can be expensive claims and it's smart to have insurance for both !

But Long Term Care is also ***EXPENSIVE !***

And yet ***80 %*** *of us, on average, don't even believe this will happen to them . . . which is the* ***FIRST STEP*** *that motivates us to plan ahead !*

Common Myths & Facts

Critical Conversations about Financing Long Term Care: Common Myths & Facts

There are many common myths about financing long term care (LTC). Learn how to recognize them! It is important to learn the facts to help you make more informed decisions and protect your financial security. Studies suggest that many people think they know about LTC, but really do not. What about you?

Myth: Most people who need LTC require skilled nursing care in a nursing home.

- **FACT**: The reality of LTC is often much different than the nursing home setting that most often comes to mind. LTC involves help with "activities of daily living," such as eating, bathing, dressing, walking, toileting, or taking medications. Typical users of LTC have multiple chronic health problems (e.g., hypertension, arthritis, heart disease, diabetes), mental disabilities (e.g., Alzheimer's disease or other dementias), or injuries from accidents that limit their ability to perform personal daily living activities. LTC can include a wide range of medical, personal, and social services provided in a variety of settings (home, community, assisted living facilities, or skilled nursing facilities), with the goal of remaining as independent as possible. The vast majority of those who need LTC receive care in their own home or in a community setting—*not* in a skilled nursing facility. Approximately 80 percent of individuals who need LTC receive the care in their own home provided by unpaid family caregivers.

Myth: There is less risk associated with LTC than with other life events that can impact an individual's financial security.

- **FACT**: There is a greater risk of needing LTC than many other life events. About 70 percent of people over age 65 will require some type of long-term care services during their lifetime. In comparison, insurance professionals cite that the probability of losing your home to a fire is 1 in 1,200, and that the chance of having a car accident is 1 in 240. Although most people have car, homeowners, and health insurance, few have planned to protect themselves against the much more likely risk of needing LTC.

Myth: The risk of needing LTC is greatest when a person turns 65 years of age.

- **FACT**: Indeed, the oldest old—that is, individuals who reach 85 years and older—are most at risk of needing help with activities of daily living, not 65 year olds. As shown in Table 1, the risk of needing LTC clearly increases with age, in both community and institutional LTC settings. For example, the average age of an assisted living resident is 86.9 years old. Keep in mind that there are big differences within the 65-plus group. Beware of relying on statistics that groups everyone over 65 years of age together.

Developed by Marlene S. Stum, Ph.D.,
Family Economics and Gerontology. 2012.

UNIVERSITY OF MINNESOTA | EXTENSION

LTC Costs For Bremerton, WA In 2018

Cost of Care

Genworth

Bremerton Area, WA

Monthly Cost	2018
Home Health Care	
Homemaker Services	$5,434
Homemaker Health Aide	$5,434
Based on annual rate divided by 12 months (assumes 44 hours per week).	
Adult Day Health Care	
Adult Day Health Care	$1,408
Based on annual rate divided by 12 months.	
Assisted Living Facility	
Private, One Bedroom	$5,720
As reported, monthly rate, private, one bedroom.	
Nursing Home Care	
Semi-Private Room	$9,733
Private Room	$10,722
Based on annual rate divided by 12 months.	

The information shown above is based on a specific scenario generated by the Genworth 2018 Cost of Care. Future years are calculated by assuming an annual 3% growth rate. For more information and location comparison, visit genworth.com/costofcare.

206401A3D 10/09/2018

Download on the App Store

Please review ***Page 13****.*

Here's a recent study from Genworth about the various annual care costs for the different types of LTC services in Bremerton, WA for 2018.

IT'S ALL EXPENSIVE !

Please read ***Page 15****.*

Our lack of planning creates the need for our family to put aside their own lives, come to our aid and bail us out !

You can see, I've highlighted on the bottom right . . .

"The ***'Average U.S. Caregiver'*** *is a 49 year old woman who works outside the home and spends nearly 20 hours a week to provide unpaid care for her Mother . . .* ***FOR NEARLY FIVE YEARS !"***

70% *of family caregivers will eventually need to quit their other jobs.*

Please review ***Page 16****.*

AARP had a study back in 2011 and they calculated, on average, this will cost your daughter, who is typically your caregiver, ***$ 324,000*** *in lost income and benefits over her lifetime ! (Now add inflation to this !)*

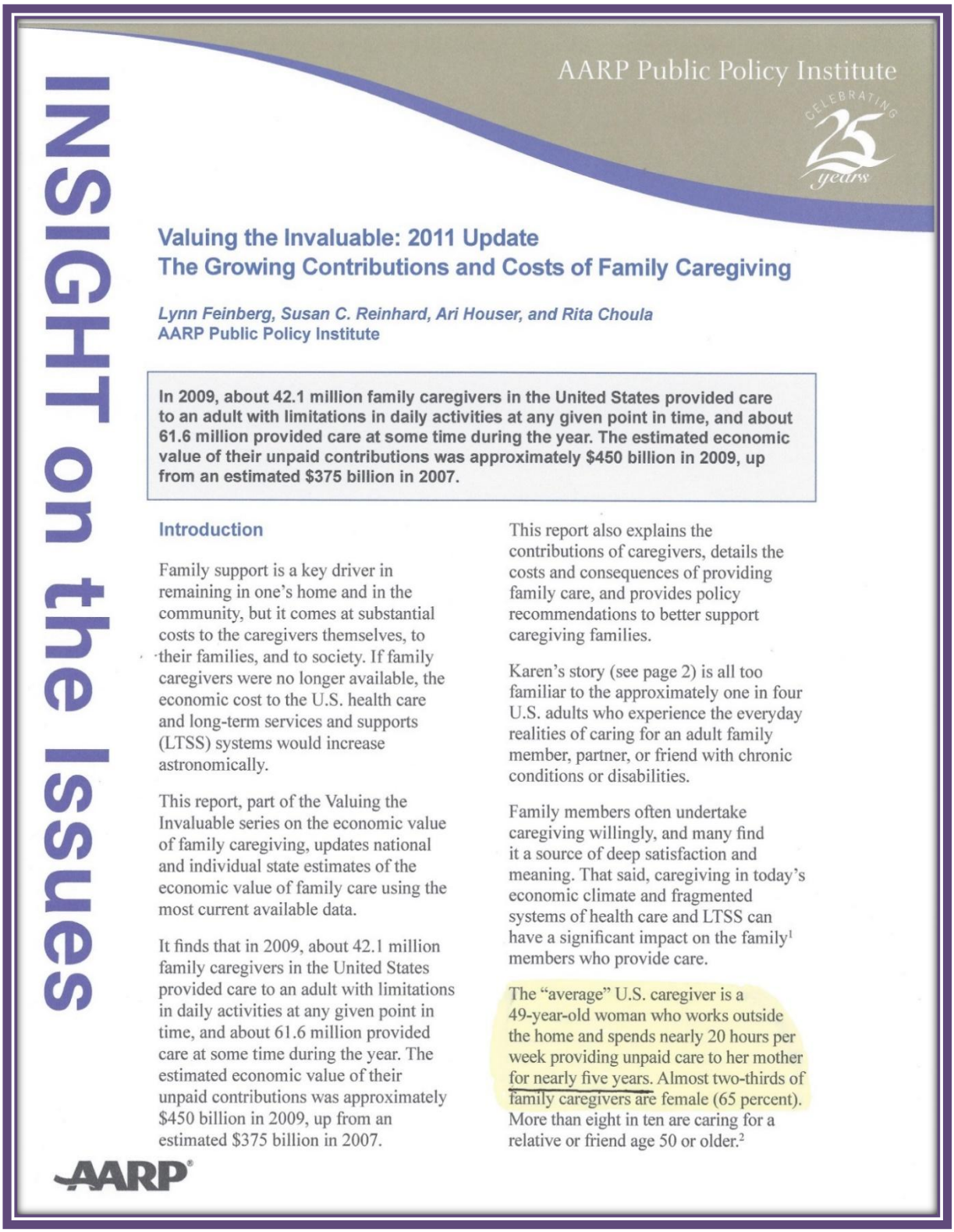
This includes not only her lost wages but also the additional losses from Social Security and pension work-credits.

I know many of us have provided care for our parents . . . and this includes a few men too (about 1/3 of the family caregivers).

But would it have been easier and less costly for the caregiver, if more money or more insurance benefits had been available to help provide them with relief and assistance ?

And would this extra money have provided better care and more choices for the patient ?

Will We Need Our Family To Help Us ?



INSIGHT on the Issues

AARP Public Policy Institute

CELEBRATING 25 years

Valuing the Invaluable: 2011 Update
The Growing Contributions and Costs of Family Caregiving

Lynn Feinberg, Susan C. Reinhard, Ari Houser, and Rita Choula
AARP Public Policy Institute

In 2009, about 42.1 million family caregivers in the United States provided care to an adult with limitations in daily activities at any given point in time, and about 61.6 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately $450 billion in 2009, up from an estimated $375 billion in 2007.

Introduction

Family support is a key driver in remaining in one's home and in the community, but it comes at substantial costs to the caregivers themselves, to their families, and to society. If family caregivers were no longer available, the economic cost to the U.S. health care and long-term services and supports (LTSS) systems would increase astronomically.

This report, part of the Valuing the Invaluable series on the economic value of family caregiving, updates national and individual state estimates of the economic value of family care using the most current available data.

It finds that in 2009, about 42.1 million family caregivers in the United States provided care to an adult with limitations in daily activities at any given point in time, and about 61.6 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately $450 billion in 2009, up from an estimated $375 billion in 2007.

This report also explains the contributions of caregivers, details the costs and consequences of providing family care, and provides policy recommendations to better support caregiving families.

Karen's story (see page 2) is all too familiar to the approximately one in four U.S. adults who experience the everyday realities of caring for an adult family member, partner, or friend with chronic conditions or disabilities.

Family members often undertake caregiving willingly, and many find it a source of deep satisfaction and meaning. That said, caregiving in today's economic climate and fragmented systems of health care and LTSS can have a significant impact on the family[1] members who provide care.

The "average" U.S. caregiver is a 49-year-old woman who works outside the home and spends nearly 20 hours per week providing unpaid care to her mother for nearly five years. Almost two-thirds of family caregivers are female (65 percent). More than eight in ten are caring for a relative or friend age 50 or older.[2]

AARP

In 2010 . . . Our Daughters Lost $ 324,044 !

about the impact of providing care on their personal savings, and more than half (51 percent) said that the economic downturn had increased their stress about being able to care for their relative or close friend.[31]

Many family caregivers make direct out-of-pocket expenditures to help support a family member or friend with a disability or chronic care needs. In one national survey of women, about one in five (21 percent) report that caregiving strains their household finances.[32] A recent online survey found that more than four in ten (42 percent) caregivers spend more than $5,000 a year on caregiving expenses.[33]

Another survey taken before the economic downturn also found that out-of pocket spending was high for family caregivers, especially those with low incomes and those providing care at a distance. Caregivers to persons age 50 and older reported spending an average of more than 10 percent of their annual income on caregiving expenses, or an average of $5,531 out-of-pocket in 2007. Long-distance caregivers had the highest average annual expenses ($8,728). Those with the lowest incomes (less than $25,000 a year) reported spending more than 20 percent of their annual income on caregiving expenses. To pay for caregiving expenses, one in three (34 percent) caregivers surveyed said they used their savings, and nearly one in four (23 percent) cut back on spending for their own preventative health or dental care. To manage the out-of-pocket caregiving expenses, nearly four in ten (38 percent) said they reduced or stopped saving for their own future, potentially putting their own financial security at risk. [34]

Impact of Caregiving on Work

The great majority (74 percent) of family caregivers have worked at a paying job at some point during their caregiving experience, and more than half (58 percent) are currently employed either full-time or part-time, balancing work with their caregiving role.[35] When it becomes stressful to juggle caregiving activities with work and other family responsibilities, or if work requirements come into conflict with caregiving tasks, some employed caregivers make changes in their work life.

Nearly seven in ten (69 percent) caregivers report making work accommodations because of caregiving. These adjustments include arriving late/leaving early or taking time off, cutting back on work hours, changing jobs, or stopping work entirely. Family caregivers with the most intense level of caregiving (those who provide 21+ hours of care each week), those with a high burden of care, or those who live with their care recipient are especially likely to report having to make workplace accommodations.[36]

Lost Wages and Retirement

Family caregivers can face financial hardships if they must leave the labor force owing to caregiving demands. Not only may they lose foregone earnings and Social Security benefits, but they also can lose job security and career mobility, and employment benefits such as health insurance and retirement savings. There is evidence that midlife working women who begin caring for aging parents reduce paid work hours[37] or leave the workplace entirely.[38]

A recent analysis estimates that the lifetime income-related losses sustained by family caregivers age 50 and over who leave the workforce to care for a parent are about $115,900 in wages, $137,980 in Social Security benefits, and conservatively $50,000 in pension benefits. These estimates range from a total of $283,716 for men to $324,044 for women, or $303,880 on average, in lost income and benefits over a caregiver's lifetime.[39] Evidence suggests

Court Says Son Has To Pay Mom's Nursing Home !

Here's an interesting and scary court case in Pennsylvania from 2012 on ***Page 18****.*

The Mother was in a car crash and she received care at a nursing home. Apparently she had applied for Medicaid (welfare) at some point to pay her bills.

The family decided to move her back to other family members in Greece and Medicaid had never approved her claim before she moved.

She left an unpaid bill of ***$ 93,000****.*

But instead of bringing a lawsuit against the Mother, the nursing home brought a lawsuit against her ***SON*** *(apparently, the only one of her kids who lived nearby and had some money !).*

The court awarded the nursing home a judgment for the full amount of ***$ 93,000 !***

The son appealed and he lost the decision.

He further appealed to the Pennsylvania Supreme Court. They refused to hear the case and the son ended up owing the ***$ 93,000*** *for his Mother's care from the nursing home . . .*

plus (likely) tens of thousands of dollars of additional legal costs !

How could this happen ?

The State of Pennsylvania has a state law that makes the children responsible for the debts of their parents for long term care !

These are known as ***"Filial Responsibility Laws"****.*

Is Our Long Term Care . . . Our Children's Obligation ?

Son Liable for Mom's $93,000 Nursing Home Bill Under 'Filial Responsibility' Law

Some 29 states currently have laws making adult children responsible for their parents if their parents can't afford to take care of themselves. These "filial responsibility" laws have rarely been enforced, but six years ago when federal rules made it more difficult to qualify for Medicaid long-term care coverage, some elder law attorneys predicted that nursing homes would start using the laws as a way to get care paid for.

It looks like this is starting to happen. In May 2012, a Pennsylvania appeals court found a son liable for his mother's $93,000 nursing home bill under the state's filial responsibility law. ***Health Care & Retirement Corporation of America v. Pittas*** (http://www.pacourts.us/assets/opinions/Superior/out/A36025_11.pdf)(Pa. Super. Ct., No. 536 EDA 2011, May 7, 2012). In March 2013 the state's Supreme Court declined to hear the case, meaning that the ruling is final.

Facts of the Case

John Pittas' mother entered a nursing home for rehabilitation following a car crash. She later left the nursing home and moved to Greece, and a large portion of her bill at the nursing home went unpaid. Mr. Pittas' mother applied to Medicaid to cover her care, but that application is still pending.

Meanwhile, the nursing home sued Mr. Pittas for nearly $93,000 under the state's filial responsibility law, which requires a child to provide support for an indigent parent. The trial court ruled in favor of the nursing home, and Mr. Pittas appealed. Mr. Pittas argued in part that the court should have considered alternate forms of payment; such as Medicaid or going after his mother's husband and her two other adult children.

The Pennsylvania Superior Court, an appeals court, agreed with the trial court that Mr. Pittas is liable for his mother's nursing home debt. The court held that the law does not require it to consider other sources of income or to wait until Mrs. Pittas's Medicaid claim is resolved. It also said that the nursing home had every right to choose which family members to pursue for the money owed.

First of a 'Wave of Lawsuits'?

The Deficit Reduction Act of 2005 made it much more difficult for the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care. With enactment of the law, advocates for the elderly said that nursing homes would likely be flooded with residents who need care but have no way to pay for it, and that in states that have filial responsibility laws, the nursing homes might seek reimbursement from the residents' children.

After Pennsylvania re-enacted its filial support law in the mid-2000s, Williamsport ElderLawAnswers member attorney **Jeffrey A. Marshall** (http://www.paelderlaw.com/) forecast that the new Medicaid law would trigger a wave of lawsuits involving adult children.

"Litigation between nursing homes and children is likely to flourish," Marshall wrote in the January 20, 2006, issue of his firm's ***Elder Care Law Alert*** (http://www.paelderlaw.com/DRA_2005.html). (To read Marshall's recent blog post on the *Pittas* ruling, **click here** (http://marshallelder.blogspot.com/2012/05/pa-ruling-son-must-pay-mothers-nursing.html).)

*On **Page 20**, here's a list of 30 states who have similar laws that will make children of long term care patients responsible for their parent's unpaid debt for care.*

Some of these laws are enforced and some are not.

But with these laws already on the books and combined with the increasing costs paid by the states, some states will have no other choice but to collect where they can in the years ahead.

So here's the question . . .

"Do Your Parents live in any of these states ?"

