



Long-Term Care Planning Guide 2012

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TABLE OF CONTENTS

	<u>PAGE</u>
I. INTRODUCTION – Long-Term Care in 2012.....	1
II. MEDICARE	2
A. Medical Expenses, Hospital and Post-Hospital Skilled Care	2
B. Gaps in Coverage	2
C. Medicare Part D (Prescription Drug Coverage)	2
III. PAYING YOUR OWN LONG-TERM CARE EXPENSES	3
A. Self-Insuring	3
B. Financial and Tax Planning for Long-Term Care	4
C. Wealth Replacement Using Life Insurance	4
IV. PRIVATE LONG-TERM CARE INSURANCE	4
A. Policy Benefits	5
B. Tax Deductability	5
C. New York State Partnership	6
D. Indemnity Benefits vs. Reimbursement	6
E. Innovative Products	6
V. MEDICAID	7
A. Income & Resource Limits	7
B. Home Care Rules	7
C. Transfer of Asset Rules	8
D. Other Medicaid Rules	10
VI. PLANNING FOR LONG-TERM CARE	11
A. Use of Trusts	11
B. Protecting the Home	12
C. Crisis Planning for Nursing Home Care	12
D. Crisis Planning for Home Care	12
E. Geriatric Care Management	13
VII. WHAT THE FUTURE HOLDS	13
APPENDIX A: NYS Medicaid Regional Rates	14

I. INTRODUCTION

Welcome to the Pierro Law Group, where we ask the tough questions:

Do you know someone who has spent time in a nursing home?

Have you ever thought about going into a nursing home yourself?

Most people answer the first question **yes**, and the second question **no**. It is one of those situations where we feel *"It could never happen to me"*. But studies show that approximately 2 out of every 5 people reaching age 65 will need some type of **long-term care**. Are you one of the many people who would **prefer to stay at home** no matter what rather than enter a nursing facility? Without proper **long-term care planning**, the lack of available services and the staggering price-tag may leave you and your family with few alternatives.

What is Long-Term Care? Long-term care involves a variety of services which help meet both the medical and non-medical needs of people with chronic illness, disability or advanced age who cannot care for themselves. Long-term care can be assistance with normal daily tasks like dressing, bathing, meal preparation and using the bathroom, or medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. People of any age many need long-term care, although it is a common need for senior citizens. By 2020, an estimated 12 million older Americans will need long-term care.

In New York State, the annual cost of nursing home care ranges from approximately **\$90,000.00** to **over \$180,000.00**, with costs in the Capital District at approximately \$130,000.00, and it is climbing each year! That is approximately \$240.00 to \$490.00, per day. If you choose to stay at home, where most of us would prefer to be, and hire home health aides, the cost of your care could be even more. Home health care costs vary widely, but agencies charge anywhere from \$18 to \$30 per hour for home health aides. In some cases, people **pay over \$200,000.00 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, in assisted living or in a nursing facility**. Paying for long-term care is a personal responsibility which has become a burden for all age groups across New York and the nation.

The causes of our long-term care crisis are many: increasing costs; a growing population of seniors (78 million Baby Boomers began turning 65 in 2010); poor government management; medical technology resulting in greater longevity, whether it be in good health or bad; and the inability of families to care for our elderly at home. The result of the crisis is that we must all "rethink" the way we plan for retirement, and take into consideration the very real possibility that long-term care may become a part of our lives. In 2006, federal legislation changed Medicaid eligibility rules to make it **more difficult to qualify**, and States including New York have enacted more cuts to reign in Medicaid spending.

This outline is designed to give you a better understanding of the components involved in long-term care planning: Medicare, Self-Insuring, Private Insurance, Medicaid, and other Long-Term Care Planning concerns, and explain how recent changes in the law, and future trends, will affect you if the need for long-term care arises.

