



## LONG TERM CARE PLANNING GUIDE

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## **I. INTRODUCTION**

### **A. LONG-TERM CARE PLANNING**

Statistics show that the average cost of Nursing Home care in New York State ranges between \$100,000 to \$150,000 per year throughout the state, and it continues to climb each year. If you choose to stay at home and hire home health aides, the cost of your care could be even more. In some cases, people pay over \$125,000.00 per year for 24 hour-a-day home care. What many people fail to realize is that their health insurance and Medicare will not cover the cost of long-term care, whether at home or in a nursing facility.

The causes of our long-term care crisis are many: spiraling costs; the increase in the number of senior citizens; poor government management; medical technology resulting in greater longevity, whether in good health or bad; and the inability of families to care for our elderly at home. The result of the crisis is that there are more frail elderly today than ever before, with ever-increasing needs.

This outline is designed to give the reader a better understanding of the components involved in long-term care planning - Medicare, Private Insurance, Medicaid, and Nursing Homes - and to explain how recent changes in the law, and future trends, will affect tomorrow's long-term care consumer.

### **B. NURSING HOME COSTS**

In the Capital District, the cost of nursing home care ranges from approximately \$90,000 to \$115,000 per year. That's roughly \$245 to \$325, *per day*. Other areas of New York State vary, but paying for long-term care has become a primary concern across our state and the nation.

### **C. MEDICARE**

Contrary to the belief of many seniors, one cannot rely on Medicare for payment of long-term care costs. Although Medicare is available to most individuals age 65 or older, coverage in 2011 is limited to: hospitalization for 150 days per benefit period with a deductible of \$1,132.00

(total) for the first 60 days and a co-payment of \$283.00 *per day* for the days 61-90 and a co-payment of \$566 per day for days 91-150, and an additional one-time post-hospital skilled nursing home care with payment in full for 20 days and a co-payment of \$141.50 *per day* for 80 days (maximum of 100 days); certain home health care (only if medically necessary) and qualified medical expenses (80% of an approved amount for doctors, surgical services, etc.). For all Medicare benefits, there are deductibles and co-payments, which can be substantial. There are excellent insurance policies available to fill these "gaps" in Medicare coverage, appropriately called "Medigap" insurance, which must be purchased privately.

Medicare does not cover hospital costs beyond 150 days, skilled nursing home costs beyond 100 days and, most importantly, custodial nursing home care and non-skilled home health care. Very few people qualify for "skilled care," and everyone else is considered a "custodial" patient.

#### **D. PAYING YOUR OWN WAY**

"Self-insuring," or paying your own way, may be an option. But you can expect to pay approximately \$95,000 per year for nursing home care, and more for better facilities. In downstate areas, the cost of care rises dramatically. If a person has sufficient fixed income and assets, which together produce total income of \$75,000 or more, this may be the way to go. But even then, what about the future well-being of the spouse, children, and families of those who need long-term care?

#### **E. PRIVATE INSURANCE**

Long-term care (LTC) insurance has been around since 1974, but became increasingly popular in the 1990's. New York State began regulating LTC insurance in January 1992 by imposing strict regulations setting minimum standards for policies.

Benefits to look for in a policy of LTC insurance include: nursing home and home care coverage; daily payouts (\$150/day is a good start); elimination periods (the number of days you must wait before benefits begin, typically 0 to 100 days); duration of benefits (2 years, 3 years, a lifetime); renewability (make sure it is *guaranteed* renewable); waiver of premiums (allows you to

stop paying premiums during the time you are receiving benefits); inflation protection; home care benefits; and assisted living benefits. As with life insurance, the older an applicant is, the more expensive LTC coverage becomes.

New York State has also adopted a program which integrates long-term care insurance into the Medicaid scheme. A project funded by the Robert Wood Johnson Foundation studied long-term care insurance and its potential uses in New York State. The result was a proposal which was adopted by New York State in 1993 creating a public/private partnership between the State Department of Social Services and the insurance industry. Insurance companies now offer policies which bear the logo of the New York State Public/Private Partnership For Long Term Care, provided they meet certain minimum policy requirements. These are known as "Partnership Policies". The basic components of these policies are: a three year benefit period for nursing home care (six years for home care); minimum daily benefits of \$241.00/day for nursing homes and \$121.00/day for home care (annually adjusted for inflation); a 5% compound annual increase in benefits; and other mandatory features. If an individual purchases a policy of "Partnership Insurance," he or she will use the insurance proceeds, supplemented by the individual's income and assets, to pay for the first three (or six) years of care. At the expiration of the applicable term, the individual will become automatically qualified for Medicaid. All of the assets owned by that person will be exempt for Medicaid purposes, and the individual will be allowed to keep an unlimited amount of resources and still qualify for Medicaid. Income, however, continues to be available, and must be "spent-down" to pay for the individual's care.

