LONG-TERM CARE PLANNING 2009

Including changes made under the Deficit Reduction Act of 2005, effective in New York August 1, 2006.

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I. INTRODUCTION

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 two (2) out of every five (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 the cost? Without proper planning, the lack of available services and the staggering price-tag may leave you with few alternatives.

In New York State, the annual cost of nursing home care ranges from approximately **$90,000.00** to **over $180,000.00**, 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 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 primary concern for all age groups across our state and the nation.

The causes of our long-term care crisis are many: increasing costs; a growing population of seniors (baby boomers start turning 65 in 2010); 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 we must all "rethink" the way we plan for the future, and take into consideration the very real possibility that long-term care may become a part of our lives. Recent federal legislation changed Medicaid eligibility rules to make it more difficult to qualify, and States including New York are considering more cuts to reign in spending on Medicaid. In 2006, New York's Medicaid budget was $45 billion out of a total state budget of $116 billion.

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

II. MEDICARE

A. Hospital and Post-Hospital Skilled Care

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 is limited to: qualified medical expenses (80% of an approved amount for doctors, surgical services, etc); hospitalization for 90 days per benefit period with a deductible of $1,068.00 (total) for the first 60 days and a co-payment of $267.00 *per day* for the remaining 30 days, and an additional one-time, lifetime benefit of 60 days, with a co-payment of $534.00 *per day* (for a maximum of 150 days); and post- hospital *skilled* nursing home care with payment in full for 20 days and a co-payment of $133.50 *per day* for 80 days (maximum of 100 days).

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 physical therapists or registered nurses, as opposed to "custodial care", which provides basic personal care and other maintenance level services. Home health care may be available 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, and all others are considered "custodial" patients. With the Medicare Trust Fund currently projected to fail in approximately 2018, gaps in coverage are widening rapidly.

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 your 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 three months before and ends three months after the month of 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 51 different Prescription Drug Plans offered by 24 different companies, and there are 40 different Medicare Advantage Plans.

The monthly premium for the Medicare Part D plan varies by company, and the basic plan costs approximately $25 per month, while the more comprehensive plans costs between $75 and $140 per month. The basic plan deductible and co-payments are as follows:

COVERED COSTS	MEMBER PAYS	PLAN PAYS
$0 - $295	Up to 100%	$0
$296- $2,700	25% -45%	75% - 55%
$2,701 - $4,350	100% + monthly premiun	$0
Above $4,350	5% co-payment	95% payment

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. Please contact us for more detailed information on the new Medicare prescription drug benefit, or to schedule an appointment for a consultation.

III. PAYING YOUR OWN LONG-TERM CARE EXPENSES

A. Self – Insuring

"Self-insuring," or paying your own way, may be an option. However, you can expect to pay approximately **$90,000.00** to **$180,000.00** per year for nursing home care, and more for better facilities. In downstate areas, the cost of care rises dramatically. Home care can be even more expensive, with 24/7 care costing in excess of $180,000 per year. If a person has sufficient fixed income, and income generating assets, which together produce total income of $150,000 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 a thorough fact-finding 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, and provide tax savings 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 have an IRA, 401(k), tax deferred annuity or other asset that you do not intend to rely upon for retirement income, you may target that asset to pay long-term care expenses should it become necessary, and purchase life insurance in an amount sufficient to replace the asset should it be depleted by long-term care costs. In this way, a securely invested 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 estate taxes if certain conditions are met. Should you never need long-term care, the family would receive both the targeted asset, and the life insurance proceeds, enhancing the legacy that you leave to your heirs.

IV. PRIVATE LONG-TERM CARE INSURANCE

Most Americans will not be able to self-insure for Long-Term Care. 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, such a policy should be integrated into your estate plan to provide protection without the need for transferring assets.

Long-term care (LTC) insurance has been around since before 1974, but in 1997 it gained widespread notoriety 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.

Benefits to look for in an LTC insurance policy include: nursing home <u>and</u> home care coverage; sufficient daily payouts ($225.00/day is a good start); elimination periods (the number

of days you must be in the Nursing Home 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); inflation protection; 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.

New York State has also adopted a program which integrates long-term care insurance with Medicaid. Insurance companies 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 policies are: a three-year benefit period for nursing home care (six years for home care at a 50% benefit rate); minimum daily benefits of $208.00/day for nursing homes and $104.00/day for home care (annually adjusted for inflation); a 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 three (or up to six, if combined with home care) years of care which could be anywhere in the country. At the expiration of the applicable term, the individual will become automatically qualified for Medicaid but only in New York State. 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. 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 $50,000.00 for individuals and $75,000.00 for married couples may be considered "high" for the purpose of this analysis) 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. It is important to analyze each individual's situation to determine the proper fit for a partnership policy, as Medicaid rules are complex, and should be fully understood prior to buying.

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, and specific features etc. calls for independent advice from a qualified professional or attorney, a service which we are pleased to provide. Please contact us for our brochure "Questions and Answers on Long-Term Care Insurance," or to schedule an appointment for a consultation.

V. MEDICAID

Unlike Medicare, Medicaid is a government program which pays medical costs and long-term care costs. Medicaid is designed as a *payor of last resort*, however, 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. In fact, on February 8, 2006, the federal Deficit Reduction Act was signed, significantly changing the rules governing Medicaid eligibility. New York State adopted the rules effective August 1, 2006.

A. Income & Resource Limits

An individual applying for Medicaid **in a nursing home** can have only $13,800.00 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 $750,000.00, 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 $109,560.00) 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 $2,739.00 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 for 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 program, the Consumer Directed Personal Assistance Program

(CDPAP), the Nursing Home Transition and Diversion Waiver (NHTD), 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 $13,800.00 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 $767.00 per month. Income over the $767.00 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 $20,100.00 in combined assets, along with the home and other exempt property, and an income allowance of $1,117.00 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? As you might expect, there are rules governing such transfers. This is one of the main areas where the rules changed on February 8, 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.