*And if you think they will not have the money to pay for their own care, I suggest you talk to a qualified **"Elder Law Attorney"** in their state.*

***30 States* Have "Filial Responsibility Laws"!**

STATES WITH FILIAL RESPONSIBILITY LAWS with statute numbers

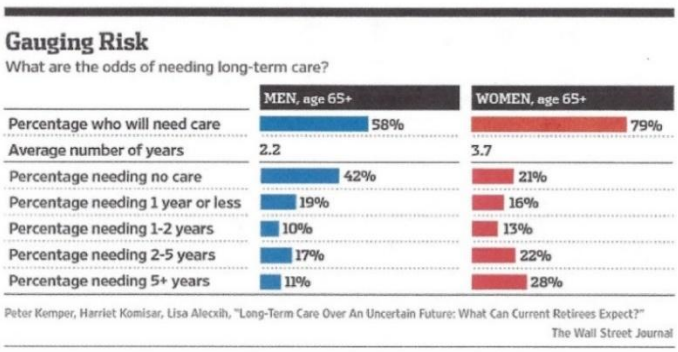
Alaska Stat. 25.20.030, 47.25.230 (Michie 2000)
Arkansas Code Ann. 20-47-106 (Michie 1991)
California Fam. Code 4400, 4401, 4403, 4410-4414 (West 1994)
California Penal Code 270c (West 1999)
California Welf. & Inst. Code 12350 (West Supp. 2001)
Connecticut Gen. Stat. Ann. 46b-215, 53-304 (West Supp. 2001)
Delaware Code Ann. tit. 13, 503 (1999)
Georgia Code Ann. 36-12-3 (2000)
Idaho Code 32-1002 (Michie 1996)
Indiana Code Ann. 31-16-17-1 to 31-16-17-7 (West 1997)
Indiana Code Ann. 35-46-1-7 (West 1998)
Iowa Code Ann. 252.1, 252.2, 252.5, 252.6, 252.13 (West 2000)
Kentucky Rev. Stat. Ann. 530.050 (Banks-Baldwin 1999)
Louisiana Rev. Stat. Ann. 4731 (West 1998)
Maryland Code Ann. Fam. Law 13-101, 13-102, 13-103, 13-109 (1999)
Massachusetts Gen. Laws Ann. ch. 273, 20 (West 1990)
Mississippi Code Ann. 43-31-25 (2000)
Montana Code Ann. 40-6-214, 40-6-301 (2000)
Nevada Rev. Stat. Ann. 428.070 (Michie 2000
Nev. Rev. Stat. Ann. 439B.310 (Michie 2000)
New Hampshire Rev. Stat. Ann. 167:2 (1994)
New Jersey Stat. Ann. 44:4-100 to 44:4-102, 44:1-139 to 44:1-141 (West 1993)
North Carolina Gen. Stat. 14-326.1 (1999)
North Dakota Cent. Code 14-09-10 (1997)
Ohio Rev. Code Ann. 2919.21 (Anderson 1999)
Oregon Rev. Stat. 109.010 (1990)
Pennsylvania Cons. Stat. 1973 (1996)
Rhode Island Gen. Laws 15-10-1 to 15-10-7 (2000)
R.I. Gen. Laws 40-5-13 to 40-5-18 (1997)
South Dakota Codified Laws 25-7-28 (Michie 1999)
Tennessee Code Ann. 71-5-115 (1995)
Tenn. Code Ann. 71-5-103 (Supp. 2000)
Utah Code Ann. 17-14-2 (1999)
Vermont Stat. Ann. tit. 15, 202-03 (1989)
Virginia Code Ann. 20-88 (Michie 2000)
West Virginia Code 9-5-9 (1998)

What About Long Term Care Insurance ?

1. WAITING TOO LONG TO BUY

Many people don't even start *thinking* about long-term-care insurance until they reach 60. And by that time, it may be too late—either because the insurance is too costly or they simply can't qualify for health reasons.

As a result, for most people, the 50s are the best time to buy a policy. That's typically when premiums are most affordable and coverage is easiest to obtain, says Mr. Gleckman.



Gauging Risk

What are the odds of needing long-term care?

	MEN, age 65+	WOMEN, age 65+
Percentage who will need care	58%	79%
Average number of years	2.2	3.7
Percentage needing no care	42%	21%
Percentage needing 1 year or less	19%	16%
Percentage needing 1-2 years	10%	13%
Percentage needing 2-5 years	17%	22%
Percentage needing 5+ years	11%	28%

Peter Kemper, Harriet Komisar, Lisa Alecxih, "Long-Term Care Over An Uncertain Future: What Can Current Retirees Expect?" The Wall Street Journal

For each year applicants in their 50s delay buying coverage, carriers typically raise premiums by 3% to 4%, simply because they are a year older, says Dawn Helwig, a principal and consulting actuary at Seattle-based Milliman Inc. In contrast, for every year someone in their 60s waits, they can expect to pay an additional 6% or more, she adds.

Those who wait may pay higher premiums for other reasons, too. Over the past decade, carriers struggling with losses on existing policies have raised the premiums on new policies an average of 4% to 8% a year, depending on the features, according to Milliman.

Consider a 65-year-old man who purchases $110,000 of coverage with benefits that grow 5% a year. To secure the same coverage 10 years earlier, at age 55, he would have paid approximately $1,032 in annual premiums, says Ms. Helwig. But because he waited, his annual premium is now about $2,770. Assuming he lives to age 85, he will pay a total of about $55,400 in premiums—or some $24,400 more than he would have spent had he bought at age 55 and lived 30 years.

Those who wait also run the risk that their health may deteriorate. Carriers, which have become stricter about how they underwrite policies, reject about 25% of applicants between ages 60 and 69, according to the American Association for Long-Term Care Insurance. They also charge those in relatively poor health as much as 40% more, says Ms. Helwig.

The Challenges of Long Term Care Insurance !

Please review ***Page 21****.*

I started my financial services career in 1984, helping Retirees with Medicare Supplements and Long Term Care insurance.

Over the past forty years, I've witnessed the extra value of owning LTC Insurance many times, when my clients needed Long Term Care.

And while our need for Long Term Care Insurance is as critical as it has ever been . . . ***the equation today, or the argument for Long Term Care Insurance, has changed dramatically over the last decade !***

There are ***THREE MAJOR PROBLEMS****.*

First, many applicants who do want to own Long Term Care Insurance . . CAN NOT QUALIFY because of their health history.

This is about 25 % of applicants in their 60's, over 50 % in their 70's and two-thirds in their 80's !

The second problem is the high cost of Long Term Care Insurance. The price for Long Term Care Insurance is much higher for new applicants than it ever was in the past. ***It is now higher than most of us can afford.***

The third problem are the inevitable future premium increases*. These average over 5 % annually and there have been many times when owners received increases of 20 %, 30 %, 50 % and more at one time !*

Genworth LOSES $ 760 MILLION From LTC !

Genworth Posts $760 Million Loss on Long-Term Care Costs

by Zachary Tracer
February 10, 2015 — 2:07 PM PST
Updated on February 10, 2015 — 3:38 PM PST

(Bloomberg) -- Genworth Financial Inc. posted a second-straight loss as Chief Executive Officer Tom McInerney works to turn around the company's long-term care insurance business.

The net loss of $760 million, or $1.53 a share, was fueled by costs to set aside more funds to cover claims on long-term care policies, the Richmond, Virginia-based insurer said Tuesday in a statement. The results included a charge of $478 million tied to LTC policies acquired before 1996.

McInerney, 58, is seeking to regain investor confidence after a stock plunge of 45 percent left Genworth as the worst-performing financial company in the Standard & Poor's 500 Index last year. Losses at the long-term care unit, pressured by low interest rates and higher claims costs, have negated gains at Genworth's businesses selling life insurance and guaranteeing mortgages.

"I am disappointed by the continued challenges in our older LTC blocks and how it is overshadowing otherwise strong performance," McInerney said in the statement. "We have taken steps on many fronts to deal with these challenges in order to strengthen and rebuild."

Genworth gained 3.3 percent to $8.07 at 6:09 p.m. in New York, reversing an earlier slump. The firm had declined 8.1 percent this year in regular trading.

'True Recognition'

"The charges, in my view, are not so large as to really scare the market at this stage, yet they are large enough to suggest that heavy lifting and true recognition of the economics is at hand," David Havens at Imperial Capital said in a note to investors.

Since taking over at the start of 2013, McInerney has raised premiums on long-term care policies sold in prior years and reduced benefits and tightened underwriting for new customers. In the third quarter, Genworth had to set aside $531 million in reserves for future long-term care costs, fueling a record net loss of $844 million.

Please review ***Page 23****.*

Genworth has more Long Term Care Insurance business than any other company. They are the ***"Grand Daddy"*** *of this business . . .*

AND THEY DECLARED A $ 760 MILLION

DOLLAR LOSS IN EARLY 2015 !

Of this total, they set aside $ 531 million in extra reserves for future claims . . . and this included $ 468 million, just for the Long Term Care Insurance policies they acquired before 1996.

As a result from needing more capital, Genworth accepted an offer of $ 2.7 billion in cash to be purchased by China Oceanwide Holdings Group Co. in October 2016. COHG also promised to finance more than another billion to pay off maturing debt and other corporate needs. (After years of failed attempts for China Oceanside, Genworth cancelled this offer in 2021.)

John Hancock Life Insurance Co., the second largest seller of Long Term Care Insurance, also announced in October 2016, they ***WILL NOT ACCEPT*** *any new applications for individual LTC insurance. (also Met Life)*

It's highly likely these three and other LTC insurers are going to need to raise their premiums for existing LTC policies. (Genworth averaged ***58 %*** *in rate increase requests across our country in 2018.)*

So if you own LTC insurance or if you're considering buying a new policy, make sure you have enough extra income, to allow for these inevitable future premium increases !

If you own LTC insurance now and you can not afford the new increases, you can likely decrease some of your benefits and hold on to the rest of your benefits as long as you can.

It's a tough equation and there are no quick answers. My suggestion is to set a time with me and let's review your situation together.

It often helps to run your numbers and take a picture of where you're at now and plan now for the years ahead. I can help you with this.

Life Insurance With Long Term Care Benefits

*Please review **Page 27**.*

In addition to traditional Long Term Care Insurance, we also have different types of Life Insurance that also offer additional long term care benefits.

North American Life offers a Life Insurance policy that also includes quality long term care benefits.

And one additional positive benefit . . . they also guarantee that both your premiums and your long term care benefits . . .

WON'T "INCREASE" AND THEY WON'T CHANGE

UNTIL YOU REACH THE AGE OF 121 !

And that's probably long enough for most of us !

I love the flexibility of this policy !

If you can qualify, the policy will pay up to 24 % of your Life Insurance Benefit each year for four years. And your beneficiaries get any amount you don't need that's left-over after you pass away.

Unlike other types of Long Term Care Insurance, you can use your benefit for whatever you want . . . ***IT'S YOUR MONEY !***

You can pay for this with a single premium or you can make ongoing payments for a limited time or your lifetime, to the age of 100.

I'll share two examples where this worked very well.

In our first example, George simply used the ***"Required Minimum Distributions"*** *from his IRA to pay for his annual premiums !*

He already had several hundred thousand dollars in both investments and fixed types of annuities under management with me.

Combo Life Insurance With LTC Benefits !

GIVING CONTROL BACK TO YOU

A chronic illness could disrupt the family and cause financial insecurity. With North American Company's CIABR, we give control back to you to help secure your family's financial future.

- This accelerated benefit rider advances a portion of the death benefit if the person covered under the policy becomes chronically ill—defined as permanently unable to perform at least two of the six Activities of Daily Living (bathing, continence, dressing, eating, toileting and transferring) without substantial assistance from another person, or has severe cognitive impairment, meaning the insured requires substantial supervision by another person to protect himself or herself from threats to health and safety due to a severe cognitive impairment.
- As outlined in the rider, when a chronic illness is present and after 90 consecutive days, you can access a portion of the death benefit subject to the maximum and minimum amounts.
- When you accelerate the death benefit due to chronic illness, the policy's death benefit is reduced by the same amount you request for acceleration. Since the accelerated benefit is paid prior to death, the benefit that you receive will be reduced by a discount factor, and will be less than the amount you request.

Frank, a loving husband and father of three, suffers a stroke just following his 75th birthday. Electing the Chronic Illness Accelerated Benefit Rider, he reduces his policy's death benefit by $125,000 and receives $106,800 in cash to help his grandchildren through college and to cover his medical expenses.[1]

1 Example used for hypothetical purposes only. Actual benefits may differ.

YOUR ROADMAP TO A MORE SECURE FINANCIAL FUTURE

The Chronic Illness Accelerated Benefit Rider is automatically included on many North American universal life insurance products. It's a standard benefit that helps protect against some of life's unexpected events. Your agent will describe the process if you choose to elect the benefits of the rider. Here are a few items to consider:

- There is no additional premium for the rider. It's automatically included on the issue date of your life insurance policy subject to age and underwriting restrictions.
- You can elect the benefit every 12 months.
- To ensure that a benefit is still available at death, a residual death benefit must be maintained. This residual benefit must be the greater of 5% of the death benefit available when the initial election is made or $10,000. Acceleration of the death benefit cannot continue if the residual death benefit is met.
- You may elect to receive the benefit as a lump sum or as two payments six months apart.
- Your policy will stay in force while an election is in effect or if 50% of the death benefit on the initial election date has been accelerated.
- A $200 administration fee is applied with each election and a debt repayment amount is applied if there is an outstanding loan balance. Each of these reduce the actual payment.
- Acceleration of the benefit reduces the death benefit, account value, surrender value and any Return of Premium or Protected Pour-In amount. Withdrawals are not available while an election is in effect. If 50% or more of the death benefit on the initial election date has been accelerated, withdrawals are no longer available.

*This included his IRA account that was worth about **$ 325,000**.*

George is single and age 75.

*I informed George that he'd have to withdraw a **"Required Minimum Distribution"** of about $ 14,000 for the year. After taxes, his RMD would be about $ 11,000.*

I asked George what he wanted to do with this. He said he didn't need the money and he'd just put it in the bank.

Of course that's not very productive with today's low rates !

George said he was in good health and we decided he will likely qualify for the North American combo plan.

*For an $ 11,000 annual premium, just the after-tax amount of his RMD, George would qualify for about **$ 280,000** in new life insurance.*

*First, I made sure we included an extra rider for the policy and this **GUARANTEED** that . . .*

GEORGE'S PREMIUM WILL NEVER INCREASE

AND HIS POLICY BENEFITS WILL NEVER DECREASE

UNTIL HE REACHES THE AGE OF 121 !

*Second, I already knew that George didn't have any Long Term Care Insurance. So I included a second policy rider that would also allow George to access up to **96 %** of his Life Insurance benefit of $ 280,000 to help him pay for his Long Term Care costs should he ever need this.*

*This would be about **$ 268,000** paid out over four years.*

Let's assume he needs $ 100,000 for his Long Term Care. North American Life would deduct this from the $ 280,000 and pay his grandchildren the income tax-free net amount of $ 180,000 after George dies and passes on.

If George never needs to collect any amount for Long Term Care, then his grandchildren will get all of the $ 280,000 income tax-free.

All of this for the ***$ 11,000 A YEAR*** *after taxes that he'll have to take out of his IRA anyway !*

THIS MAKES SENSE . . . DOESN'T IT ?

I'll share a second example.

"Dr. Joe" *was a family physician in Poulsbo and his wife Mary was a Registered Nurse at Group Health.*

They wanted to retire that year, so we met to review everything.

They were both in their early 60's and they were thinking that neither of them would take their Social Security benefits until they were each the age of 70.

Since Joe's benefit will be the higher of their two Social Security benefits, it made sense for Joe to wait until he's 70 to start his benefits.

This not only guaranteed him his highest possible benefit should he live a long life but it will also provide Mary with a higher lifetime income if she outlives Joe . . . since she'd be allowed to take his higher benefit, rather than her own, after he dies.

BUT IT'S NOT THEIR "BEST DECISION"

FOR MARY TO WAIT UNTIL SHE'S 70

TO BEGIN HER SOCIAL SECURITY BENEFITS !

They were both in good health. I also knew they did not want to pay premiums for Long Term Care Insurance.

They had over $ 3 million and they felt they could pay for this if it came up.

I pointed out that if Mary dies first, her Social Security benefits will end. So that would be a waste of money for Joe and their sons.

And if Joe died early, she'd get his higher benefit and lose her own lower benefit. Once again, more wasted money.

Here is what I suggested and this is what we did. When Mary retired later that year, I suggested they start her Social Security benefit. This will be about ***$ 1,200 A MONTH.***

After taxes, she will get about ***$ 1,000*** *every month. We took* ***$ 500 A MONTH*** *for each and each applied for their own policy.*

The insurance company issued a policy for over ***$ 305,000*** *for Joe and about* ***$ 380,000*** *for Mary.*

After the first of them dies, the survivor will receive the extra Life Insurance benefit income tax-free !

Like our first example with George, we chose the North American plan that had the extra premium guarantees and Long Term Care benefits.

I ran the numbers and here's the equation.

THIS WILL BE COMPETITIVE WITH ANYTHING ELSE

THAT PAYS A TAX-FREE ANNUAL RETURN

OF 4 % UNTIL THEIR EARLY 90's !

AND IF EITHER DR. JOE OR MARY DIE BEFORE THEN

OR IF EITHER COLLECTS BENEFITS FOR LONG TERM CARE,

THEIR "NET TAX-FREE RETURN" IS EVEN HIGHER !

THIS MAKES SENSE . . . DOESN'T IT ?

MoneyGuard® Life & LTC Combo

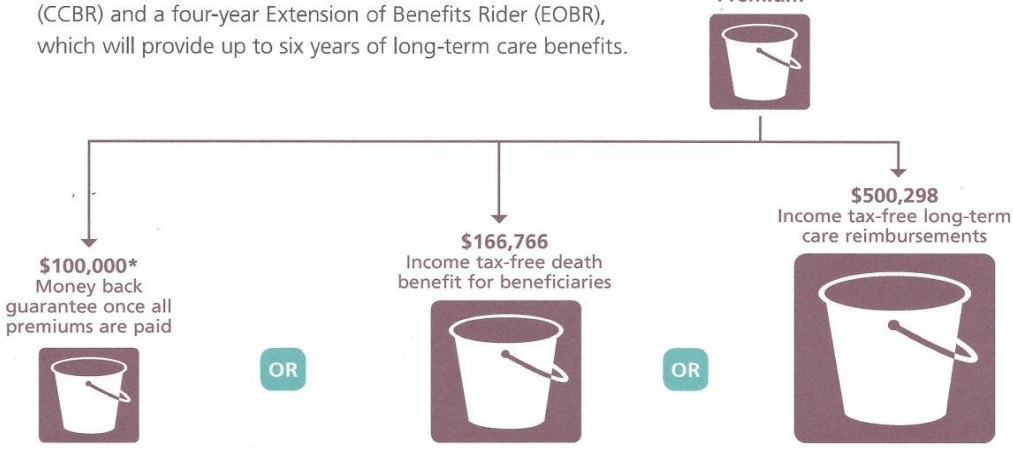
Lincoln *MoneyGuard*® Reserve Plus in action

Lincoln *MoneyGuard* Reserve Plus can reimburse you for qualified long-term care expenses while helping to protect your assets.