Counseling clients on the use of Long-Term Care Insurance has become a focus of Elder Law practitioners, and an integral part of comprehensive estate planning. Choosing a solid company, the right policy ("Partnership" or traditional), daily benefit amounts, etc. calls for independent advice from a qualified professional or attorney, which we are pleased to provide. Please contact our firm to schedule an appointment for a consultation.

## F. MEDICAID

Medicaid is a government program which pays medical and long-term care costs. Unlike Medicare, however, Medicaid is designed as a payor of last resort, and to qualify, applicants must meet strict financial requirements. An individual applying for Medicaid can have only \$13,800 in assets, an irrevocable prepaid burial fund and certain exempt assets (a car, clothing, jewelry, etc). If the Medicaid applicant is married, and enters a nursing home while the other spouse remains in the community, the "community spouse" may keep \$74,820 (or one-half of a couple's resources up to a maximum of \$109,560) in assets, plus a home. Income must also be contributed toward the cost of care, and an individual in a nursing home is entitled to keep only a \$50 per month allowance. A "community spouse" is allowed \$2,739.00 per month. Without planning, all assets and income above these levels must be spent on care or on exempt items before Medicaid will pick up the tab.

What if an individual gives assets away in order to qualify? As you might expect, there are rules governing such transfers. When you give money or property to anyone except a spouse or disabled child, you will be ineligible for institutional Medicaid for a certain number of months (the "penalty period"). The penalty period is calculated by dividing the total value of all property transferred by the average monthly cost of nursing home care in your area. The State determines this "average" each year for seven separate regions across New York State. For example, in 2011, if an Albany County resident transferred \$83,230.00, he or she would be *ineligible for Medicaid for 10 months*. \$8,323.00 is the average cost of nursing home care for 2011 in Northeastern New York as determined by the State, and the penalty period is calculated by dividing the amount of the transfer by the average monthly cost. There is no maximum period of ineligibility.

When applying for Medicaid, the County Department of Social Services will ask for financial records, bank statements, tax returns, etc. from the date of the application back for a period of 60 months, and question transactions within that time frame. The penalty period will then depend upon the value of the non-compensated transfers found by the Department of Social Services.

## G. CHANGES IN THE MEDICAID LAWS

A significant revision to the Medicaid laws took place in 1993 under the Omnibus Budget Reconciliation Act of 1993 ("OBRA '93"). This revision significantly altered the way Medicaid was administered on a federal level, and, once New York State adopted this legislation in 1994, on a state level, too. The United States Congress adopted the Deficit Reduction Act of 2005 in late 2005 and then-serving President Bush signed the Act into law on February 8, 2006 (the "DRA of 2005"). This law made additional changes to the Medicaid law, and greatly altered the Medicaid eligibility rules. New York State adopted this law, and fully implemented the DRA of 2005 in New York State. The main objectives of the federal and state legislation were to increase revenues and reduce the government's cost of supplying Medicaid services.

The DRA of 2005 and New York's implementation of that law changed many of the rules which apply to Medicaid qualification. Below is a summary of some of the current rules regarding Medicaid qualification.

**1. Look-Back Period.** For all Medicaid applications, the Department of Social Services will look back 60 months from the date of the application for nursing home benefits to determine whether the applicant has made any transfers for less than fair market value (*i.e.*, gifts). For example, if an application for Medicaid is submitted on May 1, 2011, there will be a 60 month look back period (5 years) to May 1, 2006. This means the Department of Social Services will be examining any transfers made on or after May 1, 2006.

**2. Penalty Period.** The penalty period (the period during which the Medicaid applicant is ineligible to receive benefits) begins to run as the LATER of: (1) the date when (a) the Medicaid applicant: (i) is resource eligible; (ii) is income eligible; (iii) requires nursing home level care; and (iv) has filed a Medicaid application and (b) no other period of Medicaid ineligibility is outstanding; or (2) the first day of the month after which assets have been transferred. It should be noted that it is possible to have a partial month penalty period. The penalty period is, in essence, a per diem penalty.