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How far back does Medicaid look to find asset transfers, or what is the "look-back" period?

Up until January 31, 2009, when applying for Medicaid, the Department of Social Services would ask for financial records, bank statements, tax returns, etc. for the past 36 months, or 60 months for transfers to trusts, and would question transactions within that time frame. Beginning on February 1, 2009, the "look-back" period for non-trust transfers increases by one month increments, until February 1, 2011 when the "look-back" period for non-trust transfers will also be 60 months. An easy way to remember this in 2009 - keep all bank records from February 2006 forward.

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 nonexempt transfers 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 different regions across New York State.

For example, if a Capital District resident transferred $77,660.00 and applied for Medicaid in 2008, the penalty period for that transfer would be 10 months ($77,660.00 divided by the average monthly cost of $7,766.00 in the Northeast region). Average costs in other regions are $10,852.00 in the Long Island area; $9,439.00 in the Northern Metropolitan area; $7,418.00 in the Western (Buffalo) area; $6,938.00 in the New York City region; $8,720.00 in the Rochester area and $8,720.00 in the Central New York (Syracuse) area.

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 three conditions: (1) he or she needs nursing home care; (2) he or she has $13,800.00 or less in assets; and (3) he or she applies for Medicaid.

For example, an individual from the Capital Region makes a nonexempt transfer of $31,064.00 in April of 2007. On January 1, 2009, the individual is living in a nursing home, has $13,800.00 in assets, and files a Medicaid application. At that time, a four month penalty period is imposed ($31,064.00 divided by the regional rate of $7,766.00 = 4.0 months). The individual now has to wait 4 months before he or she is eligible for Medicaid, **even though** he or she no longer has the assets to pay for the nursing home expenses. Without proper planning, anyone could fall into this situation. Our firm provides services that include advice on Medicaid eligibility, preparation and filing of the Medicaid application, and advocacy and litigation services for Medicaid denials, spousal claims and estate recoveries.

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 available for Medicaid purposes. An individual who establishes an irrevocable, income-only 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 program. New York can change this rule at any time, and in fact, the state came close to doing so at the beginning of 2006.

- **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 held in trust, and other partial transfers, such as deeds with retained life estates. The New York State Legislature, however, currently defines "estate" as the "probate" estate only, or those assets **passing by will or by intestacy**. Any non-probate assets, such as trusts (Medicaid trusts or other types of trusts), joint accounts, and annuities, currently escape recovery.

- **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. 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 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 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 are 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; family situation; and other considerations must be evaluated in order to make the right choices. (**A comprehensive questionnaire which we have prepared to assist our clients in gathering the information needed is available upon request**.)

If long-term care insurance is not an option, and personal income and resources are not sufficient, **one 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 spouses, children or other beneficiaries. When properly drafted, the trust will provide **asset protection**, with significant **tax benefits** as well, including avoidance of gift taxes, and elimination of capital gains taxes.

In addition, trust assets will **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 that gives a Trustee no discretion to distribute principal to the Grantor-Beneficiary, or to his or her spouse, is still a viable 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" 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 60 month look-back period, and then apply for Medicaid, or use other planning techniques.

If the 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, once the applicable "penalty period" has expired, along with preserving the STAR exemption and other tax benefits. However, because the penalty period begins only after the applicant is otherwise eligible for Medicaid and files a Medicaid application, the applicant must have outside funding available for his or her care needs until the penalty period expires. Consideration must also be given to the fact that if the property is sold and the grantor is in the nursing home, a portion of the sale proceeds equivalent to the value of the life estate (using Medicaid tables that give a higher value than and IRS life expectancy table) will have to be "turned over" to the nursing home.

Even if nursing home care is imminent, planning opportunities exist to protect a substantial portion of the applicant's 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 long-term care. By gifting the appropriate amount of assets, and structuring other asset transfers as an exchange for a secured interest, much like a loan, through the use of a promissory note, or a private annuity to pay for expenses during the period of ineligibility which is created by the gifts, individuals can channel assets to a trust, or to children and grandchildren, while receiving sufficient income through the note or annuity payments to pay for their care 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, because home health care may be appropriate initially, but if the individual's condition deteriorates to the point where he or she cannot be safely maintained at home, nursing home placement may be required. If this higher level of care is needed, a new application is required, and the Medicaid transfer rules 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. Also it maybe advisable for a senior to 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 homecare services.

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 vast upheavals 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 the value of a Geriatric Care Manager (GCM) becomes apparent. In consort with the attorney and the physician, the professional Geriatric Care Manager conducts a highly skilled clinical assessment of the long-term care needs of an older adult. This includes consideration of all financial and other resources available to sustain an older person at the highest possible level of independence. After a thorough assessment, care management is coordinated by the GCM.

When available we have found that our clients immediately benefit from the broad contacts with the local health care system, and our ability to develop a plan to meet long-term needs provided through the combined services of an experienced GCM and an attorney. This attorney/GCM collaboration plays out during family conferences, and in follow up activities.

VI. 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 long-term care, such as nursing home and home health care, will not be a part of any new universal health insurance program. The Deficit Reduction Act of 2005 is just the beginning; and there will be 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 **Pierro Law Group, LLC**, we are dedicated to helping you find solutions to your long-term care concerns. Please call (518) 459-2100 or 1-800-951-PLAN for a consultation, or visit us on the web at www.pierrolaw.com.

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