Legal Matters®

Elder Law
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Three reasons why giving your house to your kids isn't the best way to protect it from Medicaid

Are you afraid of losing your home if you have to enter a nursing home and apply for Medicaid? While this fear is well-founded, transferring the home to your children is usually not the best way to protect it.

Although a home generally does not have to be sold in order to qualify for Medicaid coverage of nursing home care, the state could file a claim against the house after you die. If you get help from Medicaid to pay for the nursing home, the state must attempt to recoup from your estate whatever benefits it paid for your care. This is called "estate recovery." If you want to protect your home from this recovery, you may be tempted to give it to your children. Here are three reasons not to:

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1. Medicaid ineligibility. Transferring your house to your children (or someone else) may make you ineligible for Medicaid for a period of time. The state Medicaid agency looks at any transfers made within five years of the Medicaid application. If you made a transfer for less than market value within that time period, the state will impose a penalty period during which you will not be eligible for benefits. Depending on the house's value, the period of Medicaid ineligibility could stretch on for years and not end until the Medicaid applicant is almost completely out of money.

There are circumstances under which you can transfer a home without penalty, however, so consult with your attorney before making any transfers. You may freely transfer your home to the following individuals without incurring a transfer penalty:

- Your spouse
- A child who is under age 21 or who is blind or disabled

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How to reverse Medicare surcharges when your income changes

Are you a high-income Medicare beneficiary who is paying a surcharge on your premiums but who has experienced a drop in income or is anticipating one? If your circumstances change, you can reverse those surcharges.

Higher-income Medicare beneficiaries (individuals who earn more than $85,000) pay higher Part B and prescription drug benefit premiums than do Medicare beneficiaries with lower incomes. The extra amount the beneficiary owes increases in stages as the beneficiary's income increases. The Social Security Administration uses income reported two years ago to determine a beneficiary's premiums. So the income reported on a beneficiary's 2016 tax return is used to determine whether the beneficiary must pay a higher monthly premium in 2018.

But a lot can happen in two years. If your income decreases significantly due to certain circumstances, you can request that the Social Security Administration recalculate your benefits. For example, if you earned $90,000 in 2016 but your income dropped to $50,000 in 2017, you can request an income review and your premium surcharges for 2018 could be eliminated. Income is calculated by taking a beneficiary's adjusted gross income and adding back in some normally excluded income, such as tax-exempt interest, U.S. savings bond interest used to pay tuition, and certain income from foreign sources.

You can request a review of your income if any of the following circumstances occurred:

- You married, divorced, or became widowed.
- You or your spouse stopped working or reduced your work hours.
- You or your spouse lost income-producing property because of a disaster or other event beyond your control.
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan.
- You or your spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization.

If your income changed due to any of the above reasons, you can submit documentation verifying the change in income — including tax documents, a letter from your employer, or a death certificate — to the Social Security Administration. If the change is approved, it will be retroactive to January of the year you made the request. Here is a link to the SSA's Life-Changing Event form: https://www.ssa.gov/forms/ssa-44.pdf

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HUD makes reverse mortgages less attractive

The Department of Housing and Urban Development (HUD) has made changes to the federal reverse mortgage program. Citing the need to put the program on better financial footing, HUD has raised reverse mortgage fees for some borrowers and lowered the amount homeowners can borrow. The changes took effect on October 2, 2017. They affect borrowers who take out new loans, but not existing loans.

A reverse mortgage allows a homeowner who is at least 62 years old to use the equity in his or her home to obtain a loan that does not have to be repaid until the homeowner moves, sells, or dies. In a reverse mortgage, the homeowner receives a sum of money from the lender, usually a bank, based largely on the value of the house, the age of the borrower, and current interest rates. Seniors sometimes use the loans to pay for long-term care.

HUD has changed the mortgage insurance premium fees that homeowners pay in order to obtain a loan. Formerly, homeowners paid 0.5 percent of the value of their home as an upfront mortgage insurance premium on smaller loans, but homeowners who took out a loan that was more than 60 percent of their home's value paid a 2.5 percent premium. The new rule requires homeowners to pay a standard 2 percent upfront mortgage insurance premium. To offset the upfront costs, the annual mortgage insurance premium rate has been dropped from 1.25 percent to 0.5 percent.

In addition, HUD lowered the amount that homeowners can borrow. The average that a borrower at current interest rates can now borrow is only around 58 percent of the value of his or her home, down from 64 percent.

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- A trust for the sole benefit of a disabled individual under age 65 (even if the trust is for the benefit of the Medicaid applicant, under certain circumstances)
- A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home
- A "caretaker child," who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant's institutionalization and who during that period provided care that allowed the applicant to avoid a nursing home stay.