The following are hypothetical examples. Benefit amounts vary by health status, age and gender (except in Montana, where gender does not affect rates or benefits). Product features, including rates, benefits, exclusions, limitations, terms and definitions, may vary by state.

EXAMPLE 1: LONG-TERM CARE NOW

Nancy, age 60, is a nonsmoker in good health. She is retired and concerned that she may need long-term care within the next few years. Nancy has money in her portfolio set aside to cover any long-term care expenses. A licensed insurance agent/representative recommended that she purchase a $100,000 single premium Lincoln *MoneyGuard* Reserve Plus policy with a two-year Convalescent Care Benefits Rider (CCBR) and a four-year Extension of Benefits Rider (EOBR), which will provide up to six years of long-term care benefits.



Three possibilities with Lincoln *MoneyGuard* Reserve Plus

If Nancy changes her mind
- She can request a return of her $100,000 premium.† The money returned will be adjusted for any loans, cash withdrawals or benefits paid, and may have tax implications.

OR

If Nancy never needs long-term care
- Her policy provides a $166,766 income tax-free death benefit.
- If she uses a portion of the death benefit for long-term care expense reimbursements, the remaining portion will pass to her beneficiaries, income tax-free, minus any loans or cash withdrawals.

OR

If Nancy needs long-term care
- She can receive up to $500,298 of income tax-free reimbursements for qualified long-term care expenses.
- Her maximum available benefit is $83,383 per year for six years ($6,949 per month).

*Minus any benefits paid, loans, and cash withdrawals.

† Through the Enhanced Surrender Value Endorsement, available at issue on all single premium policies and flexible premium policies for ages 35–65. See Endorsement for complete terms and conditions.

Please review ***Page 30****.*

Another life insurance option that also provides Long Term Care benefits is called ***"MoneyGuard®".***

Let's go thru this example.

We have a lady named Nancy. She is 65, a non-smoker and she enjoys average health.

She has ***$ 100,000****, sitting unproductively at her bank.*

Maybe this came from a CD or other low-paying account.

IT'S NOT LIKE THE "GOOD OLD DAYS"

AT THE BANKS ANY MORE . . . IS IT ?

If you don't need this cash, it probably makes more sense to reposition it . . .

PUT IT BACK TO WORK INTO SOMETHING

MORE PRODUCTIVE . . . LIKE MONEYGUARD !

Let's look at the bottom illustration with three buckets.

Lincoln National is the insurance company. Nancy transfers her ***$100,000*** *to Lincoln National in exchange for the MoneyGuard plan benefits.*

First, MoneyGuard ***GUARANTEES*** *that she can always . . .*

GET HER $ 100,000 BACK . . . ANY TIME SHE WANTS IT !

So the only money she ever has at risk is the interest !

And if she can only make 1 to 2 % in interest from her bank, that's not much of a risk, is it ?

Second, as soon as her policy is issued, Nancy's beneficiaries will receive ***$ 166,000*** *in this example, whenever she dies. This is the life insurance benefit and all of this will be income tax-free to her beneficiaries.*

Third, if Nancy needs Long Term Care, MoneyGuard will pay . . .

UP TO $ 500,000 . . . AND HER PREMIUM WAS ONLY $ 100,000 !

So let's assume Nancy eventually needs care and her MoneyGuard pays $ 100,000 for the cost of her care. MoneyGuard will deduct this $ 100,000 from the Life Insurance benefit of ***$ 166,000*** *and her beneficiaries will still get the remaining* ***$ 66,000 !***

And if she needs all of the $ 500,000 for her Long Term Care . . .

SHE'LL GET EVERY PENNY OF THIS "INCOME TAX-FREE" !

So if you have a life insurance policy and you own a lot of cash value, maybe it makes sense to transfer these funds to one of these ***"Combo"*** *policies with the extra Long term Care benefits !*

We can make this a tax-free transfer under IRS Section 1035.

Here's an example why this is important.

I had a client, a widow, who came to one of my seminars. Her husband had Alzheimers in his last years and had recently died.

He owned a nice life insurance policy but this did not help pay their extra expenses when he was alive.

When he died, his wife got the life insurance, which was a positive for her later.

But when we talked, she shared with me that she wished she would have had more of the life insurance benefit to help both of them to pay for the extra expenses when he was alive !

Fixed Annuity Long Term Care Solution !

FORETHOUGHT®
A GLOBAL ATLANTIC COMPANY

Home ► Annuities > Fixed Annuities > ForeCare

Fortify your finances for the unexpected.

ForeCare℠ Fixed Annuity

ForeCare offers a better, more tailored strategy for the 73% of annuity owners who identify their annuity as a means of self-insuring against the threat of long-term care expenses.[1] ForeCare is an innovative fixed annuity that incorporates a long-term care benefit to help you avoid financial hardship in the event of a health crisis that requires long-term care.

With ForeCare, you get all of the benefits of a fixed annuity, such as income options, tax-deferral and a death benefit that passes any remaining contract value directly to your named beneficiary at death. Plus, you get financial protection at two- or three-times the contract value for long-term care expenses.

In order to provide these benefits, ForeCare contracts require a simple, quick and non-invasive application process.

To find out more about ForeCare as a potential alternative for long-term care protection, talk with your financial representative.

Help prevent a health crisis from becoming a financial one

ForeCare contracts offer:

The Fixed Annuity & Long Term Care Solution !

*Please review **Page 33**.*

WHAT ABOUT YOUR "ANNUITIES" ?

*A study tells us that **73 %** of annuity owners have their annuities to help them self-insure their future Long Term Care.*

For most of my clients . . .

THIS IS THEIR "SAFE MONEY" . . . THE MONEY

THEY NEED TO BE THERE LATER !

If you own annuities, there's one problem, isn't there ?

This problem is also one of the positive annuity advantages during the accumulation years.

*I'm referring to the **"Tax Deferred Interest"**.*

We don't pay taxes on any interest during the accumulation years.

But when we take an income or a withdrawal later, the first dollars out are taxable income, up to the amount of your deferred interest in a non-qualified annuity (and of course all withdrawals are taxable income when the annuity is in an IRA).

So here's something to consider and it helps to understand some of our newer tax laws.

*If we use the annuity we have now, to help us pay for our Long Term Care when we need it . . . **the deferred interest will be taxable income.***

*Here's a **"New Option"** where new tax benefits were created by Congress in 2010 to help taxpayers create more benefits for their Long Term Care . . . **but only from the new combo tax-qualified policies.***

The new choices allow us to not only pay our Long Term Care Insurance Premiums with ***TAX-FREE DOLLARS*** *. . .*

but any amount we take out to pay for our long term care needs also comes out of the policy income tax-free !

The tax laws allow us to ***REPOSITION*** *the annuity we now own . . . with a* ***"Section 1035 Tax-Free Exchange"*** *. . .*

to a ***NEW ANNUITY*** *. . . that* ***ALSO OFFERS*** *these* ***"New Tax-Free Advantages"*** *when we need long term care . . .*

EVEN FOR THE "DEFERRED INTEREST"

YOU ACCUMULATED WITH THE ORIGINAL POLICY !

And this is a nice extra bonus !

Here is another ***LIMITATION*** *with* ***"Traditional"*** *Long Term Care Insurance . . .*

MOST OF US PAY OUR PREMIUMS WITH "AFTER-TAX DOLLARS" !

And much of this time, the money we have to pay these premiums is ***BURIED*** *in our IRAs or other retirement accounts.*

So to pay our ***"Increasing LTC Insurance Premiums"*** *. . .*

we are ***FORCED*** *to take a* ***"Taxable Distribution"*** *from our IRAs and other accounts . . . and this creates* ***MORE "TAXABLE INCOME" !***

This ***EXTRA*** ***"Taxable income"*** ***OFTEN INCREASES*** *the taxes we need to pay on our Social Security Benefits. . .*

AND ALL OF THIS ADDS TO OUR EXPENSE !

Yes, the premiums we pay for ***"Tax-Qualified Long Term Care Insurance"*** *can be* ***DEDUCTIBLE****.*

*But this **RARELY BENEFITS** most of us, unless we also have a large mortgage or high medical expenses we also claim on our **"Schedule A"**.*

*We used to do **500** tax returns a year for our clients out of our Sequim office . . . so I know my way around a **"Tax Return"**!*

*Please turn to **Page 37** . . . let's review this **"New Option"**.*

*I have **TWO** companies who offer similar choices . . . and I'll use this example called **"AnnuiCare"**.*

***"AnnuiCare"** is a **"Fixed Annuity"** and it pays us a guaranteed **"2.9% Interest Rate"** (as of 7/1/2023).*

*Nothing fancy, but **2.9%** is competitive today for conservative money.*

*Out of this, we take a **"Tax-Free Deduction"** to pay for a **"Long Term Care Rider"** that **TRIPLES** our annuity if we need Long Term Care.*

*Let's use an example of **$ 100,000**. This is a common amount we might want to use for each spouse when we can afford it.*

*You can see at the bottom . . . we can go as high as **$ 300,000** for each spouse . . . or a **MINIMUM** of **$ 36,500** . . .*

*or **$ 50,000** if you want to use your **IRA** to fund this.*

*A single premium of **$ 100,000** will create a **"Pot of Benefits"** of **$ 300,000** that will be available to you for your Long Term Care needs.*

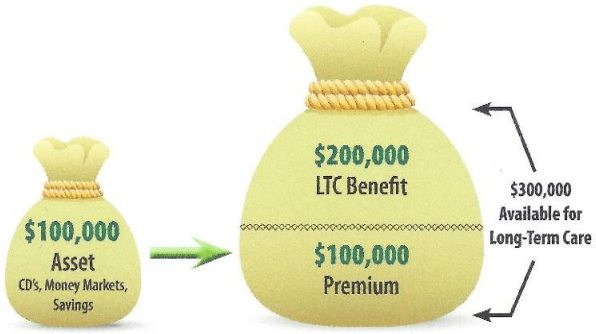
*So let me ask you a **"Dumb Question"**.*

*If you need Long Term Care, would you rather have the **$ 100,000** from what you have now . . .*

*or would you rather have **$ 300,000** available to you from that same **$ 100,000**?*

*That's an **"Easy One"** . . . isn't it?*

AnnuiCare®
THE ORIGINAL ANNUITY COMBO PRODUCT



AnnuiCare® provides up to three (3) times the annuity Accumulation Value (AV) for qualified long-term care expenses.

GUARANTY INCOME LIFE INSURANCE COMPANY – *A leader in long-term care insurance since 1999!*

- Underwriting Experience
- High Issue Rates
- Policyowner Satisfaction
- Decision Usually Within Three Business Days of Interview
- Producer Satisfaction
- NO LTC RATE INCREASES

ANNUICARE® ALLOWS YOUR CLIENTS TO MAINTAIN:

- Home Ownership
- Choices and Options
- Financial Independence
- Lifestyle of the Healthy Spouse

THE ANNUICARE® ADVANTAGE

If the AnnuiCare® policy is not needed for LTC expenses, the Cash Value is available for surrender, or the full Accumulation Value will be paid to the Owner's beneficiary.

AnnuiCare®
AT A GLANCE

- **Minimum Amount:** $36,500 – Non-qualified funds
  $50,000 – Qualified funds*
- **Maximum Amount:** $300,000
- **Maximum Issue Age for AnnuiCare® 10, AnnuiCare® 8 and AnnuiCare® 6** – Age 79
  (Funds must be received in our office prior to 80th birthday.)
- **Maximum Issue Age for AnnuiCare® 7, AnnuiCare® 5 and AnnuiCare® 4** – Age 85
  (Funds must be received in our office prior to 86th birthday.)

**Minimum issue age > 59 1/2*

*Of this **$ 300,000**, we have **"Two Pots"** of money.*

*We have our **$ 100,000** of **"Premium"** and the **$ 200,000** created by the **"Long Term Care Rider"**.*

*To help minimize your premium costs for the **"Long Term Care Rider"**, you will **"Spend Down"** **YOUR $ 100,000 FIRST** for your Long Term Care costs . . .*

*over the **FIRST TWO YEARS** . . . **OR LONGER** if you don't need care every day.*

*And then the **OTHER $ 200,000** will start after this and be paid out over the next **FOUR YEARS** . . .*

***OR LONGER** if you don't need care every day . . . at the same daily benefit.*

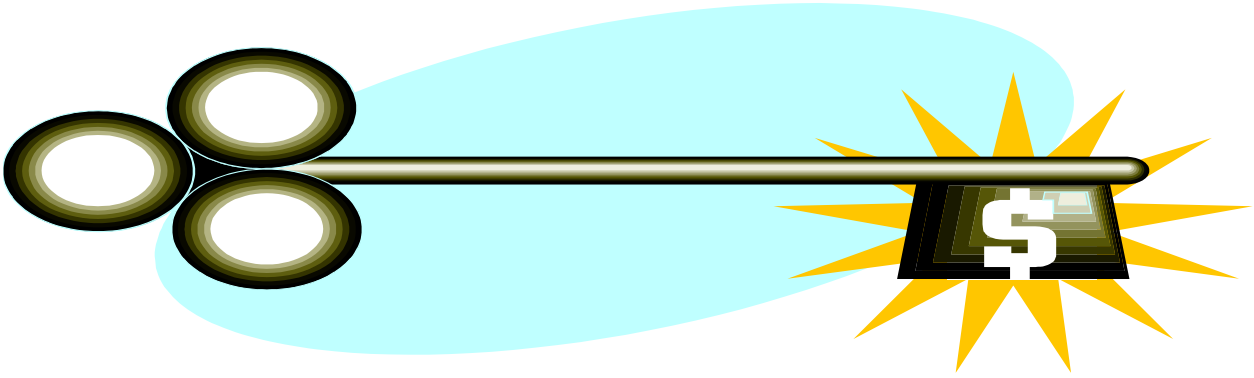
*This includes care and **"Homemaker Services"** in your home, Assisted Living, Adult Day Care and Nursing Home, if and when you need it.*

*It's like buying **QUALITY** Long Term Care Insurance . . . with a **"Two Year Deductible"**!*

*This makes **A LOT OF SENSE** for many of us . . .*

ESPECIALLY THE 90 % OF US . . . WHO HAVE ALREADY ELECTED TO "SELF-INSURE" OUR "LONG TERM CARE RISK"!

***Pages 39 and 40** will fill in the details.*



Reasons for Long-Term Care Protection

The average Long-Term Care expense in the United States in 2008 was over $68,000 per year.[1]

Long-Term Care Protection Can Help You:

- *Maintain your choices and options.*
- *Avoid the possibility of depleting your life savings.*

AnnuiCare® Advantages

AnnuiCare® is a guaranteed tax-deferred annuity that also provides Tax Qualified Long-Term Care coverage. The Long-Term Care coverage is equal to three times the value of your annuity at a fraction of the cost[1] of traditional Long-Term Care insurance. The Long-Term Care premiums are conveniently paid from the annuity's value so there are no large, out-of-pocket premiums.

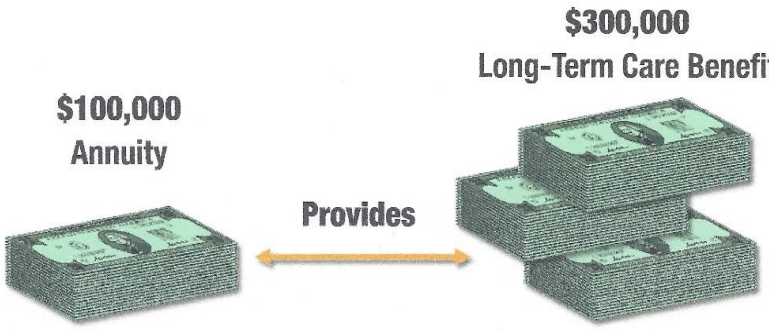
- **MONEY BACK** - *AnnuiCare® provides Long-Term Care benefits if you need them, or your annuity value, including net interest, if you don't.*
- **SAFETY** - *Your AnnuiCare® value is free from market risk.*
- **LIQUIDITY** - *Your annuity interest can be accessed easily with no withdrawal charges.*
- **LONG-TERM CARE BENEFIT** - *AnnuiCare® will reimburse up to three times your annuity value for Long-Term Care benefits for six years or longer.*
- **WAITING PERIOD** - *Claims may be filed beginning day one, and benefits may begin as soon as the 90-day Deductible Period is met.*
- **TAX-DEFERRED GROWTH** - *Interest earned in your annuity accumulates tax deferred.*
- **PRE-EXISTING CONDITIONS ARE COVERED** - *We will not deny benefits for pre-existing conditions.*
- **DEATH BENEFIT** - *The full value of your annuity will be paid directly to your beneficiaries, bypassing probate.[2]*

WITHDRAWALS FOR LONG-TERM CARE PREMIUMS AND BENEFITS ARE TAX FREE.[2]

The AnnuiCare® Concept

Combines the safety and tax advantages of an annuity with the benefits of Long-Term Care insurance. AnnuiCare® provides three times the annuity value for Tax Qualified Long-Term Care expenses.

3 FOR 1 LONG-TERM CARE BENEFITS WITH NO OUT-OF-POCKET PREMIUMS



How AnnuiCare® Works

1. You establish a guaranteed tax-deferred annuity.
2. A portion of your annuity value is used to pay for the Long-Term Care rider.
   There are no out-of-pocket premiums.
3. Benefits begin after a 90-day Deductible Period if you are certified by a Licensed Health Care Practitioner as:
   - ✓ *Being unable to perform two of the six Activities of Daily Living: bathing, continence, dressing, eating, toileting and transferring;* ***or***
   - ✓ *Having a cognitive impairment requiring substantial supervision, such as Alzheimer's Disease.*
4. Your Long-Term Care expenses will be reimbursed up to the Daily Maximum benefit. These reimbursements will be paid from your annuity value, penalty free, for at least the first two years. Thereafter, for no less than four years, benefits will be reimbursed from the AnnuiCare® rider, providing six years or more of Long-Term Care benefits.
5. Your AnnuiCare® policy will reimburse Long-Term Care expenses up to 100% of your Daily Maximum benefit for:
   - ✓ *Home Health Care*[3]
   - ✓ *Nursing Home Care*
   - ✓ *Homemaker Services*
   - ✓ *Assisted Living Facility Care*
   - ✓ *Personal Care Services*
   - ✓ *Hospice Services*
   - ✓ *Alternative Care Services*
   - ✓ *Respite Care*
   - ✓ *Adult Day Care (50% of Daily Maximum)*

THE LONG-TERM CARE BENEFIT IS DETERMINED BY YOUR ANNUITY VALUE.

