Planning for Long-Term Care: Myths and Realities

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Statistics and Trends

- As of 2014, there were 46.2 million individuals in the United States age 65 or older
- Represents 14.5% of the population
- Increase of 10 million individuals (a 28% increase overall) since 2004

Statistics and Trends

- Percentage of the population of 65+ expected to grow from 14.5% to 21.7% by 2040
- By 2060, it is anticipated that there will be 98 million individuals in the U.S. age 65 or older, more than 2X the current figure

Long-Term Care: What is it?

Poll:

Which best defines long-term care services?

A. Rehabilitative services in a nursing home

B. Help with personal care, such as eating, bathing and dressing

C. Hospice Care

Long-Term Care: What is it?

- Long-term care is defined as follows: services and supports necessary to meet health or personal care needs over an extended period of time.
- Long-term care is required if an individual has a chronic illness or disability, such that assistance is needed with activities of daily living (“ADLs”) as a result of a physical disability and/or cognitive impairment.

Long-Term Care: What is it?

- Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, or ADLs.
- ADLs include eating, bathing, dressing, toileting, transferring, etc.

Long-Term Care: Need

- Estimated that 70% of individuals over age 65 will require at least some type of long-term care services during their lifetime.
- Less than half of that group requiring long-term care services will actually require care provided in a skilled nursing facility.

Long-Term Care: Why Plan for it?

- Statistical impact on the population
- Cost of care
- Impact on estate and legacy
- Choice and control of health care decisions
- Non-financial impact on family

Long-Term Care: Legal Planning

- Autonomy
- Privacy
- Efficiency
- Opportunity to make clear decisions in advance
- Control
- Flexibility
- Peace of mind

YOU make the choices and dictate the terms

Long-Term Care: Legal Planning

Advance Directives

- Health Care Proxy
- Living Will
- Organ Donation Registry Form
- DNR
- MOLST (Medical Orders for Life Sustaining Treatment)
- Power of Attorney

Long-Term Care: Legal Planning

MYTH:

If I plan in advance, I will be able to personally control all decisions, including legal decisions, impacted by my need for long-term care at some point in the future.

Long-Term Care: Legal Planning

- It is advisable for anyone over age 18 to have a Health Care Proxy, Living Will, and Power of Attorney
- Anyone with terminal illness should consider MOLST and/or DNR
- Anyone with strong feelings on organ donation should register

Long-Term Care: Legal Planning

Power of Attorney

- New York Statutory Short Form
- See www.nysba.org/poadown/
- Changes to the General Obligations Law impacting Powers of Attorney in 2009 and 2010
- Who to appoint?
- What does it say?
- Opportunity to customize

Long-Term Care: Paying for it

A recent study polled Americans age 40 and older asking, "how much do you think you will rely on each of the following sources to support any care you need as you get older?"

- Medicare – 38%
- Social Security – 35%
- Personal savings or investments – 32%
- Pension – 22%
- Medicaid – 20%
- Family member at no cost – 18%
- Long-term care insurance – 17%

Long-Term Care: Paying for it

MYTH:

Medicare will pay for the majority of my long-term care needs.

Long-Term Care: Paying for it

Medicare: Federally funded program under the Social Security Act to provide health insurance to persons over age 65, persons under 65 with certain disabilities, and persons with end stage rental disease

Medicare Coverage:

- Part A – Hospital insurance, including limited skilled nursing home coverage
- Part B – Medical insurance
- Part C – Medicare advantage program
- Part D – Prescription drug coverage

Limits on Medicare for Long-Term Care

- Medicare will pay if a person:
  - requires daily skilled care that can only be provided on an in-patient basis
  - enters a facility following a 3 day hospitalization
  - is admitted to a certified facility within 30 days of leaving the hospital
  - is receiving treatment for the same condition as what he/she was hospitalized for in the first place
  - is certified by a doctor that he/she is in need of the services on a daily basis

Limits on Medicare for Long-Term Care

- Days 1-20 are fully covered by Medicare
- Days 21-100 require a co-pay of $164.50 per day for each benefit period (2017 rates)
- No guarantee for 100 days of coverage
- Is there supplemental health insurance coverage, or Medigap insurance, to cover the co-pay?

Long-Term Care: Paying for it

- After expiration of Medicare coverage, patient can private pay through the use of savings and other financial resources, income, Veteran's benefits, long-term care insurance, etc.
- Should resources be insufficient to pay for long-term care, Medicaid is the government program designed as the "payer of last resort."