**3. Jointly Held Assets.** If assets are held in an account by a Medicaid applicant and another individual as "joint" tenants, and funds are withdrawn by either individual, it will count as a transfer against the Medicaid applicant. For example, withdrawal of funds from a "joint" bank

account by the child of a Medicaid applicant will be treated as though the Medicaid applicant (parent) had transferred the funds. In addition, funds held in a joint account in a bank or similar financial institution will be *presumed* by the Department of Social Services to be owned entirely by the applicant.

**4. Home Care Benefits.** Medicaid is most often thought of as the government entitlement program that will pay for a person's long term care in a skilled nursing facility (a nursing home). However, Medicaid can also be used to provide benefits to a person in the community. Home and Community Based Medicaid (HCBM), or "Community Medicaid" as it is commonly referred to, can provide home care services to persons residing in the community, prior to nursing home care, or as an alternative to nursing home care. Community Medicaid is available to persons over the age of 65, as well as to disabled persons under the age of 65. The programs available under Community Medicaid have eligibility rules and transfer of asset provisions that differ significantly from the institutional Medicaid benefits. It is important to understand the differences and evaluate each individual's needs, prior to applying for Community Medicaid. We would be happy to identify your particular needs in order to make a determination as to the services available to you.

**5. Trusts.** If assets are held in a revocable trust, they are considered available assets for Medicaid purposes. If assets are held in an irrevocable income only trust (otherwise known as a "Medicaid trust"), the assets will be protected only after the expiration of the look back period of 60 months.

**6. Estate Recovery.** States are required to seek recovery of benefits paid to a Medicaid recipient from his or her estate. It has been left to each individual state to determine what assets will be included in the "Medicaid estate," which could conceivably include assets held in trust, and other partial transfers, such as deeds with retained life estates. The New York State Legislature, however, has defined "estate" as the "probate" estate only, or those assets passing by Will or by intestacy. Any non-probate assets, such as trusts (Medicaid or not), joint accounts, and annuities currently escape recovery. However, recent changes to the New York State budget indicate this may be changing.

**7. New York State's Partnership For Long-Term Care Insurance.** The DRA of 2005 permits each state to enact an insurance program allowing protection of assets by the

purchase of a long-term care insurance policy. New York State has had its Partnership Program in place since before 1994, and New York residents continue to have the ability to benefit from the asset protection provisions of such a policy.

**8. Hardship.** New York State is required to establish procedures to determine whether the denial of Medicaid eligibility would work an undue hardship on an applicant. If an individual makes transfers "innocently," which disqualify him or her from receiving Medicaid, the state may waive the eligibility requirements.

**9. Home Equity.** The DRA of 2005 modified the rules regarding how much equity an applicant may retain in his or her home. Under the law, home equity of more than \$500,000 (indexed annually for inflation) is counted as an available asset. The state may, at its discretion, raise this amount up to \$750,000, which New York State has done. An exception applies in the event a spouse or child under twenty-one, blind or disabled is lawfully residing in the home. An individual might also choose to take a reverse mortgage or home equity loan to reduce the total equity in the home.

**10. Annuities.** Under the DRA of 2005, the purchase of an annuity by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long term care services is treated as an asset transfer unless the annuity lists the State as the first remainder beneficiary for an amount equal to the value of the total medical assistance paid for the benefit of the annuity owner. An exception applies in the event the annuity owner has a community spouse or a minor or disabled child.

Moreover, annuities are treated as assets subject to transfer penalties when purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing home facility or other long term care services is treated as a transfer of an asset unless the annuity: (1) meets the requirements of certain provisions contained in Section 408 of the Internal Revenue Code; or (2) is irrevocable, non-assignable, actuarially sound, pays out in equal installments during the term of the annuity and there is no balloon or deferral.

**11. Loans or Mortgages.** Under the DRA of 2005, a loan or mortgage is treated as a transfer of assets unless the repayment terms are actuarially sound, provide for payments to be

made in equal amounts during the term of the loan, with no deferral nor balloon payments, and the indebtedness is not cancelled upon death.

**12. Purchasing a Life Estate.** Under the DRA of 2005, funds used to purchase a life interest in the home will be regarded as transferred assets unless the purchaser resides in the home for a period of at least one year after the date of purchase.