II. MEDICARE

A. Medical Expenses, Hospital and Post-Hospital Skilled Care

Contrary to the belief of many seniors, one **cannot rely on Medicare** to pay for long-term care costs. Although Medicare is available to most individuals age 65 or older, coverage is limited to:

1. **Qualified Medical Expenses** (80% of an approved amount for doctors, surgical services, etc);
2. **Hospitalization** for 90 days per benefit period (“spell of illness”) with a deductible of \$1,156.00 for the first 60 days and a co-payment of \$289.00 **per day** for the remaining 30 days. Beyond the 90 days of hospitalization per spell of illness, there is an additional one-time lifetime benefit of up to 60 days, with a co-payment of \$578.00 **per day**; and
3. **Post-Hospital Skilled Nursing Home Care** with payment in full for 20 days and a co-payment of \$144.50 **per day** for the next 80 days, for a maximum of 100 days of care. The term “skilled care” is narrowly defined (see “Gaps in Coverage”), and even though it is the only Medicare nursing home benefit, its availability is very limited.

B. Gaps in Coverage

Medicare only pays for nursing home care following a hospital stay of at least 3 days, and **only** if the care provided is considered “**skilled care**”. Skilled care is provided under the supervision of a doctor, requiring skilled professionals such as therapists (physical, occupational or speech) or registered nurses. Payment for skilled care ends when the individual is determined to have reached a “plateau”, usually in 20-30 days. “**Custodial care**” or non-skilled care provides basic personal care and other maintenance level services such as assistance with walking, bathing or dressing. Home health care may be covered in limited amounts, but only if “medically necessary”, which is a very rigorous standard. For all Medicare benefits there are deductibles and co-payments, which can be substantial, and Medicare is in the process of becoming a “means tested” program. 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, **Medicare does not cover any custodial nursing home care or non-skilled home health care**. It is difficult for a Medicare recipient to qualify even for the limited “skilled care” benefits. With the Medicare Trust Fund currently projected to run out of money within the next decade, the gaps in Medicare coverage are expected to widen rapidly, ultimately causing seniors more out of pocket expenses.

C. Medicare Part D (Prescription Drug Coverage)

Beginning in 2006, Medicare added a Part D program to cover the costs of prescription drugs. If you are offered prescription drug coverage through your employer as part of retiree benefits, you may choose to accept this coverage or to enroll in Medicare Part D. All other individuals must select a Medicare Part D Plan.

The initial period for enrollment is the period that begins 3 months before and ends 3 months after your 65th birthday (or the month you begin receiving Medicare based on disability). Individuals

may only change their plan once a year, from November 15 through December 31. There are many different plans to choose from, and the choice is often confusing. In New York, there are currently 33 different Prescription Drug Plans, and numerous Medicare Advantage Plans that are offered by each county.

The monthly premium for the Medicare Part D plan varies by company, and the basic plans cost up to \$20.00 per month, while the more comprehensive plans cost between \$75.00 and \$140.00 per month. For 2012, the basic plan has an initial deductible of \$320.00 and then the plan will cover 75% of prescription costs up to \$2,930.00 per year. From \$2,930.00 to \$4,700.00 there is a **coverage gap** where the beneficiary must pay out of pocket often referred to as the “donut hole”. Then once the beneficiary has prescription costs in excess of \$4,700.00 in a given year, the remaining prescription costs are completely covered by Part D insurance until the end of that year.

The basic plan deductible and co-payments are as follows:

PRESCRIPTION COSTS	MEMBER PAYS	PLAN PAYS
\$0 - \$320	100%	\$0
\$320 - \$2,930	25%	75%
\$2,930 - \$4,700	100%	\$0
Above \$4,700	\$0	100%

Note: Beginning in 2011, Part D enrollees will receive a 50% discount on the total cost of their brand-name drugs while in the “donut hole”, while the full retail cost of the drug will still apply to getting out of the donut hole. Enrollees will pay a maximum of 86% of the cost for generic drugs as a co-pay amount while in the “donut hole”.

If you are a low income Medicare recipient, the government offers “extra help” in meeting your premium, deductible and co-payment costs.

There are a number of factors that you should take into account in deciding whether to enroll in a Medicare Part D plan and which plan to choose. Differences in terms of deductibles, co-payments and coverage gaps are all important considerations. Please contact us for more detailed information on the Medicare prescription drug benefit, or to schedule an appointment for a consultation.

III. PAYING YOUR OWN LONG-TERM CARE EXPENSES

There are several ways in which a senior or an individual with a disability can pay for his or her own long-term care expenses.