The daily average cost of care in your area should determine the annuity amount you choose.

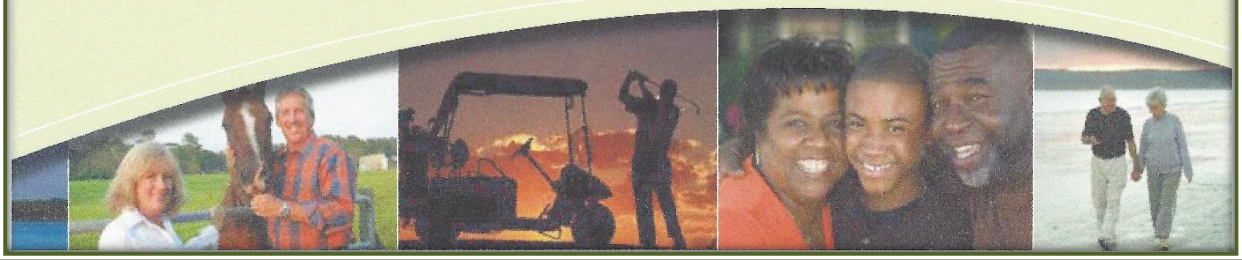
Initial Annuity Value	Total Long-Term Care Benefit	Daily Maximum Benefit
$50,000	$150,000	$68.49
$100,000	$300,000	$136.99
$150,000	$450,000	$205.48

AS YOUR ANNUITY VALUE GROWS, YOUR LONG-TERM CARE BENEFIT ALSO GROWS.

Below is an example of a 65 year old who purchases a $100,000 AnnuiCare® plan. The chart illustrates how the annuity value will grow based on the net interest credited. As the annuity value grows, the Daily Maximum benefit grows at the same rate. This helps you meet the rising cost of Long-Term Care expenses.

End of Contract Year	Annuity Value[4]	Daily Maximum Benefit
1	$102,113	$139.88
5	$110,680	$151.62
10	$122,408	$167.68
20	$149,721	$205.10

[1] *U.S. Department of Health and Human Services – National Clearinghouse for Long-Term Care Information – www.longtermcare.gov.*
[2] *Effective 1/1/2010, all benefit payments are tax free, and LTC premiums are paid with pre-tax dollars from your annuity. The premiums will reduce your cost basis which may result in additional taxes if you surrender your AnnuiCare® policy. GILICO does not give tax advice. Please consult your tax advisor for additional information.*
[3] *Includes Adult Foster Care in Oregon.*
[4] *This illustration assumes no withdrawals or additions, an interest rate of 3%, and current long-term care monthly premium deductions.*



Please review ***Page 42****.*

You'll see where any remaining amount of your own accumulated value in your ***"AmeriCare Annuity"*** *that you* ***DON'T NEED*** *for long term care, goes to your named beneficiaries* ***WITHOUT PROBATE !***

A little ***LOWER*** *on the* ***"Left Side"*** *. . . you'll see where the* ***"LTC Premiums"*** *. . .*

ARE ABOUT "TWO-THIRDS LESS" . . .

than ***"Traditional"*** *Long Term Care Insurance.*

And on the top right, we can also buy ***"Annuicare"*** *with our IRAs and other retirement accounts . . .*

and we can ***SPREAD-OUT THE "TAXABLE DISTRIBUTIONS" OVER FIVE YEARS !***

"AnnuiCare" *is a* ***SOLID WAY*** *to help us* ***"Self-Insure"*** *our Long Term Care . . . with a* ***MINIMUM*** *of* ***"Insurance Costs"*** *. . .*

and ***EXTRA*** ***"Tax-Free Benefits"*** *when we need care . . .*

AND THE "MEDICAL UNDERWRITING"

IS MUCH EASIER TO QUALIFY FOR !

For many of us, it makes sense for us to sell off a slice of our investments to fund this.

My company is a licensed ***"Registered Investment Advisor"*** *and I well-understand the argument . . . when we think our investments will do better over time.*

And you might be right in ***SOME MARKETS****.*

But we typically have to accept ***"Higher Risks"*** *to get the* ***"Higher Returns"****, don't we ?*

What happens to my annuity if I never need Long-Term Care benefits?

Your annuity will continue to earn tax-deferred interest. You may choose to receive your annuity value in a lump sum, periodic payments including a lifetime income, or it will be paid to your beneficiaries. **The Annuity Value will pass on to the beneficiaries as a death benefit, if not needed.**

How is AnnuiCare® different from other Long-Term Care insurance?

AnnuiCare® combines the savings feature of a tax-deferred annuity with the protection of a traditional Long-Term Care policy. The dollars you put aside for Long-Term Care are spent only if you need them, but not lost if you never use them.

Does AnnuiCare® pay for the same Long-Term Care services as a traditional Long-Term Care policy?

Yes, it does! AnnuiCare® is Tax Qualified Long-Term Care insurance.

How does the cost of AnnuiCare®'s LTC riders compare to traditional LTC insurance plans?

The LTC premiums deducted from your annuity are generally about one-third of the out-of-pocket premium you would pay for a traditional plan with substantially similar benefits. This savings is available to you because your annuity value is used first for LTC benefits. *(Cost estimate is based on examples by age provided at U.S. Department of Health and Human Services - National Clearinghouse for Long-Term Care Information - www.longtermcare.gov.)*

How do I qualify for AnnuiCare®?

AnnuiCare® has a simplified underwriting process. After completing the application, ages 69 and younger will have a telephone interview with a registered nurse. If you are age 70 or older, the interview will be conducted in person at your convenience. No physical exam or lab work is needed. Underwriting is usually completed within three business days of your interview.

Can I buy AnnuiCare® with qualified money?

You can buy AnnuiCare® with a qualified account such as an IRA. The qualified account is transferred into AnnuiCare®. Then over a five year period, the funds are distributed into the non-qualified annuity portion of the AnnuiCare® policy. You will receive a 1099 and will be taxed on the portion that is transferred each year, allowing you to spread the income tax over a five year period.

How does the Pension Protection Act of 2006 affect AnnuiCare®?

Effective January 1, 2010, annuity value withdrawn to pay Tax Qualified Long-Term Care premiums is not taxed. All AnnuiCare® policies receive this tax benefit.
That means: **Tax Free Premiums and Tax Free Long-Term Care Benefits.**

How do I qualify to receive Long-Term Care benefits from my AnnuiCare® policy?

If you are unable to perform at least two of six Activities of Daily Living or have cognitive impairment requiring substantial supervision, you will qualify to receive benefits after a one time 90-day Deductible Period. **AnnuiCare® has no waiting periods.**

How long must the policy be in force before Long-Term Care benefits can be accessed?

AnnuiCare® is unique because it has no long waiting periods. **Claims may be filed beginning day one, and benefits may begin as soon as the 90-day Deductible Period is met.**

Be sure to ask your agent for a personalized AnnuiCare® illustration.

GUARANTY
Income Life Insurance Company

929 Government Street
Baton Rouge, LA 70802
800.535.8110 / 225.383.0355
Fax: 225.343.1747
e-mail: sales@gilico.com
www.gilico.com

Important: This information is intended only as an overview of AnnuiCare® and does not include all terms, conditions, and rules of the contract. The policy has limitations and exclusions. This is not an application. To apply for AnnuiCare®, you must be presented with a personalized illustration, an Outline of Coverage, and other material required by the insurance laws of your resident state. AnnuiCare® is not approved for sale in all states. AnnuiCare® is a deferred annuity with Long-Term Care riders underwritten by Guaranty Income Life Insurance Company, Baton Rouge, LA.
Annuity forms are 1FPA-5 (10/10), 1FPA-7 (10/10), 1FPA-10 (10/10), 1SP4-MVA-M (11/03), 1SP6-MVA-M (11/03), 1SP8-MVA-M (11/03) or state variations; 1FPLTC7 (TX 8/08) and 1FPLTC10 (TX 8/08).
Long-Term Care rider forms are LTC-2, LTC-2E and LTC-3.

And if we need Long Term Care, we will need this money ***TO BE AVAILABLE*** *if we need it . . . we can't wait for the market to come back !*

Let's go back to ***2008*** *. . .* ***"Tens of Thousands of Investors"*** *needed Long Term Care in* ***2008*** *and* ***2009****.*

For those who ***"Self-Insured"*** *their Long Term Care with their* ***INVESTMENTS*** *. . .*

many were ***FORCED TO "SELL" . . . AT THE "WRONG TIME" !***

THEY WERE FORCED TO SPEND THAT MONEY AND IT NEVER GOT RE-INVESTED . . . FOR WHEN THE MARKET CAME BACK !

THIS IS WHY LEVERAGE, BALANCE, GUARANTEES AND "LIQUIDITY" ARE SO IMPORTANT !

So let me ask ***"The Investors"*** *a question.* ***HOW MUCH*** *do we have to earn from our investments each and every year . . .*

TO EQUAL WHAT WE CAN GET *. . .*

from this fixed annuity, called ***"AnnuiCare"****, with the* ***EXTRA*** *Long Term Care benefits . . .*

IF WE'RE ONE OF THE "70 %" WHO EVENTUALLY NEED LONG TERM CARE ?

We ***CAN'T*** *answer this yet.*

It really depends on when we will ***NEED*** *the* ***"Extra Care"*** *and* ***HOW LONG*** *we'll need it ! (The* ***"Unknown"*** *is a large part of our risks !)*

*To help all of us, I did a **"Little Math"**.*

*If we needed Long Term Care in **TEN YEARS**, we'd need to earn . . .*

OVER 12 % EVERY YEAR *. . .*

*to create enough to equal the **$ 300,000** of benefits available from this **"AnnuiCare Annuity"** . . . that pays us only a **2.9 % FIXED RATE !***

*We'd need to earn **OVER 8 % EVERY YEAR** if we need care in **15 YEARS**.*

*And we'd still need to earn **OVER 6 % EVERY YEAR** if we need care in **20 YEARS**.*

AND ALL OF THIS IS "NET" AFTER

ALL EXPENSES AND ALL TAXES !

I RECOMMEND ANNUICARE *for the many of us who want to **"Self Insure"** our personal risk for the devastating costs of Long Term Care !*

AND FOR US WHO WANT TO ENHANCE WHAT WE OWN TO MAKE LIFE "A LITTLE EASIER" FOR OUR "LOVED ONES" . . .

WHO ARE MAKING THE "SACRIFICES" TO BE OUR "CAREGIVER" !

*The **"Medical Underwriting"** for **"Annuicare"** . . .*

IS ALSO MUCH "EASIER" AND "SIMPLER" *. . .*

*than for either **"Life or Long Term Care Insurance"**.*

*Even if you already own Long Term Care Insurance . . . it's likely that what you have **WON'T COVER EVERYTHING !***

*So if you can't afford or don't want to pay **THE INEVITABLE LTC PREMIUM INCREASES** . . . here's **"Another Choice"** to help you create more benefits from your savings and annuities when you need them !*

WHY NOT Reposition Your Home's Equity To Be Available When You Are One Of The 70 % Of Us Who Need Long Term Care ?

My company is also a licensed Mortgage Broker, specializing in HECM Reverse Mortgages and we have helped ***OVER 1,000*** *of our clients get their HECM Reverse Mortgage since 2006.*

The ***"Average Retiree"*** *. . .*

HAS ALMOST HALF OF THEIR "NET WORTH" BURIED IN THE "EQUITY" OF THEIR HOME.

It's what we call ***"Dead Equity"*** *!*

It's rarely available when we need it !

WHY NOT *reposition your home equity, with a Reverse Mortgage, to have it available when you might need it ?*

I've written another book I named ***"MAXIMIZE Your Retirement Income And THE TRUTH About Reverse Mortgages"****.*

It is a solid 130 pages, illustrating the federal HECM program and the many ways it can help us, including our Long Term Care needs.

The HECM is endorsed by many of the leading professors, economists and other Retirement Income Professionals and I have shared many of their thoughtful comments about this in my book.

In my opinion, it is a ***MUST READ*** *for anyone who is serious and has concerns about their future retirement income, including how to help us pay for our Long Term Care. (Don't say* ***"NO"*** *. . . until you understand it !)*

On ***Page 46****, I've given you some examples that illustrate the* ***"Loan Amount"*** *that's available for different home values and ages.*

Your "Loan Amount" For Various Ages

NOTES:

*The **"Loan Amount"** is called the **"Principal Limit"**. (Your **"Closing Costs"** and any mortgages, or other liens you owe, will be deducted from this.)*

*The **"Expected Interest Rate"**, in addition to the appraised value and age of the youngest Borrower, determines your **"Principal Limit"**. This can change weekly. Amounts below, are based on a 2.25 margin as of **3/30/23**. (The 10 year U.S. Treasury Bond closed that day at 3.55.)*

Principal Limit (Loan Amount)

Home Appraised Value

	$ 400k	$ 500k	$ 600k	$ 700k	$ 800k	$ 1,000,000
Age 62	$ 148,000 (37.0 %)	$ 185,000 (37.0 %)	$ 222,000 (37.0 %)	$ 259,000 (37.0 %)	$ 296.000 (37.0 %)	$370,000 (37.0 %)
Age 67	162,400 (40.6 %)	203,000 (40.6 %)	243,600 (40.6 %)	284,200 (40.6 %)	324,800 (40.6 %)	406,000 (40.6 %)
Age 72	171,200 (42.8 %)	214,000 (42.8 %)	256,800 (42.8 %)	299,600 (42.8 %)	342,400 (42.8 %)	428,000 (42.8 %)
Age 77	188,400 (47.1 %)	235,500 (47.1 %)	282,600 (47.1 %)	329,700 (47.1 %)	408,100 (47.1 %)	471,000 (47.1 %)
Age 82	208,200 (52.2 %)	261,000 (52.2 %)	313,200 (52.2 %)	365,400 (52.2 %)	417,600 (52.2 %)	522,200 (52.2 %)
Age 87	234,400 (58.6 %)	293,000 (58.6 %)	351,600 (58.6 %)	410,200 (58.6 %)	468,800 (58.6 %)	586,000 (58.6 %)
Age 92	263,200 (65.8 %)	329,000 (65.8 %)	394,800 (65.8 %)	460,600 (65.8 %)	526,400 (65.8 %)	658,000 (65.8 %)

Disclosure: Please note that these materials are not from HUD or FHA and were not approved by HUD or a government agency.

*As you can see, the percentage of the available **"Loan Amount"**, given the same appraised value . . . **INCREASES AS WE GET OLDER**.*

*The amount of our **"Loan Amount"**, in relation to the **"Appraised Value"** of our home, is **ABOUT 37 %** in our **"Early 60's"** . . . .*

*and it **STEADILY INCREASES** up to **66 %** when we reach the age of **90**.*

*Just to clarify, our **"Closing Costs"** and any other mortgages or liens you now have, will need to be **DEDUCTED** from this **"Loan Amount"**.*

WHY THE "LINE OF CREDIT" OPTION IS SMART !

*What if you **DON'T** have any mortgage(s) now ?*

Why does a Reverse Mortgage make sense ?

*Even though we might not need a Reverse Mortgage today, here's why owning a Reverse Mortgage **TODAY** will help many of us **LATER**.*

BUT THIS WILL ONLY WORK

IF YOU PLAN AHEAD

AND HAVE YOUR REVERSE MORTGAGE

IN PLACE BEFORE YOU ACTUALLY NEED IT !

Here's what I mean. To qualify for a Reverse Mortgage . . .

YOUR HOME MUST BE YOUR "PRIMARY RESIDENCE" !

*If you're already in a **"Long Term Care Facility"** . . . **YOU WON'T QUALIFY FOR A REVERSE MORTGAGE !***

So it makes sense to have this in place and position your home equity to be available when you need it !

Projected "Line of Credit" Increases !

- *Assume we have a **$ 1,000,000** home in this example.*
- *The **"Initial Line of Credit"**, Year 0, is based on interest rates from **3/28/2023**. Rates can change weekly for new loans. The numbers illustrated are **"Net"**, after estimated **"Closing and Loan Costs"**.*
- *Future growth for projections below are assumed to increase at the rate of **6.21 %** annually (based on the **"Expected Interest Rates"** from **3/23/2021** of **5.71 %** (assuming a 2.25 % margin) plus **0.50 %** for FHA Insurance. 10 year U. S Treasury rates closed at 3.537 on 3.27/23.).*
- *Assumes that you have no other debt beyond the **"Closing Costs"** for the loan. (You must keep a loan balance of $ 100 minimum.). **If your loan is paid off, the loan will be closed-out by the lending bank.**)*

Year	Age 62	Age 72	Age 82	Age 92
0	$ 339,551	$ 397,551	$ 491,551	$ 627,551
5	458,915	537,304	664,348	848,156
10	620,239	726,184	897,889	
15	838,274	981,463	1,213,528	
20	1,132,956	1,326,481		
25	1,531,229	1,792,784		
30	2,069,509			
35	2,797,012			

Note: For Example Only

Disclosure: Please note that these materials are not from HUD or FHA and were not approved by HUD or a government agency.

*The **POWER** Of Your "Line Of Credit Option" !*

Have you read in AARP or other magazines and publications . . .

"THAT IT MAKES MORE SENSE TO WAIT AND GET YOUR REVERSE MORTGAGE LATER . . .

ONCE YOU GET OLDER . . .

BECAUSE YOU'LL QUALIFY FOR MORE MONEY WHEN YOU'RE OLDER ?"

While this is true in some respects, I'm going to show you . . .