## II. PLANNING FOR LONG-TERM CARE

What can be done to plan for long-term care, ensure an individual's security and dignity, and provide for family and loved ones? As you may have already gathered, the answer is not simple. A careful analysis of each individual's personal and financial situation must be done to formulate the proper plan. Factors such as income from social security, pensions and investments; the nature and value of assets; age and health; family situation; and others must be evaluated in order to make the right choices.

If *insurable*, and LTC insurance premiums are *affordable*, such policies can be integrated into an estate plan to provide protection without the need for transferring assets. If an individual falls in the "target range" for a New York State Partnership policy, the asset protection feature provided by automatic Medicaid qualification would be a valuable benefit. When income levels exceed the "target range," and asset protection is not the only planning goal, traditional policies of Long-Term Care Insurance using a lifetime benefit may be preferred. Again, it is important to analyze each individual's situation to determine the proper fit for a Long-Term Care policy.

If LTC insurance is not an option, a popular planning technique is to transfer assets into a "Medicaid" trust, retaining the income for the Grantor and preserving the principal of the assets (the assets held by the Trustee) for the children or other beneficiaries of the Grantor. When properly drafted, the Trust will provide significant tax benefits, including avoidance of gift taxes, elimination of capital gains taxes, and reduction of income taxes, and in addition trust assets will avoid probate. The Trust may provide the Trustee with access to the principal during the Grantor's lifetime for the benefit of his or her children or other beneficiaries, provided the Trustee cannot give the principal directly to the Grantor. Most Grantors also choose to maintain the right (called a Special Power of

Appointment) to change the ultimate beneficiaries of the trust, by "re-appointing" the assets to different family members at a later date. This power retains control for the Grantor, and prevents transfers to the trust from being treated as taxable gifts.

Although changes in the law have complicated the use of "Medicaid Trusts," properly drafted "income-only" trusts that give a Trustee no discretion to distribute principal to the, or to his or her spouse, do not come within the definition of a "disqualifying trust" under the federal and state statutes. Therefore, a senior may keep the income for himself or herself from an Irrevocable Trust, with the remainder distributable to specific beneficiaries, and qualify for Medicaid without the assets in the trust being counted.

If using a trust is not desired, it is still possible to make "outright" gifts of property. However, any such gifting must be done carefully because the DRA of 2005 altered the rule as to when the penalty period begins to run. If a home is the only asset to protect, a deed to children or others, with a retained life estate for the Grantor, will protect the property and the right to Medicaid; however, a transfer of any asset will be subject to the rules outlined in the DRA of 2005.

Even if nursing home care is imminent, planning opportunities exist to protect assets. Proper use of the Medicaid transfer rules allows individuals to provide a legacy to their families, while ensuring that they will receive long-term care. By entering into a transfer plan carefully crafted by professionals, individuals can channel assets to a trust, or to children and grandchildren, while ensuring they are properly cared for until Medicaid is available.

One very important fact to remember is that if an individual can live at home with the assistance of home health care, it is possible to transfer assets and qualify for Medicaid immediately to cover home care costs. Caution must be exercised, however, in light of the fact that home health care may be denied or discontinued under the State's "fiscal assessment" standard if the cost of providing it reaches a level which equals 90% of the cost of paying for care in a nursing home. The Department of Social Services may then require institutionalization, resulting in imposition of the Medicaid transfer rules. When planning for *home care*, the possible need for institutional services must be evaluated before transfers are made.

### III. WHAT THE FUTURE HOLDS

The crisis in health care and long-term care will shape public policy for years to come. The President, Congress and the Governor continue to formulate major changes in our health care and long-term care systems. It has become evident that long-term care, such as nursing home and home health care, will not be a part of any new universal health insurance program, and that existing programs, including Medicare and Medicaid, will continually be curtailed. Therefore, it is incumbent upon seniors, those approaching retirement age, and the families of those needing long-term care to take advantage of the planning opportunities that exist today; however, it is even more important to seek professional advice before implementing any of the options available under the DRA of 2005.

Everyone's situation is unique, and it is impossible to discuss all of the possible planning opportunities in this outline. As with any planning, a good way to begin is to seek competent advice from a qualified professional. All of the firm members of **Burke & Casserly, P.C.** are dedicated to helping you find solutions to life's perplexing problems and assist you in the process of solving them. Please call us at **518.452.1961** and ask for our firm administrator, Cheri Terzian, to schedule your free ½ hour initial consultation and to discuss our fee structure. We look forward to hearing from you!