A. Self-Insuring

“Self-insuring”, or paying your own way, is one available option. However, you can expect to pay approximately **\$90,000.00 to \$180,000.00 per year** for nursing home care depending on where you live, and more for better facilities. In downstate NY areas, the cost of care rises dramatically. Home care can be even more expensive, with 24/7 care costing \$120,000.00 to \$200,000.00 per year. If a person

has sufficient fixed income, and income generating assets, which together produce total income of \$130,000 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?.

B. Financial and Tax Planning for Long-Term Care

Planning to “self-insure” for long-term care expenses requires a collaboration of financial planning, and estate and tax planning, to ensure that sufficient income can be generated to prevent the depletion of assets. Use of our thorough fact-finding *Long-Term Care Questionnaire* is highly recommended to assemble all the necessary information regarding assets, income, expenses and other factors, such as where care will be provided and what support can be expected from family caregivers. This information provides a foundation for the planning required to maximize the value of Social Security income, fixed pensions, dividend and interest income and other income streams, along with maximizing deductions for things such as medical expenses and other deductible items. Investment strategies to produce growth and income sufficient to fund projected expenses are a key ingredient for successful retirement, and a qualified financial planner or investment advisor should be consulted. Once investment strategies are in place, and projections for income and expenses are done, the plan to “self-insure” can be implemented.

C. Wealth Replacement Using Life Insurance

Creative tax and financial planning can further maximize the value of existing assets and income, provide tax savings, and legacy planning should long-term care become necessary. One example is the targeting of retirement funds (IRA's, 401(k)s and other retirement vehicles) to pay long-term care expenses. Qualified long-term care expenses are fully income tax deductible as a medical expense, subject to a floor of 7.5% of adjusted gross income. For example, if an individual has \$50,000 of adjusted gross income, medical expenses above \$3,750 are fully deductible. If the need for long-term care should arise, accessing assets such as retirement funds, tax deferred annuities and U.S. savings bonds may provide an excellent opportunity to utilize the medical expense deduction to offset income tax consequences created by liquidation of those assets. Should you target that asset to pay long-term care if necessary, the purchase of life insurance in an amount sufficient to replace the asset should it be depleted by long-term care costs provides a legacy tax free to your heirs. In this way, an otherwise taxable asset can be used to pay long-term care expenses, while the life insurance policy is used to replace the value for your family, free of income and estate taxes if certain conditions are met. Should you never need long-term care, your family would receive both the targeted asset, and the life insurance proceeds, doubling the legacy that you leave to your heirs.

IV. PRIVATE LONG-TERM CARE INSURANCE

Based upon the current cost of long-term care and the average net worth of an American household, most people will not be able to self-insure for Long-Term Care. A study by the U.S. Department of Health and Human Services says that four out of every ten people who reach age 65 will enter a nursing home at some point in their lives. Therefore, based upon the current condition of health care, long-term care and Medicaid, if you are insurable and long-term care insurance premiums are affordable, private long-term care insurance should be integrated into your estate plan to provide

protection without the need for liquidating or divesting assets.

Long-term care insurance has been around since the 1970's, but in 1997 it gained widespread acceptance through federal legislation. New policies are very flexible, providing coverage (including cash benefits) for all levels of care, and should be considered as part of a sound financial plan. New York State regulates LTC insurance, and in January 1992 strict regulations were put in place which set minimum standards for these policies, protecting consumers in New York.

A. Policy Benefits

Benefits to look for in a LTC Insurance policy include but are not limited to:

- Nursing home and home care coverage (Get care where you want it);
- A sufficient daily payout (\$250.00/day is a good start);
- Elimination period (the number of days you must be in need of long-term care before benefits begin, typically 0 to 100 days);
- Duration of benefits (3 years, 5 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); and
- Inflation protection (5% compound, 5% simple, CPI, etc.).

As with life insurance, the older an applicant is, the harder it is to obtain a policy, and the more expensive LTC coverage becomes. More importantly, you must be **insurable**. The average age for the purchase of Long-Term Care Insurance is now 57, and is trending downward.