HOW THAT ADVICE MAY COST YOU HUNDREDS OF THOUSANDS OF DOLLARS

THAT COULD BE C-R-I-T-I-C-A-L TO YOUR FINANCIAL NEEDS LATER IN LIFE !

THIS IS IMPORTANT . . . SO PLEASE INVEST THE TIME TO UNDERSTAND THIS !

*On **Page 48**, I've listed an example of the values of this **"Line of Credit"** for different ages. (Less any mortgages or other liens you now owe.)*

*Let's concentrate on **AGE 62**. Using current interest rates, assuming we have a home worth **$ 1,000,000** and also assuming we've paid off the other mortgages . . .*

WE COULD SET UP A "LINE OF CREDIT" FOR THE AMOUNT OF ABOUT $ 340,000 AT AGE 62 . . .

AND THIS IS "NET TO US" . . . AFTER THE LOAN'S ESTIMATED CLOSING COSTS.

WE <u>ARE NOT CHARGED</u> ANY INTEREST . . .

ON THE <u>UNUSED</u> "LINE OF CREDIT".

Under Federal Law, our bank will have to pay us . . .

ANY AMOUNT WE WANT OF OUR AVAILABLE CREDIT LINE <u>WITHIN FIVE BUSINESS DAYS</u> OF OUR REQUEST . . .

OR FEDERAL LAW REQUIRES THE BANK TO PAY A PENALTY TO US !

AND NONE OF THIS IS "TAXABLE INCOME" WHENEVER WE WANT SOME MONEY !

Here is why we want to do this ***<u>JUST AS SOON AS WE CAN !</u>***

<u>OUR "UNUSED LINE OF CREDIT"</u>

<u>WILL G-R-O-W EVERY MONTH !</u>

Most people, including most in the media . . .

DON'T UNDERSTAND <u>THE POWER</u> OF THIS !

Our ***"Line of Credit" <u>WILL INCREASE EVERY MONTH !</u>***

And this is based on the loan's ***"Actual Current Interest Rate" . . . <u>PLUS 0.50 %</u>*** *(the FHA IMIP cost).*

Based on the longer-term (10 year) ***"Expected Interest Rates"*** *the banks use now to determine the* ***"Original Loan Amount"****, on average over time, we'll assume for our example, this will likely* ***<u>GROW</u>*** *about* ***<u>5.75 %</u>*** *every year. (And more – when interest rates increase in the years ahead !)*

When this 62 year old in our example is ***72*** *. . .*

INSTEAD OF HAVING THE $ 340,00 "LINE OF CREDIT" THEY STARTED WITH . . .

THEY'LL NOW HAVE ABOUT $ 620,000

OF EXTRA "TAX FREE CASH"

WHENEVER THEY WANT IT !

If you don't feel you need a Reverse Mortgage today . . .

YOU NEED TO FULLY UNDERSTAND THE EXTRA VALUE THAT IS OFFERED TO US BY THE "LINE OF CREDIT" !

Let's go through this again on ***Page 48****.*

Let's start again at ***AGE 62*** *and we start with a* ***"Credit Line"*** *of* ***$ 340,000****.*

AND IN "YEAR 10" . . . THIS HAS GROWN TO ABOUT $ 620,000 !

Now let's look at the next column to the right for ***AGE 72****. (Please note that this is also 10 years later than age 62 !)*

The beginning value . . .

IS ONLY $ 397,500 . . . AND NOT $ 620,000 !

AND THE "DIFFERENCE" COMPOUNDS MORE IN THE YEARS AHEAD !

Let's do this one more time. If we go back to ***AGE 62*** *and we look down to the* ***20th YEAR*** *of our example . . .*

THE "LINE OF CREDIT" HAS GROWN TO ABOUT $ 1,133,000 !

And if we compare this to the ***"Beginning Value"*** *. . .*

IF WE HAD <u>WAITED</u> 20 YEARS TO APPLY AT THE AGE OF <u>82</u> . . .

OUR "INITIAL LINE OF CREDIT" <u>IS ONLY ABOUT $ 491,500.</u>

So let me ask you a question. Let's assume you're now in your 80's and either you or your spouse will need more income or Long Term Care.

WOULD YOU RATHER HAVE THE <u>$ 491,500</u>

OR THE <u>$ 1,133,000</u> . . . TO HELP YOU ?

Maybe the value of your home will go ***<u>UP</u>*** *or maybe it will go* ***<u>DOWN</u>****.*

It would be nice to have that ***"Crystal Ball"****, wouldn't it ? But consider this . . .*

IF YOU GET YOUR REVERSE MORTGAGE <u>NOW</u> . . .

THE VALUES AND TERMS ARE <u>GUARANTEED</u> EVEN IF THE "YOUNGEST BORROWER" . . .

<u>LIVES TO THE AGE OF 150 !</u>

AND ALL OF THIS IS <u>INSURED BY FHA !</u>

The bank may go out of business and the value of your home ***<u>COULD GO DOWN</u>****.*

AND IT WOULD <u>NOT AFFECT</u> YOUR "UNUSED LINE OF CREDIT" IN ANY WAY !

<u>THINK ABOUT THE EXTRA SECURITY OF THIS !</u>

*And all of this is **EXTRA CASH** beyond your other investments that you will never have otherwise (unless you sold your home and this is often offset by other new costs).*

WITH THE REVERSE MORTGAGE . . . ASSUMING WE

SATISFY OUR LOAN OBLIGATIONS . . .

WE CAN NOT ONLY KEEP OUR HOME

BUT WE ALSO HAVE THE EXTRA CASH

THE EXTRA INCOME OR THE CREDIT LINE !

This extra could help us pay for our Long Term Care . . .

OR IT COULD EXTEND OUR RETIREMENT INCOME FOR MANY YEARS !

*We'll have **MORE OPTIONS** to manage the rest of our money . . .*

AND KEEP OUR OTHER INVESTMENTS WORKING MORE PRODUCTIVELY FOR US.

We won't have to . . .

GIVE OUR MONEY TO THE BANKS FOR THEIR STUPID CD'S AND OTHER LOW-PAYING TAXABLE ACCOUNTS . . .

JUST TO HAVE AN "EMERGENCY FUND".

REMEMBER . . . WE CAN GET CASH FROM OUR "LINE OF CREDIT" . . . WITHIN FIVE BUSINESS DAYS.

*We can also afford to lower our premiums and have **HIGHER DEDUCTIBLES** for our Long Term Care and other insurance.*

We can afford ***TO INVEST FOR A LONGER TERM****.*

Or we can ***"Tone-Down"*** *our investments . . .*

BECAUSE WE WON'T NEED TO TAKE ON EXTRA INVESTMENT RISKS !

We can now afford to ***MINIMIZE*** *our* ***"Taxable Distributions"*** *from our IRAs and other retirement accounts . . . and let them create* ***VALUABLE NEW TAX ADVANTAGES*** *for both ourselves and our Beneficiaries.*

AND THE SOONER WE PUT THIS TOGETHER . . .

THE MORE SECURITY WE'LL HAVE

FOR OUR LATER YEARS !

THE "IMPORTANT QUESTION" . . . IS NOT "WHY WE SHOULD GET A REVERSE MORTGAGE ?" . . . RATHER, IT IS WHY NOT GET A REVERSE MORTGAGE ?

Medicare And Medicaid LTC Challenges

Let's start with Medicare. If you have a need for short-term recovery or rehabilitation, Medicare may offer some benefits and if Medicare approves your care, then your Medicare Supplement or other medical insurance will likely pay the balance for most of your costs.

*With this said, I **DO NOT** consider Medicare, Medicare Supplements or other medical insurance to be a significant part of our planning for LTC.*

*Medicare **DOES NOT** pay for **"Custodial Care"** and there are other significant limitations, including a three day prior hospital requirement and care is limited to a Medicare Approved Skilled Nursing Home and I've often seen where any benefits are all-too-often taken away arbitrarily.*

*Past studies have consistently shown us that about **FOUR OUT OF EVERY FIVE OF US** who are of retirement age . . .*

DO NOT UNDERSTAND THESE HUGE LIMITATIONS !

So my advice is not to assume that Medicare will pay a penny of your LTC costs . . . but be aware of what they do offer for short-term situations.

*If we can not pay for our own LTC costs, or if we run out of money once we are there, what we do need to be aware of is **MEDICAID**.*

"MEDICAID" IS NOT "MEDICARE" !

*Medicaid is a **"Needs-Based Program"** . . . it' is **"Welfare"**.*

I MEAN "NO DISRESPECT" !

IT IS AN "IMPORTANT PROGRAM"

AND A "CRITICAL BENEFIT" FOR MANY OF US

WHEN WE RUN OUT OF "OTHER CHOICES".

*On **Pages 57–78**, I've included two publications from Columbia Legal Services. They update these each year and both are current as of July 2023.*

*The first is **"Questions and Answers on the COPES Program"** on **pages 57–67**. This is primarily for our home and other non-nursing home long term care services that will need to be paid for by Medicaid.*

The COPES program is limited to those who can qualify with low income and assets, in addition to their long term health care needs.

*Next on **pages 68–78**, I've included Columbia Law's 2nd publication, **"Questions and Answers on Medicaid For Nursing Home Residents"**.*

*Included for both programs are the **"2023 Exemptions"** for a patient and their spouse, to enable the patient to qualify financially for any **"Medicaid Benefits"**, to help pay for their Long Term Care.*

IN OTHER WORDS . . . THIS IS ALL YOU'LL GET TO KEEP !

*For nursing home patients, if you are **Single** . . . you'll get to keep **$ 2,000** in total non-exempt assets and in addition, you'll only get **TO KEEP $ 100 MONTHLY** from your Social Security and any other income !*

*You will have to **"Spend Down"** **EVERYTHING ELSE**, if you want Medicaid to pay for your care.*

*If you have a spouse, your spouse has **EXTRA EXEMPTIONS**.*

*Medicaid will not pay a **"Penny of Benefits"** for the spouse who needs care . . . until the **"Couple's Combined Accounts and Assets"** have been **"Spent-Down"** to these limits. (**"Separate Property"** is included.)*

*This allows the **COUPLE**, a total of **$ 68,301**.*

*This may be increased up to **$ 136,602** . . . based on the formula that the Community Spouse can keep **50 %** of their assets, within these limits.*

*However, **MEDICAID ALLOWS** the **"Healthy Spouse"** to keep any **INCOME** that is specifically in his or her name only.*

QUESTIONS AND ANSWERS ON THE COPES PROGRAM

COLUMBIA LEGAL SERVICES — APRIL 2019

THIS PAMPHLET IS ACCURATE AS OF ITS DATE OF REVISION. THE RULES CHANGE FREQUENTLY.

1. What is COPES?

COPES is a Home and Community Based Services (HCBS) waiver program that pays for services for people in community settings. These services help people who would otherwise need to be in nursing homes. "COPES" stands for Community Options Program Entry System.

The services offered through the COPES program are administered by Home and Community Services, a division of the Washington State Department of Social and Health Services (DSHS) and the Health Care Authority (HCA), which determines financial eligibility for services.

Apply for COPES one of two ways: by filing an application online or by submitting a paper application to a local DSHS Home and Community Services (HCS) office.

The website for filing an online application is Washington Connection

https://www.washingtonconnection.org/home/

The website for downloading a paper application [form HCA 18-005, Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage] is

http://www.hca.wa.gov/medicaid/forms/Documents/18-005.pdf.

You may also pick up the application form at a HCS office. A paper application may be returned to PO Box 45826 Olympia WA 98504 or to your local HCS office. To find the right office, call 1-800-422-3263 or use the online tool to find the HCS office in your county https://www.dshs.wa.gov/altsa/resources

2. How is COPES eligibility determined?

To get COPES you must be financially eligible (see Questions 5-7). Also you must need help, because of a physical or cognitive disability, with certain activities of daily living. Those activities are eating, bathing, transfer (e.g., moving from a bed to a chair), bed mobility (positioning), locomotion (walking or moving around), using the toilet and medication management.

To qualify for COPES, you must need extensive help with two or more of the listed activities of daily living, or at least some help with three or more. A person who needs supervision because of a cognitive impairment may qualify for COPES if extensive help with one of the listed activities is needed. Finally, HCS must determine that you need the help described above and that your needs can be met adequately by services available through COPES.

Individuals under age 65 who are not on or eligible for Medicare may be eligible for health care, known as MAGI Medicaid, through the Health Benefit Exchange (http://wahbexchange.org/). MAGI Medicaid includes nursing facility coverage

but does not include COPES coverage. The information and rules in this publication apply to MAGI Medicaid individuals that need COPES services. A disability determination is required for a MAGI individual needing COPES services and the individual must meet the income and resource requirements of the COPES program.

Note: The Washington State Health Care Authority (HCA) uses the term "Apple Health" to refer to all Medicaid and state medical programs, including long-term care programs. MAGI Medicaid refers to Medicaid medical for qualifying individuals under age 65 who are not on or eligible for Medicare. Classic Medicaid, also known as SSI-related Medicaid, is Medicaid medical for qualifying individuals age 65 and over. These are both Apple Health programs.

3. How much does COPES pay?

What COPES will pay for depends on the service(s) you are assessed for in your individualized assessment in CARE. Almost everyone receiving services through COPES will also receive services through the Community First Choice (CFC) program. CFC pays for personal care (and some other services), while COPES may pay for other "wrap-around" services, including home-delivered meals, home health aides, skilled nursing care, adult day care, and training to help you increase what you can do for yourself.

Medicaid may also pay for care in a group facility or home. Payment depends on the type of facility and its location. The amounts Medicaid pays for an adult family home ordinarily ranges from $2,101 to $5,610 per month. For an assisted living facility, the payment ordinarily ranges from $2,011 to $5,676 per month. The actual amount depends on the county and level of care needed. Under rare circumstances, when more intensive care is needed, Medicaid may pay a higher rate. A growing number of adult family homes and assisted living facilities are requiring residents to privately pay for a specified number of months, or years, before allowing a resident to convert to a Medicaid status. It is important to be aware of this practice when looking for a facility.

All COPES recipients get Medicaid coverage for other medical expenses, including physician services, prescription drugs and home health services. In addition, they get case management services—help in planning and monitoring their care.

The Health Care Authority (HCA) also pays the Medicare premiums, co-payments and deductibles for COPES program participants.

4. When does COPES coverage begin?

COPES coverage does not begin until HCS approves a plan that describes your needs and the services that will meet them. The *medical* coverage you get with COPES is effective as of the first day of the month in which your COPES coverage begins.

5. How are income and resources defined for purposes of COPES?

To get COPES services, both your income and your resources must be within set limits. In counting your *income* for a month, DSHS looks at what you *received that month*. Income typically includes such things as Social Security, VA benefits, pension payments and wages, in the month they are received.

In counting your resources for a month, DSHS essentially takes a snapshot of your resources as of the first moment of the first day of the month. Whatever resources exist at that exact moment are the resources counted. Resources typically include such things as

real estate, funds in bank accounts (but not including this month's income) and stocks. Funds from a payment that counted as income last month will count as resources this month if you still have them as of the first of this month. Not all resources count for purposes of determining resource eligibility.

The income and resource standards for Medicaid programs are adjusted yearly and can be found here

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources

6. Am I "income eligible" for COPES?

An applicant is income eligible if the applicant's monthly income is no greater than $7,304 after reducing income by the amounts below.

- Income from certain sources (see WAC 182-513-1340)
- General disregard ($20)
- Earned income disregard (first $65 of earned income and one-half of any additional earned income)
- Health insurance premiums, other than Medicare (prorated monthly over a 12-month certification period); and
- Outstanding allowable medical bills

For married applicants, this applies only to the applicant's income and not to the income of the non-applicant spouse.

If you are income eligible for COPES, you will be allowed to keep a specified amount of income and will be required to use any additional amounts for certain purposes (see Questions 8-9).

7. Am I "resource eligible" for COPES?

The limit for resources (assets, property, and savings) that a single person may have is $2,000. Certain "exempt" resources are not counted in determining whether you fall within this limit. Exempt resources are described in Question 11.

A spouse of a COPES recipient is allowed to keep substantially more resources. What resources a spouse can keep is explained in the answer to Question 10. Rules about the consequences of giving away your resources are described in the answer to Question 12.

Note: A regulation, effective April 16, 2015, considers resources transferred to another individual or entity to pay for your long-term care as available to you, which will usually make you ineligible because you have excess resources. (see Question 12).

8. What *income* can I keep if I go on COPES?

If you are on COPES, you will be allowed to keep a specified amount of income, called a "personal needs allowance." As described in detail below, if you have more than the allowable amount, you must use the rest for certain purposes, such as paying for care services.

If you are on COPES and live at home, you will be allowed to keep the following amount of countable income for your personal needs allowance (which includes home maintenance): if you are single, $1,041 a month; if you are married and your spouse is *not* on COPES, $771 a month; if you are married and your spouse is also on COPES, $1,041 for each spouse ($2,082 total).

If you are on COPES and live in an adult residential care facility, assisted living facility or adult family home, you can keep a personal needs allowance of $70 per month

(or $38.84 for certain residents on the state-funded Aged, Blind, Disabled (ABD) cash program). The next $701 must be paid to the facility for room and board. ($70 + $701= $771.)

The spouse of a COPES recipient may be allowed to keep some of the income of the COPES recipient, as explained in Question 9. This amount is called a "spousal income allowance."

However, a spousal allowance can only be allocated if your spouse is not in a medical institution and meets the income requirements for receiving the allowance, and if you have sufficient income remaining after other allowable deductions. Deductions from income are allowed in a hierarchy. After allowing for the personal needs allowance (including room and board), deductions from income are allowed in the following order:

(1) An amount allowed for an earned income deduction (currently $65), and ½ of your remaining earned income (if you are working);
(2) an amount for guardianship fees and administrative costs;
(3) an amount for current and/or back child support garnished or withheld from the current month's income according to a child support order;
(4) an amount for your spouse, if you have one;
(5) an amount for dependent family members; and
(6) an amount for unpaid allowable medical expenses.

The total amount of the deductions for your personal needs allowance, earned income, and guardianship fees/costs cannot exceed $2,313. The number and amount of deductions actually allowed will depend on the individual's income and the amount of each deduction.