2. Loss of control. Transferring your home to your children means that you will no longer own the house, which means you will not have control of it. Your children can do what they want with it. In addition, if your children are sued or get divorced, the house will be at risk.

3. Adverse tax consequences. Inherited property receives a "step up" in basis when you die, which means the basis is the current value of the property. However, when you give property to a child, the tax basis is the same price that you purchased the property for. If your child sells the house after you die, he or she would have to pay capital gains taxes on the difference between the tax basis and the selling price. The only way to avoid some or all of the tax is for the child to live in the house for at least two years before selling it. In that case, the child can exclude up to $250,000 ($500,000 for a couple) of capital gains from taxes.

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There are other ways to protect a house from Medicaid estate recovery, including putting the home in a trust. To find out the best option in your circumstances, consult with your attorney.

Should you enroll in two popular Medigap plans while you can?

If you will soon turn 65 and be applying for Medicare, you should carefully consider which "Medigap" policy to enroll in because two of the most popular plans will be ending soon.

Between copayments, deductibles, and coverage exclusions, Medicare does not cover all medical expenses. Medigap (or "supplemental") plans offered by private insurers are designed to supplement and fill in the "gaps" in Medicare coverage. There are 10 Medigap plans currently being sold, identified by letters. Each plan package offers a different combination of benefits.

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Plans F and C are popular Medigap plans in part because they both offer coverage of the Medicare Part B deductible. According to the Kaiser Family Foundation, 53 percent of Medigap enrollees have either plan F or plan C.

But as a result of legislation passed by Congress in 2015, starting in 2020 Medigap insurers will no longer be allowed to offer plans that cover the Medicare Part B deductible — in other words, Plans F and C. The reasoning is that both plans encourage people not to think about the cost of going to the doctor. However, people currently enrolled in Plans F and C, as well as those who buy policies before 2020, may keep their coverage for the rest of their lives.

Although this appears to offer an incentive to "lock in" these two comprehensive plans while you still can, new Medicare beneficiaries should think carefully before enrolling in Plans F or C. While the plans are comprehensive, without new enrollees after 2020 experts warn that premiums may go up as the enrollees in Plans F and C age and get sicker. An alternative is Plan G, another comprehensive plan that does not cover the Part B deductible. But some experts believe that premiums will rise for this plan too, as more beneficiaries in poor health enroll in it.

The choice of Medigap plan is important because once you choose one, it is difficult to switch. Medigap plans cannot consider pre-existing conditions when you enroll during the open enrollment period, which is a six-month period that begins on the first day of the month in which you are 65 or older and enrolled in Medicare Part B. But if you don't enroll during the open enrollment period, there is no guarantee that the insurance company won't charge you more for a pre-existing condition.

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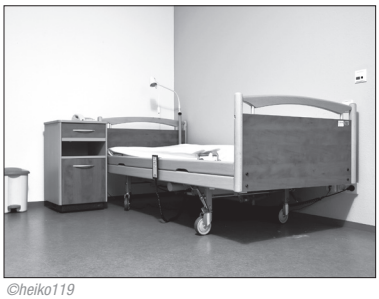
What happens when a nursing home closes?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The expansion of alternatives to nursing homes, such as assisted living and community care, has been financially challenging for the nursing home industry, and every year a small percentage of facilities close their doors. The state or federal government may also shutter a facility for safety issues.

Moving into a nursing home can be a stressful experience by itself. If that nursing home closes, residents can experience symptoms that include depression, agitation, and withdrawn behavior, according to The Consumer Voice, a long-term care consumer advocacy group. While there may not be much that can be done to prevent a closure, residents do have some rights.

When a nursing home is closing, it must provide notice to the state and any residents at least 60 days before the closure. The notice must include the following:

- The date of the closure and the reason for closing.
- Information on the plan to relocate residents, including assurances that the nursing home will transfer residents to the most appropriate facility in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.
- Information about the residents' appeal rights.
- The name and address of the state's long-term care ombudsman.

In addition, the nursing home must provide information to the receiving facility, including:

- Contact information for the doctor responsible for each resident.
- Information on each resident's representative.
- Information about any advance directives.
- Any special instructions or precautions for ongoing care and any care plan goals.

Once a nursing home announces it is closing, it cannot admit any new patients. The facility must also provide orientation to residents to ensure a safe and orderly transfer.

For more information from The Consumer Voice on what is required when a nursing home closes, see: http://theconsumervoice.org/uploads/files/issues/1_-_Nursing_Home_Closure_Issue_Brief_5-15-2017.pdf