B. Tax Deductibility

Individuals may deduct the cost of long-term care insurance premiums paid as a medical expense, subject to the limitation that medical expenses must exceed 7.5% of the individual's adjusted gross income. An individual may deduct the lesser of the premium paid or the amount in the following chart:

Age-Based Long-Term Care Insurance Premiums	
<u>Age at End of Taxable Year</u>	<u>Premium Limit - 2012 Amount</u>
40 or Less	\$350
41 Through 50	\$660
51 Through 60	\$1,310
61 Through 70	\$3,500
71 and Older	\$4,370

Unless your adjusted gross income is low, or you have significant other medical expenses, the federal deduction may be of little value. Business Owners, such as sole proprietors, partners and shareholders, however, may deduct LTC insurance premiums without having to itemize their deductions or meet the floor of 7.5% of adjusted gross income. For New York State residents, there is a substantial benefit in the form of a 20% tax credit for the payment of long-term care insurance premiums. This credit produces a dollar-for-dollar savings off of your New York State income tax bill.

Tax laws involving Long-Term Care are complex, and each individual's situation is unique. It is highly recommended that you consult with the Pierro Law Group or your tax advisor if you have questions.

C. The New York State Partnership

New York State has adopted a unique program which integrates long-term care insurance with Medicaid. Insurance companies may 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. The basic components of the New York Partnership Policy includes:

- Benefit period of 3 years for nursing home care and 6 years for home care (at a 50% benefit rate) or 4 years for both nursing home care and home care (at a 100% benefit rate);
- Minimum daily benefits of \$253.00 per day for nursing homes and \$127.00 per day for home care (annually adjusted for inflation);
- 5% compound annual increase in benefits; and other mandatory features.
- The inflation protection is optional for persons 80 years of age or older.

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 3, 4 or 6 years of care (depending on nursing home or home care) which could be anywhere in the country. At the expiration of the applicable term, the individual will become qualified for Medicaid (but only in New York State) with all of the assets owned by that person exempt for Medicaid purposes. Thus, the individual will be allowed to keep an **unlimited amount** of resources and still qualify for Medicaid, although income continues to be available, and must be "*spent-down*" to pay for the individual's care. If you fall 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. However, when income levels are high (roughly \$60,000.00 for individuals and \$75,000.00 for married couples) or asset protection is not the only concern, traditional policies of long-term care insurance that utilize a cash or indemnity benefit, and increased home care coverage, may be preferred.

D. Reimbursement vs. Indemnity Benefits

A cash or indemnity policy can allow you to receive a monthly payment, tax free, and to use the money **any way you choose**. With a reimbursement contract, you must hire approved providers, pay them, and then seek reimbursement from the policy carrier. It is important to analyze your individual situation to determine the proper fit for a partnership policy, as rules are complex, and should be fully understood prior to buying a policy.

E. Innovative Products

Recently, certain insurance companies have begun marketing creative, new hybrid insurance products which offer features of both life insurance and long-term care insurance. We expect these policies may be of interest to clients who want life insurance coverage, with the guarantee that there will be a death benefit for their heirs if the long-term care feature is not used, and access to the death benefit during life if a chronic illness should occur.

Counseling clients on the use of Long-Term Care Insurance has become a sub-specialty of Elder Law, 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, a service which we are pleased to provide. If you or a loved one is considering long-term care insurance or would like to know more, please contact the Pierro Law Group to schedule an appointment for a consultation.

V. MEDICAID

If an individual is unable to self-insure and does not have or cannot get a long-term care insurance policy, he or she may need to access Medicaid to pay for long-term care. Unlike Medicare, Medicaid is a government program which pays both medical costs and long-term care costs. However, Medicaid is designed as a **payor of last resort** and to qualify you must meet **strict financial and other eligibility requirements**. The rules governing Medicaid are complex, and frequently change, requiring great care in the planning and application for benefits. Further, laws designed to limit access to Medicaid went into effect in New York in 2006. This legislation has forced many middle class seniors and people with disabilities, who have not done proper planning, to spend their entire life savings before Medicaid steps in. Pierro Law Group is well versed in navigating the “minefield” of the Medicaid planning and filing process. If you or a loved one is considering Medicaid options, please contact our office to schedule a consultation. There are planning options available for long-term care, but under the new Medicaid eligibility rules, waiting to plan is NOT one of those options.