Any remaining income must be used to pay for part of the cost of the services you were approved for. This includes both the cost of COPES and CFC services. The part of the cost you pay is called your "participation." DSHS covers the rest. You are only responsible to pay participation up to the *actual* cost of the care services that are provided.

Example 1
You are approved for long term care services in your own home and your participation is $500. However, your CARE plan only calls for 30 hours of help at $10.00 per hour. In this example, you pay only $300 to your provider, not $500.

Example 2
You are approved for long term care services in an assisted living facility and your participation is $3,000. However, your assisted living facility state rate is $2,635 per month. In this example, you pay only $2,635 to your provider, not $3,000.

If the actual cost of services is lower than your participation amount, you should be careful that the difference does not raise your resources over the $2,000 limit on the first of the following month.

Your COPES eligibility and personal needs allowance usually will not be affected by items or services that are given to you or that you receive because someone else pays for them.

9. What *income* can we keep if my spouse goes on COPES?

If your spouse goes on COPES and you are not on COPES or Medicaid, your spouse is

allowed to keep $771 per month and you are allowed certain additional income.

You (the spouse not on COPES) can always keep all income paid in your name, no matter how much. In addition, if the income paid in your name is less than $2,058 you can keep as much of your spouse's income exceeding the $771 as is necessary to bring your income up to $2,058 per month. And, if your housing costs (rent or mortgage, maintenance fee for a condominium or cooperative, property taxes, homeowner's insurance, and utilities) exceed $618 per month, the $2,058 can be increased up to $3,161 by the amount of this excess. (In calculating housing costs, your actual costs for rent, mortgage, maintenance fee for a condominium or cooperative, taxes, and insurance are used. For utilities, however, a standard figure of $430 per month is used.)

If your COPES-recipient spouse is in an adult family home or other residential facility, then all but $70 of the first $771 of his or her income must be paid to the facility for room and board. If this does not leave the couple with enough income to allow you (at home) the amount you would otherwise get, as described in the last paragraph, there is a special problem. You can ask HCS to make what is called "an exception to rule" to lower the amount of room & board paid to the facility, so that the money can be available to the spouse instead. (There is a dispute about whether denial of such a request would be allowed under federal law. If that problem affects you, you may wish to seek legal advice.)

Whether or not you can receive an allowance from your spouse's income will depend on the amount of your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your income are allowed in a hierarchy order (see Section 8).

Examples

Your spouse is at home and on COPES.

- If $2,400 is paid in your name and $786 is paid in your spouse's name, you can keep $2,400. Your spouse can keep $771 of his or her income and would pay $15 to the COPES provider.

- If $771 is paid in your name and $2,400 is paid in your spouse's name, you can keep your $771 plus you may be able to keep at least $1,287 of your spouse's income ($2,058 - $771= $1,287). And if your housing costs are $800 per month, you can keep an **additional** $182 of your spouse's income because the $2,058 level is increased by the excess of your housing costs over $618 ($800 - $618 = $182). Whether or not you can receive an allowance from your spouse's income will depend on the amount of your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your spouse's income are allowed in a hierarchy order (see Section 8).

A spouse of a COPES recipient may be allowed to keep more of a COPES recipient's income if a superior court judge orders higher support (for example, in a legal separation proceeding) or if an administrative law judge decides that there are "exceptional circumstances resulting in extreme financial duress."

A COPES recipient may also be entitled to an additional allowance for the care of a dependent family member.

10. What *resources* can we have when my spouse applies for COPES?

When your spouse applies for COPES, the two of you can have any resources that are "exempt" – a home and a car, for example. Exempt resources are explained in the answer to Question 11.

You can also have non-exempt resources up to a certain value. (Non-exempt resources include such things as cash, most funds in bank accounts, and investments.) The limit includes the $2,000 that a single COPES recipient is permitted to have plus an amount established by the "Community Spouse Resource Allowance" or "CSRA."

The CSRA is $55,547. When your spouse applies for COPES, you and your spouse can have $57,547 of non-exempt resources ($55,547 allowed for you and $2,000 allowed for your spouse) and possibly more. At the time of application, it does not matter which spouse owns what or whether the $57,547 or any part of it is community or separate property. All resources of both spouses will be added together to determine eligibility.

Sometimes the CSRA can be more than $55,547. It can be more if one of the following exceptions applies:
(1) If your spouse is currently institutionalized (in a hospital or nursing home), and you can show that the combined resources of both spouses were more than $111,094 when their current period of institutionalization began, then you may be entitled to a CSRA of more than $55,547. If this applies, the CRSA is increased to half of the combined resources that the couple had at the time the period of institutionalization began. The maximum amount that the CSRA can be increased to is $126,420.

(2) You *may* be allowed to keep more non-exempt resources if the combined *income* of both spouses is not enough to give you what is allowed by the rules explained in the answer to Question 9 above ($2,058 to $3,161). To do this, a spouse who is not on COPES must request a decision from HCS, at the time of application, that more resources are necessary to produce the permitted income level.

(3) If your spouse is currently institutionalized (in a hospital or nursing home) and the current period of institutionalization began before August 1, 2003, then your CSRA is $126,420.

You can reduce excess resources that make your spouse ineligible for COPES in various ways. You can spend the excess resources on such things as medical care, on home repair, on the purchase of exempt resources, or on consumable goods or services, so long as you receive fair value for your money. Or you can buy an annuity that converts the excess resources to monthly income, *if the annuity satisfies the requirements of Health Care Authority (HCA) regulations.* To determine whether a particular annuity satisfies HCA requirements and whether a particular financial plan makes sense in your particular case, you should consult a lawyer familiar with Medicaid law.

The explanation above responds to the question "What resources can I have when my spous*e applies* for COPES?" An entirely different rule applies once your spouse is *already on* COPES. After an application is approved, continuing eligibility of the spouse on COPES will not be affected by increases in the resources of the spouse who is not on COPES. In other words, if one spouse is already on COPES, the other spouse's resources can increase above the limit that applied at the time of the eligibility determination. The increase will not affect the COPES eligibility of the spouse on COPES.

At the time of application, it does not matter which spouse owns resources. But, within a year after a COPES application is approved, anything over $2,000 must be transferred to the non-COPES spouse. Then, the spouse on COPES must not have more than $2,000 worth of non-exempt resources in his or her name.

11. What resources are not counted to determine COPES eligibility?

A. What are exempt resources?

Some resources are considered exempt and are not counted toward the $2,000 and $55,547 to $126,420 resource limits that were discussed in the previous section. Exempt resources can include your home, household goods and personal effects, some real estate sales contracts, a car, life insurance with a face value of $1,500 or less, most burial plots and prepaid burial plans, and certain other property and items used for self-support. Some of these are discussed in more detail below.

Also, *non-exempt* resources that cannot be sold within 20 working days are temporarily disregarded while being sold.

B. When is a home exempt?

A home (which may be a house and surrounding land, a condominium or a mobile home) may be an exempt resource. The exemption applies if the COPES recipient lives in the home, or is temporarily absent but intends to return to it. It also applies as long as the recipient's spouse or, in some cases, a dependent relative continues to live in the home.

The exemption does not apply to a home in which the COPES recipient has an equity interest of more than $585,000 unless one of the following exceptions applies: (1) the recipient is receiving services based on an application for Medicaid long-term care services filed before May 1, 2006; or (2) the recipient's spouse or the recipient's child who is under 21 or blind or disabled resides in the home. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

Even when a home is exempt, a married Medicaid applicant or recipient still may wish to transfer his or her interest in it to a spouse. Such a transfer may be made to prevent future recovery of Medicaid costs from a Medicaid recipient's estate (see Question 13), or to make it easier for the spouse to sell or otherwise dispose of the home. But, such a transfer is not always a good idea. It may, for example, have adverse tax or other consequences in some cases. Before making such a transfer, you should consult with a lawyer familiar with Medicaid rules and estate planning.

The proceeds from the sale of an exempt home are also exempt if, within three months of when they are received, they are used to purchase a new exempt home.

C. When is a sales contract exempt?

The seller's interest in any sales contract entered into before December 1, 1993 is an exempt resource unless it is transferred. A sales contract entered into after November 30, 1993 is exempt only if it is a contract for the sale of the seller's home and includes fair market terms. A sales contract entered into after May 2004 is exempt only if it is for the sale of the seller's principal residence at the time he or she began a period in a medical facility (including a nursing home) or on COPES and if it requires repayment of the principal within the seller's "anticipated life expectancy." The *payments* received under an exempt sales contract will be treated as *income*.

D. When is a car exempt?

One car is exempt, no matter how much it is worth, if it is used for transportation for the COPES recipient or for a member of the recipient's household.

E. When is life insurance exempt?

The cash surrender value of life insurance may be claimed as exempt if the total *face* value (amount payable at death) is not more than $1,500. For couples, each spouse may claim $1,500. If the face value of an individual's life insurance is more than $1,500, the entire *cash surrender* value (the amount payable if the policy is canceled) is counted as a non-exempt resource. (It will count as part of the $2,000 or $55,547 to $126,420 resource limits discussed in the previous section.) Life insurance with no cash surrender value has no effect on COPES eligibility.

F. When are burial funds and burial spaces exempt?

A burial fund of $1,500 for an individual (and an additional $1,500 for a spouse) may be claimed as exempt if set aside in a clearly designated account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a COPES recipient has exempt life insurance with a face value of $1,000, then only $500 may be exempted in a designated account for burial expenses.

An *irrevocable trust* for burial expenses or a *pre-paid burial plan* may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan will count against the exemption for burial funds or life insurance.

Burial spaces for COPES recipients and immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

Household furniture and other household goods, as well as clothing, jewelry and personal care items are exempt regardless of value.

H. When is an entrance fee paid to a continuing care retirement community or life care community exempt?

An entrance fee paid by a long term care Medicaid applicant to a continuing care retirement community or life care community is still considered a resource available to the applicant to the extent that: (1) the applicant has the right to use the fee (including using it to pay for care); (2) the contract allows for the refund of any remaining entrance fee on death or termination of the contract and leaving the community; and (3) the fee does not convey an ownership interest in the community.

I. When is the dollar value of insurance proceeds paid out under a long-term care policy considered exempt?

The dollar value of insurance proceeds paid out for long-term care expenses, under a Long-Term Care Partnership insurance policy, will be deemed exempt at the time of Medicaid application and will not be subject to Medicaid estate recovery at death (the exemption applies only to the value of insurance proceeds paid out under a qualified Long-Term Care Partnership insurance policy).

12. Can I transfer resources without affecting COPES eligibility?

A. Rules for transfers of a home

A *home* may be transferred without penalty to any of the individuals described below. (The

person making the transfer does not need to live in the home at the time of the transfer.)

- A *spouse*
- A *brother* or *sister* who has an equity interest in the home and has lived there at least one year immediately before the date when their sibling's COPES coverage or institutionalization began.
- A *child* who has lived in the home and cared for the parent for two years immediately before the date of the parent's current COPES coverage or institutionalization. (If this requirement is met, it does not matter *when* the property is transferred to the child.) The care must have enabled the parent to remain in the home and it must be verifiable, and it must not have been paid for by Medicaid. A physician's statement of needed care is required.
- A *child* who is under 21, or blind or disabled. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

B. Rules for other transfers to a spouse or disabled child

There is no penalty for transferring resources to a spouse or a disabled child. (Again, the disability criteria are the same as those used for Social Security disability determinations.)

Remember that the resources of both spouses are added together in determining initial COPES eligibility. So, if a couple has more resources than are permitted at the time of application, a transfer from one spouse to the other will not solve that problem.

A transfer to a spouse or to a disabled child may be made without penalty either before or after an individual qualifies for COPES or Medicaid.

C. Rules for other transfers to someone other than a spouse or disabled child

(1) Transfers without penalty

(a) There is no penalty if you sell your resources for their fair market value.

(b) *Exempt* resources (see Question 11), *other than the home or a sales contract*, may be given to anyone without penalty.

(c) There is no penalty for gifts made after April 2006 as long as the total amount in any calendar month is $323 or less. (Different rules apply if you made gifts before May 2006 *and* you applied for COPES or Medicaid for nursing home care before May 2009.)

(d) There is no penalty for gifts of any value made more than 60 months before applying for COPES or Medicaid for nursing homes.

(e) No matter when a transfer is made, there is no penalty if you can demonstrate that the transfer was not made to qualify for COPES or Medicaid for nursing home care, or made to avoid estate recovery.

(2) Transfers resulting in penalties

There may be a penalty if you transfer *non-exempt* resources, or sales contracts, or a home (except to one of the people listed above), for less than fair market value within 60 months of applying for Medicaid. The penalty is a period of ineligibility for COPES or Medicaid for long-term care services. The length of ineligibility depends on the value and timing of the transfer. There is no maximum length for a period of ineligibility.

(3) Calculating periods of ineligibility

The process of calculating periods of ineligibility is slightly complicated. After reading the following explanation, if you are left with questions about the effects of gifts

you have made or are considering, you should talk with a lawyer who knows Medicaid rules.

Note: The explanations below apply to COPES applications made between October 1, 2018 and September 30, 2019. (The numbers change each October.)

To determine the period of ineligibility, take the total of all gifts made within 60 months before applying and divide the total by 323. The number of days of ineligibility is the result of this division. This divisor of 323 is the daily statewide average of private nursing facility rates (currently $323).

The period of ineligibility does not begin to run until an applicant for Medicaid-funded long-term care services is eligible in all other respects except for the period of ineligibility. This means that the applicant must satisfy the income and resource eligibility requirements and must meet the level-of-care requirements for COPES or Medicaid for nursing home care. Also, in order to start running the period of ineligibility, the Department requires that an individual make an application—in effect, seeking a determination by the Department that he or she is "otherwise eligible."

Example:

If you made gifts totaling $20,000 between October 2018 and January 2019 and entered a nursing home and applied for Medicaid in September 2019, you would calculate the period of ineligibility by dividing 20,000 by 323 to produce 62 days of ineligibility resulting from those gifts. (20,000 ÷ 323 = 61.9195, which rounds up to 62). The period of ineligibility would begin on September 1, 2019, assuming that you were otherwise eligible for Medicaid on that day.

If the gift is made when an individual is already receiving COPES coverage, then the period of ineligibility normally begins on the first day of the month following a notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery by the agency of the transfer. There is one exception to this norm. The penalty period will begin later if another penalty period is already in progress. In that case the new penalty period starts after the current one is completed.

Generally, before you apply for COPES or Medicaid for nursing home care, the same restrictions apply to transfers by you or your spouse. If you or your spouse gives away resources, either gift may result in a period of ineligibility for you. Once you are receiving COPES or Medicaid for nursing-home care, however, gifts made by your spouse will not affect your continuing eligibility.

(4) Transfers Affecting Resource Eligibility

A regulation, effective April 16, 2015, provides that the transfer of cash and other resources by an applicant or current recipient of long-term care services (or his or her spouse) to another person or entity to pay for the applicant's or recipient's long-term care services are considered resources available to the applicant or recipient, unless otherwise excluded. This will usually make you ineligible because you have excess resources. In that situation, the period of ineligibility will not begin to run.

(5) **Eligibility for Community First Choice**

If you are ineligible for COPES services due to a transfer of resources, you may still be eligible to receive personal care services through a program called Community First Choice (CFC), if you meet the income and resource standards for that program. See the pamphlet entitled *Questions and Answers on Community First Choice Program*, which is

available on the website www.washingtonlawhelp.org.

(6) Waiver of periods of ineligibility

Home and Community Services may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. A hardship waiver may be granted in cases where there has been denial or termination of benefits based on transfer of assets or excess home equity. Such a waiver may lead to imposition of a civil fine on the recipient of a gift if the recipient "was aware, or should have been aware," that the gift was made for the purpose of qualifying for Medicaid.

A hardship waiver may be granted for transfers between couples who are married or for transfers between registered domestic partners.

13. Will COPES payments result in a lien or claim against my estate?

DSHS may be entitled to recover, from a Medicaid client's estate, the amount the State of Washington paid for the client's care. Whether or not Medicaid is entitled to recover depends on the type of services the client received and the dates when the services were provided to the client. See the Columbia Legal Services publication entitled Estate Recovery for Medical Services Paid for by the State, which is available on the website www.washingtonlawhelp.org.

Recovery will be delayed if, at the time of death, the COPES recipient has a surviving spouse, registered domestic partner, or surviving child who is under 21 or blind or disabled.

The DSHS estate-recovery claim only applies to property owned at death by a COPES recipient. *No claim can be made against property solely owned by a spouse or child.* This may be an important reason to consult a lawyer familiar with COPES and Medicaid rules about permissible transfers of property.

14. Can I get help with the application process?

Many people need help applying for COPES or Medicaid. Often there are family members or friends, or staff members of a hospital or nursing home or other agency, who are able to help. Help is also available from HCS staff, especially for people who have physical or mental impairments that make it hard to get through the application process on their own.

If you need help in the application process from HCS, you or someone else should tell the HCS representative that you need help. DSHS rules require what are called "necessary supplemental accommodation services" when they are needed. These services include help filling out forms and help finding information or papers needed for your application.

COPES rules are complicated. Before taking steps you don't understand, you should get individualized legal advice.

COPES 04-2019

COLUMBIA LEGAL SERVICES
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QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

COLUMBIA LEGAL SERVICES APRIL 2019

THIS PAMPHLET IS ACCURATE AS OF ITS DATE OF REVISION. THE RULES CHANGE FREQUENTLY.

1. What is Medicaid?

Medicaid is a government program that pays for medical services including nursing home care. It is administered by Health Care Authority (HCA). The Washington State Department of Social and Health Services (DSHS) is the designee of HCA in administering the nursing facility program.

To get Medicaid payment for nursing home care, you must be financially eligible. The financial eligibility requirements are described below. Also, you must need the kind of care provided in a nursing home.

Apply for **Long Term Care Medicaid** for nursing home residents one of two ways: by filing an application online; or by submitting a paper application to a local DSHS Home and Community Services (HCS) office. The website for filing an on-line application is Washington Connection https://www.washingtonconnection.org/home/

The website for downloading a paper application [form HCA 18-005 (3/14) *Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage*] is http://www.hca.wa.gov/medicaid/forms/Documents/18-005.pdf. You may also pick up the application form at a DSHS office.

A paper application may be returned to PO Box 45826 Olympia WA 98504 or to your local Home and Community Service (HCS) office. To find the right HCS office, call 1-800-422-3263 or use the online tool to find the HCS office in your county https://www.dshs.wa.gov/altsa/resources.

Individuals under age 65 who are not on or eligible for Medicare may be eligible for health care, known as MAGI Medicaid, through the Health Benefit Exchange (http://wahbexchange.org/). MAGI Medicaid *includes* nursing facility coverage. The information in this publication addressing income, resources, and participation in cost of care does not apply to MAGI Medicaid clients requiring nursing facility care. However, the information addressing home equity limitations, transfer of assets, and estate recovery does apply to MAGI clients.

Note: The Washington State Health Care Authority (HCA) uses the term "Apple Health" to refer to all Medicaid and state medical programs, including long-term care programs. MAGI Medicaid (Medicaid medical for qualifying individuals under age 65 who are not on or eligible for Medicare) and Classic Medicaid (Medicaid medical for qualifying individuals age 65 and over) are both Apple Health programs.

2. What are Medicaid's basic financial eligibility requirements for nursing home care?

To get Medicaid for nursing home care, both your *income* and your *resources* must be within limits set by law.

In counting your *income* for a month, DSHS looks at what you *received that month.* Income typically includes such things as Social Security, VA benefits, pension payments and wages, in the month in which they are received.

In counting your resources for a month, DSHS essentially takes a snapshot of your resources as of the first moment of the first day of the month. Whatever resources exist at that exact moment are the resources counted. Resources typically include such things as real estate, funds in bank accounts (but not including this month's income) and stocks. Funds from a payment that counted as income last month will count as resources this month if you still have them as of the first of this month. Not all resources count for purposes of determining resource eligibility.

A. Income

Your monthly income must be less than the following total: the Medicaid rate for nursing home care plus your regular monthly medical expenses. The Medicaid rate – the rate charged for Medicaid residents – is different for different nursing homes. You can find out the rate for a particular nursing home by asking at the home or by calling DSHS at 1-800-422-3263.

Example:

Seaside Nursing Home Medicaid rate	*$6,000.00*
Your regular monthly pharmacy bill	*$275.00*
Total	*$6,275.00*

If your monthly income is less than $6,275, your income is within the Medicaid eligibility limit for care at Seaside Nursing Home.

If your income is more than the Medicaid nursing home rate plus your regular medical expenses, but less than the rate charged for non-Medicaid residents plus your regular allowable medical expenses, you may still be eligible for assistance. If you apply and are eligible on this basis, the nursing home will charge you only the lower Medicaid rate.

Once you are determined eligible for Medicaid nursing home coverage, you will be allowed to keep $70 per month for your personal needs. The rest of your income will be used as follows:

(1) an amount for mandatory income taxes owed;
(2) an amount for wages from an approved training or rehabilitative program;
(3) an amount for guardianship fees and administrative costs;
(4) an amount for current and / or back child support garnished or withheld from the current month's income according to a child support order;
(5) an amount for your spouse if you have one, as explained in the answer to Question 3 below;
(6) an amount for certain dependent family members;
(7) an amount for unpaid allowable medical expenses including health insurance premiums and medical bills for services not covered by Medicaid that were incurred up to three months before the month of filing an application; bills must be still owed and not covered by any insurance (long term care expenses for nursing facility care are reduced to the state rate for the facility that provided care); and

(8) an amount for a single person or an institutionalized couple only, an amount (not more than $1,041) for the maintenance of a home for up to 6 months, but only if a physician has certified that the person or a member of the couple is likely to return to the home within the 6-month period (even without any physician's certification, if there is rental income from a home to which a Medicaid recipient or spouse intends to return, that income may be used for payment of home maintenance, taxes and insurance).

The list shown above is a hierarchy list. Deductions are allowed, in order, according to the list.

The total amount of the deductions for your PNA, income taxes owed, wages from an approved program, and guardianship fees/administrative costs cannot exceed $771. The number and amount of deductions actually allowed will depend on the individual's income and the amount of each deduction.

Any remaining income must be paid to the nursing home for your care. The part of the cost of your care you pay for is called your "participation." Medicaid covers the rest.

B. Resources

The limit for resources (assets, property, savings) that a single person may have is $2,000. Certain "exempt" resources are not counted in determining whether you fall within this limit. Exempt resources are described in the answer to Question 5 below. When a married person applies for Medicaid for nursing home care, his or her spouse is allowed to have substantially more resources. The rules relating to resources for married applicants and their spouses are explained in the answer to Question 4. Rules about the consequences of giving away your resources are described in the answer to Question 6.

Note: A regulation, effective April 16, 2015, provides that resources transferred to another individual or entity to pay for your long-term care is still considered "available" to you. This will usually make you ineligible because you have excess resources. (See Question 6).

3. What *income* can I keep if my spouse goes into a nursing home?

If your spouse goes into a nursing home and you remain at home, Medicaid always allows you to keep all income paid in your name, no matter how much.

In addition, if the income paid in your name is less than $2,058, you may be allowed to keep as much of your spouse's income as is necessary to bring your income up to $2,058 per month. And, if your housing costs (rent or mortgage, taxes, insurance, maintenance fee for a condominium or cooperative, and utilities) exceed $618 per month, then the $2,058 can be increased up to $3,161 by the amount of this excess. In calculating housing costs, your actual costs for rent, mortgage, maintenance fee, taxes, and insurance are used. For utilities, however, a standard figure of $430 per month is used.

Whether or not you can receive an allowance from your spouse's income will depend on the amount of your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your income are allowed in a hierarchy order (see Section 2.A.).

Examples:

If $2,400 is paid in your name and $771 is paid in your spouse's name, you can keep $2,400.

If $771 is paid in your name and $2,400 is paid in your spouse's name, you can keep your $771 plus at least $1,287 of your spouse's income ($2,058 - $771 = $1,287). And if your housing costs are $800 per month, you can keep an ***additional*** *$182 of your spouse's income because the $ 2,058 level is increased by the excess of your housing costs over $ 618 ($800 - $ 618 = $182).*

A spouse at home may be allowed to keep more of an institutionalized spouse's income if a superior court judge orders higher support (for example, in a legal separation proceeding) or if an administrative law judge decides, in an administrative proceeding, that there are "exceptional circumstances resulting in extreme financial duress."

An additional amount may also be allowed for the care of a dependent family member.

4. What *resources* can we have when my spouse applies for Medicaid?

A. When Your Spouse Applies for Medicaid

The amount of resources you can have when your spouse *applies* for Medicaid for nursing home care is different from the amount you can have once your spouse *is receiving* Medicaid. When your spouse applies, at the time of application all resources of both spouses will be added together to determine eligibility. It does not matter which spouse owns what resource or whether resources are community or separate property.

When your spouse applies for Medicaid for nursing home care, the two of you can have all of the resources that are "exempt"– a home and a car, for example. Exempt resources are explained in the answer to Question 5 below.

In addition, you are allowed to have non-exempt resources up to a set value limit. (Non-exempt resources include such things as cash, most funds in bank accounts and investments.) The limit includes the $2,000 that a single Medicaid applicant has plus an additional amount established by what is called the "Community Spouse Resource Allowance" or "CSRA." (Non-exempt resources include such things as cash, most funds in bank accounts and investments.)

The CSRA is at least $55,547. This means that if your spouse goes on Medicaid, you and your spouse can have at least $57,547 of non-exempt resources ($55,547 allowed for you and $2,000 allowed for your spouse). Remember, at the time of application, it does not matter which spouse owns what resource or whether the $57,547 or any part of it is community or separate property.

Sometimes the Community Spouse Resource Allowance can be more than $55,547. It can be more if one of the following exceptions applies:

(1) If your spouse is currently institutionalized (in a hospital or nursing home), and you can show that the combined resources of both spouses were more than $111,094 when the current period of institutionalization began, then you may be entitled to a CSRA of more than $55,547. If this exception applies, the CSRA is increased to half of the combined resources that the couple had at the time the period of institutionalization began. The maximum amount that the CSRA can be increased to is $126,420. To take advantage of this exception, you will have to be able to show what the combined resources were when the period of institutionalization began.

(2) You *may* be allowed to keep more non-exempt resources if the combined *income* of both spouses is not enough to provide what is allowed by the rules explained in Question 3 above ($2,058 to $3,161). To keep more

resources, a spouse not on Medicaid must request a decision from DSHS at the time of application that more resources are necessary to produce the permitted income level.

(3) If your spouse is currently institutionalized (in a hospital or nursing home) and the current period of institutionalization began before August 1, 2003, then your CSRA is $126,420.

You can reduce excess resources that make your spouse ineligible for Medicaid for nursing home care in various ways. You can spend the excess resources on such things as medical care, on home repair, on the purchase of exempt resources, or on consumable goods or services, so long as you receive fair value for your money. Or you can buy an annuity that converts the excess resources to monthly income, *if the annuity satisfies the requirements of DSHS regulations.* To determine whether a particular annuity satisfies the requirements and whether a particular financial plan makes sense for you, you should consult a lawyer familiar with Medicaid law.

B. When your spouse is on Medicaid

Although it does not matter which spouse owns the resources at the time of application, an entirely different rule applies once the application is approved.

Within a year after the application is approved, any of the couple's resources in excess of $2,000 must be transferred to the spouse who is not on Medicaid. After that, the spouse on Medicaid cannot have more than $2,000 in non-exempt resources in his or her name.

The spouse who is not on Medicaid can keep the resources transferred into his or her name and can increase resources without affecting the continuing eligibility of the spouse on Medicaid.

5. What resources are not counted to determine Medicaid eligibility?

A. What are exempt resources?

Some resources are considered exempt and are not counted toward the $2,000 and $55,547 to $126,420 resource limits that were discussed in the previous section. Exempt resources can include your home, household goods and personal effects, some real estate sales contracts, a car, life insurance with a face value of $1,500 or less, most burial plots and prepaid burial plans, and certain other property and items used for self-support. Some of these are discussed in more detail below.

Also, *non-exempt* resources that cannot be sold within 20 working days are temporarily disregarded while they are being sold.

B. When is a home exempt?

A home (which may be a house and surrounding land, a condominium or a mobile home) may be an exempt resource. The exemption applies as long as the recipient's spouse or, in some cases, a dependent relative continues to live in the home. The exemption also applies if a nursing home resident *intends* to return to the home and states that intention to DSHS. It applies even if it seems unlikely that the resident will be able to return.

The exemption does not apply to a home in which the Medicaid recipient has an equity interest of more than $585,000 unless one of the following exceptions applies: (1) the Medicaid recipient is receiving services based on an application for DSHS long-term-care services filed before May 1, 2006; or (2) the Medicaid recipient's spouse or the recipient's child who is under 21 or blind or disabled resides in the home. (The disability criteria

for this purpose are the same as those used for Social Security disability determinations.) Even when a home is exempt, a married Medicaid applicant or recipient still may wish to transfer his or her interest in it to a spouse. Such a transfer may be made in order to prevent future recovery of Medicaid costs from a Medicaid recipient's estate (discussed in the answer to Question 7 below), or in order to make it easier for the spouse to sell or otherwise dispose of the home. On the other hand, such a transfer is not always a good idea. For example, it may have adverse tax or other consequences in some cases. It makes sense to consult with a lawyer familiar with Medicaid rules and estate planning before making such a transfer.

The proceeds from the sale of an exempt home are also exempt if they are used to purchase a new exempt home within three months of receipt.

C. When is a sales contract exempt?

The seller's interest in any sales contract entered into before December 1, 1993 is an exempt resource unless it is transferred. A sales contract entered into after November 30, 1993 is exempt only if it was received for the sale of the seller's home and includes fair market terms. A sales contract entered into after May 2004 is exempt only if it is for the sale of the seller's principal residence at the time he or she began a period in a medical facility (including a nursing home) or on COPES and if it requires repayment of the principal within the seller's "anticipated life expectancy." *Payments* received under an exempt sales contract are treated as *income*.

D. When is a car exempt?

One car is exempt, no matter how much it is worth, if it is used for transportation either for the Medicaid recipient or a member of the recipient's household.

E. When is life insurance exempt?

The cash surrender value of life insurance is exempt if the total *face* value (amount payable at death) is not more than $1,500. For couples, each spouse may claim $1,500. If the face value of an individual's life insurance is more than $1,500, the entire *cash surrender value* (the amount payable if the policy is canceled) is counted as a non-exempt resource. (It will count as part of the $2,000 or $55,547 to $126,420 resource limits discussed in the previous section.) Life insurance with no cash surrender value has no effect on Medicaid eligibility.

F. When are burial funds and burial spaces exempt?

A *burial fund* of $1,500 for an individual (and an additional $1,500 for a spouse) may be claimed as exempt if it is set aside in a clearly designated account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a Medicaid recipient has exempt life insurance with a face value of $1,000, then only $500 more may be exempted in a designated account for burial expenses.

An *irrevocable trust* for burial expenses or a *pre-paid burial plan* may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan will count against the exemption for burial funds or life insurance. *Burial spaces* for Medicaid recipients and immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

Household furniture and other household goods, as well as clothing, jewelry, and

personal care items are exempt regardless of value.

H. When is an entrance fee paid to a continuing care retirement community or life care community exempt?

An entrance fee paid by a long term care Medicaid applicant to a continuing care retirement community or life care community is still considered a resource available to the applicant to the extent that: (1) the applicant has the right to use the fee (including it using to pay for care); (2) the contract allows for the refund of any remaining entrance fee on death or termination of the contract and leaving the community; and (3) the fee does not convey an ownership interest in the community.

I. When is the dollar value of insurance proceeds paid out under a long-term care policy considered exempt?

The dollar value of insurance proceeds paid out for long-term care expenses, under a Long-Term Care Partnership insurance policy, will be deemed exempt at the time of Medicaid application and will not be subject to Medicaid estate recovery at death (the exemption applies only to the value of insurance proceeds paid out under a qualified Long-Term Care Partnership insurance policy).

6. Can I transfer resources without affecting Medicaid eligibility?

A. Rules for transfers of a home

A *home* may be transferred without penalty to any of the individuals described below.

- A *spouse*.
- A *brother* or *sister* who has an equity interest in the home and has lived there at least one year immediately before the date when their sibling's COPES coverage or institutionalization began.
- A *child* who has lived in the home and cared for the parent for two years immediately before the date of the parent's current COPES coverage or institutionalization (If this requirement is met, it does not matter *when* the property is transferred to the child.) The care must have enabled the parent to remain in the home, it must be verifiable, and it must not have been paid for by Medicaid. A physician's statement of needed care is required.
- A *child* who is under 21, blind, or disabled (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

The person making the transfer does not need to live in the home at the time of the transfer to one of the people listed above.

B. Rules for other transfers to a spouse or disabled child

There is no Medicaid penalty for transferring resources to your spouse or to your disabled child. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.) Remember that the resources of both spouses are added together in determining initial Medicaid eligibility. (See the answer to Question 4 above.) So, if a couple has more resources than are permitted at the time of the application, a transfer from one spouse to the other will not solve that problem.

A transfer to a spouse or disabled child may be made without penalty either before or after an individual qualifies for Medicaid.

C. Rules for other transfers to someone other than a spouse or disabled child

(1) Transfers without penalty

D. When is a car exempt?

One car is exempt, no matter how much it is worth, if it is used for transportation for the COPES recipient or for a member of the recipient's household.

E. When is life insurance exempt?

The cash surrender value of life insurance may be claimed as exempt if the total *face* value (amount payable at death) is not more than $1,500. For couples, each spouse may claim $1,500. If the face value of an individual's life insurance is more than $1,500, the entire *cash surrender* value (the amount payable if the policy is canceled) is counted as a non-exempt resource. (It will count as part of the $2,000 or $55,547 to $126,420 resource limits discussed in the previous section.) Life insurance with no cash surrender value has no effect on COPES eligibility.

F. When are burial funds and burial spaces exempt?

A burial fund of $1,500 for an individual (and an additional $1,500 for a spouse) may be claimed as exempt if set aside in a clearly designated account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a COPES recipient has exempt life insurance with a face value of $1,000, then only $500 may be exempted in a designated account for burial expenses.

An *irrevocable trust* for burial expenses or a *pre-paid burial plan* may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan will count against the exemption for burial funds or life insurance.

Burial spaces for COPES recipients and immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

Household furniture and other household goods, as well as clothing, jewelry and personal care items are exempt regardless of value.

H. When is an entrance fee paid to a continuing care retirement community or life care community exempt?

An entrance fee paid by a long term care Medicaid applicant to a continuing care retirement community or life care community is still considered a resource available to the applicant to the extent that: (1) the applicant has the right to use the fee (including using it to pay for care); (2) the contract allows for the refund of any remaining entrance fee on death or termination of the contract and leaving the community; and (3) the fee does not convey an ownership interest in the community.

I. When is the dollar value of insurance proceeds paid out under a long-term care policy considered exempt?

The dollar value of insurance proceeds paid out for long-term care expenses, under a Long-Term Care Partnership insurance policy, will be deemed exempt at the time of Medicaid application and will not be subject to Medicaid estate recovery at death (the exemption applies only to the value of insurance proceeds paid out under a qualified Long-Term Care Partnership insurance policy).

12. Can I transfer resources without affecting COPES eligibility?

A. Rules for transfers of a home

A *home* may be transferred without penalty to any of the individuals described below. (The

September 2019, you would calculate the period of ineligibility by dividing 20,000 by 323 to produce 62 days of ineligibility resulting from those gifts. (20,000 ÷ 323 = 61.9195, which rounds up to 62). The period of ineligibility would begin on September 1, 2019, assuming that you are otherwise eligible for Medicaid on that day.

Generally, before you apply for Medicaid for nursing home care, the same restrictions apply to transfers by either you or your spouse. This means that if you or your spouse gives away resources either gift may result in a period of ineligibility for you. Once you are receiving Medicaid, however, subsequent gifts made by your spouse will not affect your continuing eligibility.