A. Income & Resource Limits

An individual applying for Medicaid in a **nursing home** can have only \$14,250 in total assets, plus an **irrevocable** burial fund of any reasonable amount and certain exempt assets (a car, clothing, etc.). Income must also be contributed toward the cost of care, and an individual in a nursing home is entitled to keep only a \$50.00 per month allowance. If the individual owns a home that is occupied by his or her child who is under the age of 21, or certified blind or disabled, the home is not included in the total asset calculation and is not subject to a Medicaid lien. If the individual owns a home that is not occupied by one of those people, and the individual’s equity interest in the home is greater than \$786,000, the amount of excess equity is counted towards the total amount of assets that can be kept.

If the Medicaid applicant is married, and enters a nursing home while the other spouse remains in the community, the “community spouse” may keep \$74,820.00 (or one-half of a couple’s resources up to a maximum of \$113,640.00) in assets, in addition to the home. The spouse in the nursing home is entitled to keep only a \$50.00 per month allowance while the “community spouse” is allowed a minimum income of \$2,841.00 per month, with adjustments for certain items. Without proper planning, all assets and income above these levels must be spent on care or on exempt items before Medicaid will **pick up the tab**.

B. Home Care Rules

Individuals seeking to obtain Long-Term Care services outside of a nursing home must navigate a different set of Medicaid eligibility rules, depending on the type of services required. One of the primary

goals expressed by our clients is to remain in their own homes or at least in the most independent setting possible. Navigating the maze of community care requires an in-depth knowledge of the services available in the home, and in adult homes and assisted living facilities, and an ability to manage income and resources to maximize their value, while utilizing Medicaid services wherever available to supplement the care provided by the individual and their family.

Community-based Medicaid services are available through several programs, including the Personal Care Aid (“PCA”) program, the Consumer Directed Personal Assistance Program (“CDPAP”), the Nursing Home Transition and Diversion Waiver (“NHTD”), Long-Term Home Health Care (“LTHHC”, also know as the Lombardi program) and traditional home care. Generally, however, Medicaid does not pay for adult home or assisted living care (with limited exceptions), which under existing rules must be paid for privately.

In order to access community-based care, an individual is allowed to keep the same \$14,250.00 in total assets, but he/she may also retain the home in which they live along with the other exempt assets listed above. Recipients of Medicaid home care are allotted an income allowance of \$792.00 per month. Income over the \$792.00 limit will have to be spent on medical care. However, an alternative is to contribute the excess income to either a First Party Supplemental Needs Trust or a “**Pooled Trust**”, which can then be used to pay other expenses necessary to live in the community. When one member of a married couple seeks community-based Medicaid, the couple is subject to extremely harsh rules in order to obtain those services. In order to qualify, the married couple can only have a total asset allowance of \$20,850 in combined assets, along with the home and other exempt property, and an income allowance of \$1,159.00 per month combined. Detailed information on the various home care programs, and the planning available to access community-based Medicaid, is available upon request.

C. Transfer of Asset Rules

What if an individual gives assets away in order to qualify for Medicaid? As you might expect, there are rules governing such transfers. This is one of the main areas where the state and Federal laws changed in 2006. When one gives money or property away, that individual and their spouse will be **ineligible for “institutional” Medicaid for a certain number of months**, known as the “**penalty period**.” Exceptions are made for transfers to a spouse or a disabled child and for certain transfers of the home to siblings or caretaker children. The transfer of asset rules **does not currently** apply to Community Based Medicaid, leaving open the possibility of transferring assets and qualifying for Medicaid immediately; however, if the individual later needs “institutional” Medicaid, the prior transfers may cause a penalty period for such Medicaid services.

How far back does Medicaid look to find asset transfers, or what is the “look-back” period? When applying for Medicaid, the Department of Social Services will ask for financial records, bank statements, tax returns, etc. for the past 60 months, and will question transactions within that time frame. A thorough analysis of all transactions within the look-back period must be undertaken prior to filing for Medicaid.

How is the penalty period calculated? The penalty period for non-exempt transfers is calculated by dividing the total value of all assets transferred by the average monthly cost of nursing home care in your area, called the “Monthly Regional Rate”. The State determines this “average” each year for different regions across New York State. See **Appendix A** for a list of Regional Rates.

Example 1:

Mrs. Jones, a widow who lives in the Capital District, transferred her non-exempt home worth \$196,420 to her only child in January, 2008. Mrs. Jones, once reaching the \$14,250 asset limit and in a skilled nursing setting, applies for Medicaid in January, 2012. The resulting penalty is 23 months.

$\$196,420$ (value of transfer made within the look-back period) divided by $\$8,540$ (Northeastern Regional Rate) = 23 month penalty period

Example 2:

Mr. Smith, who is single and lives in New York City, transferred a bank account and savings bonds worth \$383,495 to his 2 nephews in 2006. Mr. Smith, once reaching the \$14,250 asset limit applies for Medicaid in January, 2012. There is NO resulting penalty period.

Why? The transfer of his assets was completed 6 years ago and is now outside the look back period. Had Mr. Smith waited until 2008 to transfer assets, the resulting penalty period would be 35 months.

$\$383,495$ (value of transfer made within look-back period) divided by $\$10,957$ (NYC Regional Rate) = 35 month penalty period.

When does the penalty period begin to run? Under the old Medicaid laws, the penalty period began to run on the first day of the month following the month in which the transfer was made. This rule still applies to transfers completed *prior* to February 8, 2006. This rule dramatically changed under the new Medicaid laws, which took effect on February 8, 2006. Now the penalty period does not **begin** to run until the applicant meets 3 conditions:

- (1) he or she needs skilled nursing care;
- (2) he or she has \$14,250.00 or less of countable assets; and
- (3) he or she applies for Medicaid.

In the above **Example 1**, Mrs. Jones transferred her home in January, 2008. Assuming a 23 month penalty period, under the old rules the penalty period would have started in February 2008 and run through December 31, 2009. However, under the new rules in effect at the time of Mrs. Jones' transfer of assets, the penalty period would not start running until January 2012, the date when Mrs. Jones applies for Medicaid. Now Ms. Jones will not start receiving institutional Medicaid benefits until after the 23 month penalty period expires on November 30, 2013. **Who pays for Mrs. Jones' care for that time period?** Remember, she has already spent her life savings and only has a mere \$14,250.00 left. The Pierro Law Group can help advise on solutions to this question.

The new rules still leave many unanswered questions for the elderly, individuals with disabilities, and their families. The new laws were put in place not to solve the long-term care crisis, but to merely cut the Medicaid budget. Without proper planning, anyone could fall into these "Medicaid Trap" situations. The Pierro Law Group regularly advises clients on Medicaid eligibility, preparation and filing of the Medicaid application, asset protection, advocacy and litigation services for Medicaid denials, spousal claims and estate recoveries. In addition to proactive planning, our attorneys may be able to

help in crisis or last minute situations where families want to protect assets but need to access care immediately.

D. Other Medicaid Rules

How Does Medicaid Treat Jointly Held Assets? If assets are held in an account by a Medicaid applicant and another individual as “joint” owners, 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 to the child. 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**. If both signatures are required to withdraw funds (i.e., some brokerage accounts require all named owners to sign), only ½ of the value will be counted as belonging to the applicant. Each asset must be evaluated to determine ownership and ownership rights prior to filing a Medicaid application.

How Does Medicaid Treat Trusts? If assets are held in a **revocable** trust, they are considered fully available for Medicaid purposes. An individual who establishes an **irrevocable** trust (otherwise known as a “Medicaid Trust”), will protect the assets held by the trust after the expiration of the applicable penalty period imposed as a result of the transfer of property into the trust. Income generated by assets held in an irrevocable trust will be considered available to pay for the cost of long-term care. Decisions regarding the use of a trust as part of a Medicaid plan require careful review of an individual’s circumstances.

What are the Rules for Home Care Benefits? Under current law, **transfers do not count** against an applicant who is seeking only Medicaid benefits under New York’s home care and waiver programs. New York can change this rule at any time, and in fact, the state came close to doing so at the beginning of 2006. If the applicant starts with a home care program and transitions to a skilled nursing facility, past transfers will be considered.

Can Medicaid Recover from a Beneficiary’s Estate? 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 which are exempt during life and other partial transfers, such as deeds with retained life estates.