(4) Transfers Affecting Resource Eligibility

A new regulation, effective April 16, 2015, provides that the transfer of cash and other resources by an applicant or current recipient of long-term care services (or his or her spouse) to another person or entity to pay for the applicant's or recipient's long-term care services are considered resources available to the applicant or recipient, unless otherwise excluded. This will usually make you ineligible because you have excess resources. In that situation, the period of ineligibility because of a gift will not begin to run.

(5) Waiver of periods of ineligibility

DSHS may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. A waiver may be granted in cases where there has been denial or termination of benefits based on transfer of assets or excess home equity. Such a waiver may lead to imposition of a civil fine on the recipient of a gift that was made for the purpose of qualifying for Medicaid if the recipient of the gift "was aware, or should have been aware," of the purpose.

A hardship waiver may be granted for transfers between same-sex couples who are married or for transfers between registered domestic partners.

7. Will DSHS have a lien or claim against my estate?

DSHS may be entitled to recover, from a Medicaid client's estate, the amount the State of Washington paid for the client's care. Whether or not Medicaid is entitled to recover depends on the type of services the client received and the dates when the services were provided to the client. See the Columbia Legal Services publication entitled Estate Recovery for Medical Services Paid for by the State, which is available online at http://www.washingtonlawhelp.org Recovery will be delayed if, at the time of death, a Medicaid recipient has a surviving spouse or registered domestic partner or a surviving child who is under 21 or blind or disabled.

The DSHS estate-recovery claim only applies to property owned at death by a Medicaid recipient. *No claim can be made against property solely owned by a spouse or child.* This may be an important reason to consult a lawyer familiar with Medicaid rules about permissible transfers of property. Note regarding TEFRA (pre-death) liens: Effective July 1, 2005 the state may file a pre-death lien on property owned by clients residing in a long-term care facility who are "permanently" institutionalized, with no potential for discharge. However, MAGI clients are excluded from TEFRA (pre-death) liens because they do not pay towards the cost of their care.

8. What if I need help with the Medicaid application process?

Many people need help applying for Medicaid. Often there are family members or

you have made or are considering, you should talk with a lawyer who knows Medicaid rules.

Note: The explanations below apply to COPES applications made between October 1, 2018 and September 30, 2019. (The numbers change each October.)

To determine the period of ineligibility, take the total of all gifts made within 60 months before applying and divide the total by 323. The number of days of ineligibility is the result of this division. This divisor of 323 is the daily statewide average of private nursing facility rates (currently $323).

The period of ineligibility does not begin to run until an applicant for Medicaid-funded long-term care services is eligible in all other respects except for the period of ineligibility. This means that the applicant must satisfy the income and resource eligibility requirements and must meet the level-of-care requirements for COPES or Medicaid for nursing home care. Also, in order to start running the period of ineligibility, the Department requires that an individual make an application—in effect, seeking a determination by the Department that he or she is "otherwise eligible."

Example:

If you made gifts totaling $20,000 between October 2018 and January 2019 and entered a nursing home and applied for Medicaid in September 2019, you would calculate the period of ineligibility by dividing 20,000 by 323 to produce 62 days of ineligibility resulting from those gifts. (20,000 ÷ 323 = 61.9195, which rounds up to 62). The period of ineligibility would begin on September 1, 2019, assuming that you were otherwise eligible for Medicaid on that day.

If the gift is made when an individual is already receiving COPES coverage, then the period of ineligibility normally begins on the first day of the month following a notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery by the agency of the transfer. There is one exception to this norm. The penalty period will begin later if another penalty period is already in progress. In that case the new penalty period starts after the current one is completed.

Generally, before you apply for COPES or Medicaid for nursing home care, the same restrictions apply to transfers by you or your spouse. If you or your spouse gives away resources, either gift may result in a period of ineligibility for you. Once you are receiving COPES or Medicaid for nursing-home care, however, gifts made by your spouse will not affect your continuing eligibility.

(4) Transfers Affecting Resource Eligibility

A regulation, effective April 16, 2015, provides that the transfer of cash and other resources by an applicant or current recipient of long-term care services (or his or her spouse) to another person or entity to pay for the applicant's or recipient's long-term care services are considered resources available to the applicant or recipient, unless otherwise excluded. This will usually make you ineligible because you have excess resources. In that situation, the period of ineligibility will not begin to run.

(5) Eligibility for Community First Choice

If you are ineligible for COPES services due to a transfer of resources, you may still be eligible to receive personal care services through a program called Community First Choice (CFC), if you meet the income and resource standards for that program. See the pamphlet entitled *Questions and Answers on Community First Choice Program*, which is

available on the website www.washingtonlawhelp.org.

(6) Waiver of periods of ineligibility

Home and Community Services may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. A hardship waiver may be granted in cases where there has been denial or termination of benefits based on transfer of assets or excess home equity. Such a waiver may lead to imposition of a civil fine on the recipient of a gift if the recipient "was aware, or should have been aware," that the gift was made for the purpose of qualifying for Medicaid.

A hardship waiver may be granted for transfers between couples who are married or for transfers between registered domestic partners.

13. Will COPES payments result in a lien or claim against my estate?

DSHS may be entitled to recover, from a Medicaid client's estate, the amount the State of Washington paid for the client's care. Whether or not Medicaid is entitled to recover depends on the type of services the client received and the dates when the services were provided to the client. See the Columbia Legal Services publication entitled Estate Recovery for Medical Services Paid for by the State, which is available on the website www.washingtonlawhelp.org.

Recovery will be delayed if, at the time of death, the COPES recipient has a surviving spouse, registered domestic partner, or surviving child who is under 21 or blind or disabled.

The DSHS estate-recovery claim only applies to property owned at death by a COPES recipient. *No claim can be made against property solely owned by a spouse or child.* This may be an important reason to consult a lawyer familiar with COPES and Medicaid rules about permissible transfers of property.

14. Can I get help with the application process?

Many people need help applying for COPES or Medicaid. Often there are family members or friends, or staff members of a hospital or nursing home or other agency, who are able to help. Help is also available from HCS staff, especially for people who have physical or mental impairments that make it hard to get through the application process on their own.

If you need help in the application process from HCS, you or someone else should tell the HCS representative that you need help. DSHS rules require what are called "necessary supplemental accommodation services" when they are needed. These services include help filling out forms and help finding information or papers needed for your application.

COPES rules are complicated. Before taking steps you don't understand, you should get individualized legal advice.

COPES 04-2019

COLUMBIA LEGAL SERVICES
101 Yesler Way, Suite 300, Seattle, WA 98104

*Let's discuss **"Gifting"**. If you will need Medicaid to pay for your care, **ANY** gifts you have made in the previous **5 YEARS** . . . that exceed a total of **$ 323** in any month*

WILL BE COUNTED AGAINST YOU

starting back from the date you apply for Medicaid !

*This includes any gifts you've made to your children, friends or charities . . . and this includes what you gave to your church **IN THE PAST "FIVE YEARS" !***

IT'S IMPORTANT TO UNDERSTAND THAT

WE ARE ALLOWED

TO GIFT AN "UNLIMITED AMOUNT"

TO OUR SPOUSE . . .

AND THERE IS NO "WAITING PERIOD" . . .

AND NO "FIVE YEAR LOOK-BACK" !

*But for any **OTHER AMOUNT** over $ 323 in any month . . . **YOU GAVE AWAY** to anyone else within the previous **FIVE YEARS** . . .*

MEDICAID WILL NOT PAY ANY BENEFITS . . .

ON YOUR BEHALF . . . UP TO THAT AMOUNT !

If you have made any gifts that are not excluded . . . and if you don't have any other way to pay for your LTC costs . . .

ALL I CAN SAY IS "GOOD LUCK" . . .

BECAUSE YOU ARE TRULY ON YOUR OWN !

The following simplified example illustrates how the asset rules for spouses work. It assumes a couple has combined countable assets of $78,000. The state in which the couple resides has set the asset limit for an institutionalized spouse at $2,000, and the community spouse is allowed to retain one-half of the couple's assets, up to a maximum of $100,000. This year, the husband enters a nursing home and applies for Medicaid.

Total countable assets:	$78,000
Maximum allowance for nursing home spouse:	– 2,000
Maximum allowance for community spouse (half of assets):	– 39,000
Amount exceeding maximum asset allowance:	$37,000

The maximum allowance for the nursing home spouse ($2,000) plus the maximum allowance for the community spouse ($39,000) results in a total asset allowance for the couple of $41,000. To qualify for Medicaid assistance, this couple must spend down $37,000 of their joint countable assets.

Estate Recovery

Federal laws require states to recover Medicaid-paid expenses for long-term care from the estates of individuals who were institutionalized. This is known as **estate recovery** and occurs after the individual's death. If the decedent, as the Medicaid recipient, was 55 years old or older at the time of death and received Medicaid benefits on or after October 1, 1993, the state must initiate a recovery claim for expenses it paid for nursing facility services and home and community-based services. States also have the option of seeking recovery for payments for other Medicaid services. Estate recovery cannot be initiated if the Medicaid recipient leaves a surviving spouse or a child under the age of 21 (or a child of any age who is blind or disabled).

Estate Recovery Rules

Assets subject to recovery include both real and personal property. **Real property** includes homes and land. **Personal property** includes vehicles, furniture, bank accounts, and similar assets. The state may claim a portion of personal property owned jointly with another person. Property that was deemed not countable for purposes of qualifying for Medicaid *can* be subject to estate recovery at the Medicaid recipient's death.

Recovery of assets from an estate may be made

- after the death of an unmarried Medicaid recipient;
- after the death of a surviving spouse;
- when the Medicaid recipient has no surviving child under age 21; or
- when the Medicaid recipient has no surviving child of any age who is blind or totally disabled.

In cases where estate recovery would create an **undue hardship** for surviving family members, the right to immediate recovery may be waived by the state. The administrator of a Medicaid recipient's estate must apply for a hardship waiver within six months of the decedent's death or within 30 days of receiving notice of a claim against the estate, whichever is later. The request for a hardship waiver must be in writing.

*On **Page 80**, we have an overview of the **"Estate Recovery Rules"** for Washington. If Medicaid has provided LTC benefits, Federal laws require the states to recover these costs from the estates of Medicaid recipients unless there is **"Undue Hardship"** for surviving family members.*

What I have just shared with you about Medicaid is only an introduction. If you will need this and have assets or income you want to protect for your loved ones, you will need to work with an "Elder Law Attorney".

*Columbia Legal Services is an example of who you'll need to contact. There are also private attorneys who specialize in this. As a Financial Planner who has worked around this for 40 years, I have a good understanding of these rules . . . but they change often and I would never do this on my own without a qualified **"Elder Law Attorney"** to help.*

Sam's Wife Has Alzheimers and Her Needs Are Getting More Expensive !

Let's have an example and bring some of this together.

Sam was a retired federal employee and his wife, Ruth, was a retired teacher. Ruth has had Alzheimers Disease for about five years. Sam has been her primary caregiver but he feels he now needs to hire extra help.

Sam feels, if he could eliminate their $ 1,000 monthly mortgage payment, he'd have enough to get the help he needs and take care of Ruth at home for a while longer.

He called me to see if a Reverse Mortgage loan was a solution for them. We ran the numbers and yes, they owned enough equity in their home, to create a Reverse Mortgage loan that was large enough to pay off their current mortgage and eliminate their mortgage payments.

Sam decided to proceed and apply.

Yes, they would still have to pay their property taxes, homeowner's insurance and homeowner association dues . . . but they would be able to eliminate their mortgage's principal and interest which was about $ 1,000 monthly.

The next question was if Sam should apply for a Fixed Rate Reverse Mortgage option or the Adjustable Rate Reverse Mortgage option. Sam said he wanted the Fixed Rate option . . . ***but I recommended he apply for the "Adjustable Rate Option".***

I explained to Sam that the Adjustable Rate Option would allow him to use his remaining Loan Amount as a Line of Credit, that would provide him more for later, if he should need it. I further explained that this Line of Credit is guaranteed to grow every month, currently at an annualized rate of 5 ½ to 6 % or more, tax-free, in the years ahead.

Sam replied and pointed out to me, that in their situation, he didn't have that much left over, to create a significant Line of Credit from his Reverse Mortgage Loan Amount, after he used this to pay off his current mortgage and the Reverse Mortgage loan costs.

Then I showed Sam an important valuable reason to do this that he had never thought about. Many retirees make this same mistake, from what I often see.

Sam thought he had too much income in his name for Ruth to qualify for Medicaid to pay for her care in the future. ***I showed him how Medicaid WOULD NOT CONSIDER HIS INCOME, as the Community Spouse (spouse at home).***

Sam and Nancy also owned about ***$ 200,000*** *in other savings and investments, in addition to their home.*

*Under their asset calculations, Medicaid **DOES INCLUDE THE ASSETS** of the Community Spouse, (but not his/her income), in addition to the spouse applying for Medicaid benefits. Ruth could only own a maximum of $ 2,000 in her own name.*

Sam would be allowed to keep about $ 100,000, or half, of their combined assets, in addition to their home.

THIS LEADS US TO THE NEXT QUESTION . . . IS THERE A LEGAL WAY THAT SAM COULD ALSO KEEP THE OTHER, CURRENTLY NON-EXEMPT $ 100,000 ?

*If he left this where it was, in their various savings and investment accounts, the answer would be **NO**. The $ 100,000 of non-exempt assets would have to be spent-down before Ruth could qualify for Medicaid benefits to pay for her care.*

HOWEVER, MEDICAID DOES ALLOW SAM AND RUTH'S HOME TO BE AN EXEMPT ASSET !

(As couple's home equity is exempt up to $ 1,033,000 in 2023. A Reverse Mortgage Line of Credit is included in this $ 1,033,000 ! See DSHS comment - page 84.)

I advised Sam that here is where the Adjustable Rate Reverse Mortgage Option creates extra value. Rather than spending this down on Ruth's care, or other exempt assets, I showed Sam how he could take the $ 100,000 from their other savings and investments, before Ruth applied for Medicaid, and use all of this, to reduce their Reverse Mortgage Loan Balance.

And with the Adjustable Rate loan, most of this would then create a higher Line of Credit, a Line of Credit that grows every month (less any withdrawals taken). Sam would have that much more to use for his own needs. And if Sam doesn't need it for himself, he would be able to leave more to his beneficiaries later.

*If Sam had the Fixed-Rate Option Reverse Mortgage, yes, he could still take the extra non-exempt $ 100,000 to reduce his loan balance . . . **but there would not be any Line of Credit with a Fixed Rate Option to allow Sam to use for his own needs.***

Just like most senior homeowners who don't own a Reverse Mortgage loan, his equity would be buried in his home and he could not access any of this unless he sold his home.

Sam decided to follow my recommendation and get the Adjustable Rate option. This is an example of how I often create additional value for my Reverse Mortgage clients.

Reverse Mortgages and Lines of Credit

We do not count as an available resource, beyond the idea, that it comprises home equity. It is not a resource all by itself. A line of credit is simply one method, someone can access their home's equity in a reverse mortgage. The equity is still in the home until the credit line is used.

Once the client takes a cash advance payment from the line of credit, the cash they take could become an available resource, if they still have it on the first of the month, after receiving payment.

A client takes out a reverse mortgage of $ 150,000 (principle before fees) and took the proceeds as a $ 150,000 line of credit. Until the client actually uses the line of credit, it is still part of the home's equity. In that sense, it is a resource, but the client does not have a separate available resource of $ 150,000. If on March 2, they took a cash advance of $ 50,000 on their line of credit, the home's equity has been reduced by $ 50,000. The remaining $ 100,000 in the line of credit, is still part of the home's equity until it is accessed. If they put that $ 50,000 from the line of credit into a bank account, whatever is still in the account on April 1, is an available resource.

If a client who has $ 555,000 equity in their home, had taken out a reverse mortgage line of credit of $ 150,000 but had not accessed the credit, the client still had $ 555,000 (maximum allowed when this was written – now up to $ 1,033,000 in 2023 – Dave updated) equity (less any loan fees). If the client did not have a spouse, minor child, or dependent child residing in the home, then the client would not be eligible. The client still has equity in excess of $ 555,000 (maximum allowed when written – now $ 1,033,000 in 2023 – Dave updated.)

However, if the client had accessed their line of credit and had used $ 60,000 on debts, the home's equity is reduced by $ 60,000 by the time they request LTC, then the client's equity is less than $ 555,000 and is potentially eligible, (Again, increased to $ 1,033,000 for 2023 – Dave)

Source

https://www.hca.wa.gov/health-care-services-

supports/programadministration/reverse-mortgage-

promissory-notes-and-loans

What Do You Do Now ?

I hope this book was helpful. My goal was to provide you with an overview of this expensive problem and some of the better solutions for the different situations many of us have.

I sincerely believe that any Financial or Retirement Plan is incomplete, without also developing a meaningful ***"Long Term Care Game-Plan"*** *and understanding the various ways to pay for any care we eventually need.*

Some of us have high income, some have significant assets, many own their home and have ***"Dead Equity"*** *that could make a positive difference. Others will need Medicaid.*

As I stated at the beginning, most of us will need a ***COMBINATION*** *of resources to pay for an extended and expensive need for Long Term Care.*

I believe it's critical that we leverage and ***CREATE MORE*** *with whatever we do own. This includes the life insurance choices, the annuity choices, the Reverse Mortgage and increasing Line of Credit when available.*

A majority of Retirees initially tell me, they don't need or want a Reverse Mortgage. But after further discussion, they also tell me, they don't know how they will pay for their Long Term Care if they need it.

Yes, they may be able to get a Reverse Mortgage later if they need it but they can often have much more later . . . if they simply re-positioned their home's equity into a Line of Credit earlier, that grows every month at a current annual rate of 5 ½ to 6 % and more. ***This is just common sense !***

Serious planning begins when we accept the fact that we are more likely to be one of the ***70 %*** *who will need Long Term Care. (But only 20 % of us believe this . . . and the rest dump the problem on their loved ones.)*

I understand and I offer my clients, all of the meaningful financial solutions. I can also refer and work together with knowledgeable Elder Law attorneys for Medicaid and Estate Planning.

I invite you to call for an appointment and review your personal choices.

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