Until recently, New York State defined “estate” as the “probate” estate only, or those assets passing by **passing by will or by intestacy** (without a will). In 2011 the New York State Legislature amended existing law to expand estate recoveries to include assets which pass outside of the probate estate, but which the Medicaid recipient had an interest in at the time of death. Emergency regulations were issued on September 8, 2011, which included jointly held assets, assets with retained life estates and interests in revocable trusts as assets subject to estate recovery. These proposed regulations expired on December 6, 2011, and the implementation of the new law has been suspended until new regulations are issued. We are closely monitoring this situation and will advise clients once the new regulations are issued.

Can Medicaid Recover from a Community Spouse's Estate? If assets are held by a community spouse, the state may have rights to recover for Medicaid paid on behalf of the applicant spouse from amounts that exceed the Resource Allowance. These rules are evolving, and must be analyzed in each case.

Are There any Exceptions to the Medicaid Eligibility Rules, or what does Medicaid Consider an "Undue Hardship"? New York State is required to establish procedures to determine whether the denial of Medicaid eligibility would pose 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 if:

- (1) the applicant meets the other eligibility requirements;
- (2) the applicant or his or her spouse is unable to get the transferred assets back, despite his or her best efforts; and
- (3) the applicant cannot get appropriate medical care that would endanger his or her health or life if Medicaid did not pay for nursing home care or the penalty period would deprive the applicant of food, clothes, shelter or other necessities of life.

As a practical matter, these hardship exceptions are difficult to prove and not often granted.

VI. PLANNING FOR LONG-TERM CARE

What can be done to plan for long-term care, ensure that a health crisis or chronic illness will not erode 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 of applicant; family situation; and other considerations must be evaluated in order to make the right choices. Please see our comprehensive **Long-Term Care Planning Questionnaire** to assist in gathering the information needed.

A. Use of Trusts

If long-term care insurance is not an option, and personal income and resources are not sufficient to pay the future costs of Long-Term Care, the most 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 a spouse, children or other beneficiaries. When properly drafted, the trust will provide **asset protection** along with significant **tax benefits**, including avoidance of gift taxes, elimination of capital gains taxes, and keep real property tax exemptions (NY STAR). In addition, trust assets can **avoid probate**.

The trust allows the Trustee to access the principal of the trust during the Grantor's lifetime for the benefit of the Grantor's children or other beneficiaries, although 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 "reappointing" 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.

A properly drafted “income-only” trust which gives a Trustee no discretion to distribute principal to the Grantor-Beneficiary, or to his or her spouse, is a valuable long-term care planning tool. Therefore, a senior doing estate planning may keep the income from an irrevocable, “income only” trust for himself or herself, with the remainder distributable to specific beneficiaries, and qualify for Medicaid (once the applicable “penalty period” for nursing home benefits has expired) without the assets in the trust being considered by the Department of Social Services as available to pay for the cost of long-term care.

If use of a trust is not desired, it is still possible to make “outright” gifts of property, wait until the expiration of the look-back or penalty period (not applicable for home care), and then apply for Medicaid, or use other planning techniques.

If the Grantor or the Grantor’s spouse was a **Veteran**, the senior may wish to alter the income benefit of the trust so that it would exempt both trust income and principal if the Grantor applies for Veteran’s Aid and Attendance benefits. The Pierro Law Group is an approved Veteran’s Benefits Counselor, and can help you determine if Veteran’s benefits are available and tailor a plan accordingly.

B. Protecting the Home

Before the new estate recovery law was passed in 2011, a deed to children or others, with a retained life estate for the Grantor, would protect the property and the right to Medicaid, once the applicable “penalty period” had expired, along with preserving the STAR exemption and other tax benefits. However, the new estate recovery law and proposed regulations will expand the definition of estate recovery to include deeds with retained life estates, meaning that if a Medicaid recipient dies owning a retained life estate interest in a house (no matter when it was created), then Medicaid can recover up to the amount of the life estate interest in the house. Although the estate recovery law is not currently in effect while we are awaiting final regulations, we are not currently recommending the use of a deed with a retained life estate interest. Rather, we are recommending that individuals transfer their residence to an Irrevocable Trust, and retain the right to use and occupancy of the residence through the trust document. This area of the law is in flux and we will continue to keep clients updated with the latest information on the new estate recovery law as it unfolds in 2012.

C. Crisis Planning for Nursing Home Care

Even if skilled nursing care is imminent, **planning opportunities still exist** to protect a substantial portion of the applicant’s assets (generally approximating half of on-exempt assets). Proper use of the Medicaid transfer rules allows individuals to provide security for themselves and a legacy to their families, while ensuring that they will receive quality long-term care. The Pierro Law Group can advise families on the use of creative planning, such as **Promissory Notes** and **Private Annuities**, as vehicles which permit last minute gifts and transfers. Proactive planning is always a *better solution*, but we understand that families do not always realize the need to plan until a crisis presents itself.

D. Crisis Planning for Home Care

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. Medicaid benefits for home care are a well-kept secret, and the Pierro Law

Group prides itself on being proactive advocates for our clients who wish to stay in their own home. Caution must be exercised, however, because while home health care may be appropriate initially, the individual's condition may deteriorate to the point where he or she cannot be safely maintained at home and skilled nursing facility placement may be required. If this higher level of care is needed, a new application is required, and the Medicaid transfer rules - including the 5 year lookback - will be imposed. Thus, when planning for *home care*, the possible need for institutional services must be evaluated before transfers are made.

Moving in with a relative or family member may also be an option for a senior. There are several programs available through Medicaid to help pay for personal care aides and home health aides to supplement care provided by family. In addition, a senior can put in place a **Caregiver Agreement** and/or **Personal Service Contract** to make a transfer to a family member as compensation for their agreement to provide home care services.

E. Geriatric Care Management

In the past, families facing a senior crisis could count on help from a variety of sources, including hospital social workers, discharge planning nurses or home care assistants. These positions have been virtually eliminated, however, due to cost-cutting measures in the health care system. Comprehensive planning assistance for families and follow-through services for newly discharged older persons have all but disappeared from the hospital scene.

This is where a Geriatric Care Manager (GCM) becomes a vital cog in the planning wheel. In consort with the attorney and the physician, the professional Geriatric Care Manager conducts a comprehensive clinical assessment of the long-term care needs. This includes consideration of all financial and other resources available to sustain the individual at the highest possible level of independence. After a thorough assessment, a plan is developed and care management is then coordinated by the GCM.

We have found that our clients benefit from the GCM's varied contacts and vast knowledge of the local health care system, and we have integrated GCM services into Long-Term Care Planning so the GCM and attorney work as a team to develop and follow through on a long-term care plan to ensure success.

VII. WHAT THE FUTURE HOLDS

The crisis in health care and long-term care will shape public policy for years to come. It has become clear that individuals need to make their own plans for long-term care, such as nursing home and home health care. Governments face continuing pressure to limit expenditures on existing programs, including Medicare and Medicaid. Within the past year, reform of Medicare, Social Security and Medicaid has risen to the top of the government's agenda in Washington, Albany and every county in the state. **It is thus imperative that seniors, those approaching retirement age, and the families of those needing long-term care take advantage of the planning opportunities that exist today.** Everyone's situation is unique, and it is impossible to discuss all of the planning opportunities in this outline.

As with any planning, a good way to begin is to seek competent advice from a qualified professional. At the Pierro Law Group, we are dedicated to helping you find solutions to your long-term care concerns. Please call us at 518-459-2100, 212-661-2480, or toll-free at **1-866-951-PLAN** for a consultation, or visit us on the web at www.pierrolaw.com.

Appendix A: NYS Medicaid Regional Rates

Region	Counties	2012 Monthly Rate
New York City	Brox, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island)	\$10,957
Long Island	Nassau, Suffolk	\$11,849
Northern Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	\$10,335
Western (Buffalo)	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	\$8,337
Northeastern (Albany)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	\$8,540
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	\$9,363
Central (Syracuse/ Utica)	Broom, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	\$8,015

Use the region in which the individual resides or in which the facility is located. For out of state facilities, use the region closest to the location of the facility.

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The information in this guide is provided for informational purposes only. While every effort has been made to ensure accuracy, it cannot be relied upon as legal advice and laws can change at any time. Applicability of the legal principles discussed may differ substantially in individual situations, and you should always consult with your legal advisor.

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