Long-Term Care: Paying for it

Long-term care insurance
GOALS:

- Paying for long-term care services
- Providing opportunity to dictate choice of care:
  - Home care
  - Assisted living
  - Choice of skilled nursing care
- Preserve legacy

Medicaid Overview

- At its core, Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities
- It is a joint program of the federal government and the states
- It is administered by the states according to federal requirements, and is funded jointly by the states and federal government

Medicaid Overview

- Medicaid provides the primary source for long-term care services in NYS
- Medicaid can provide benefits for care in the community and in skilled nursing facilities
- Eligibility rules for these programs have significant differences

Medicaid in New York State in 2017

Go to:
http://www.health.ny.gov/health_care/medicaid/publications/

- Administrative Directives (ADMs)
- General Information System Messages (GIS)
- Informational Letters (INF)

SEE GIS 16 MA/018: 2017 Medicaid Levels and Other Updates

Medicaid in New York State in 2017

Single Individual

- Resource allowance = $14,850
  - Chronic Care or Home and Community Based Medicaid
- Monthly income
  - Chronic Care Medicaid - $50/month
  - Home and Community Based Medicaid - $825/month + $20/month disregard

Medicaid in New York State in 2017

Married Couple – "Medically-needy Spouse" (or "A/R Spouse") and "Community Spouse"

- Resource allowance
  - **Chronic Care Medicaid**
    - A/R Spouse - $14,850
    - Community Spouse - $74,820 - $120,900*
      - *Spousal share = ½ of married couple's resources up to $120,900

Medicaid in New York State in 2017

Married Couple – "Medically-needy Spouse" (or "A/R Spouse") and "Community Spouse"

- Resource allowance
  - **Home and Community Based Medicaid**
    - Normally, couple can only keep $21,750 in resources
    - BUT, SEE Spousal Impoverishment variations, including certain waivers, MLTC, and Immediate Need – LATER

Medicaid in New York State in 2017

Married Couple (cont'd)

- Monthly Income
  - **Chronic Care Medicaid**
    - A/R Spouse - $50/month
    - Community Spouse - $3,022.50/month (MMMNA) + portion in excess*
      - *Typically contribution will be 25% of excess
    - SEE Chronic Care Spousal Budgeting - LATER

Medicaid in New York State in 2017

Married Couple (cont'd)

- Monthly Income
  - **Home and Community Based Medicaid**
    - Normally, couple can only keep $1,209/month + $20/month disregard
    - BUT, SEE Spousal Budgeting variations – LATER

Medicaid in New York State in 2017

Married Couple – Both Spouses are "Medically-needy"(or "A/Rs")

- **Chronic Care Medicaid**
  - Resource allowance
    - Each Spouse - $14,850, so $29,700
  - Monthly income
    - Each Spouse - $50/month, so $100

Chronic Care Medicaid
First Step: Medical Eligibility

- Medicaid only pays for nursing home care that is medically necessary

- PRI (Patient Review Instrument)/SCREEN is standardized test administered by a Registered Nurse that scores an applicant to determine medical need for nursing home care

Chronic Care Medicaid
Second Step: Income Eligibility

- There is a difference between "eligibility" and "post-eligibility Medicaid budgeting"
- During the eligibility review, it is critical that an Applicant's income (as that term is defined by Medicaid) does not exceed his/her medical expenses (cost of care)
  - Look at the Applicant's gross income
  - Deduct "permissible disregards, " such as health insurance costs
  - If the cost of care exceeds income, Applicant is income eligible

Chronic Care Medicaid
Third Step: Resource Eligibility - Single Applicant

- Assets: $14,850
- Assets in excess of $14,850 will result in a denial of benefits until threshold is reached
  - Applicant may "spend-down" excess resources, implement a Gift/Note plan, or engage in some other strategic planning
- Exempt assets: pre-paid irrevocable burial fund; personal property, some limited life insurance (face value not exceeding $1,500)

Chronic Care Medicaid
Third Step: Resource Eligibility - Married Applicant

- Assets: $14,850 for Applicant, with Community Spouse Resource Allowance (CSRA) $74,820 = $89,670 total
  - In limited situations, Community Spouse may keep more (1/2 up to $120,900)
- If Community Spouse is over the resource threshold: consider 5 year plan, spousal refusal, Gift/Note plan, spend-down, or other planning options
- Exempt assets for Community Spouse = Home (up to $840,000 in equity); automobile; personal property; pre-paid irrevocable burial fund; some limited life insurance

Chronic Care Medicaid
Fourth Step: Transfer of Asset Review

MYTH:

I can give away $14,000 per year without impacting my eligibility for Medicaid.

Chronic Care Medicaid
Fourth Step: Transfer of Asset Review

- Eligibility for Medicaid benefits for nursing home care is also dependent upon a review of financial records for a specified period of time (60 months)
- Transfers (gifts or sales at less than fair market value) by A/R or spouse will result in a period of ineligibility during which the A/R cannot receive Medicaid benefits

Chronic Care Medicaid
Fourth Step: Transfer of Asset Review

- When the A/R has resources below the threshold ($14,850 or $89,670), the Local County Department of Social Services then engages in the "look-back" and may impose a "penalty period" of ineligibility if it discovers transfers or gifts within the look-back period

Chronic Care Medicaid
Fourth Step: Penalty Period

- If the LCDSS finds that transfers were made for less than fair market value (gifts or transfers), a penalty period will be imposed
- Penalty period is the period of time during which one is determined ineligible for Medicaid benefits
- Calculated by dividing the value of the gift/transfer by the regional rate of care

Chronic Care Medicaid
Fourth Step: Penalty Period

- SEE GIS 16 MA/016
  - Rates – Use the rate in the region *where facility is located*
    - Central - $9,511
    - **Northeastern - $10,242**
    - Northern Metro - $12,198
    - NYC - $12,157
    - Long Island - $12,811
    - Western - $10,078
    - Rochester – $11,237

Chronic Care Medicaid
Fourth Step: Penalty Period

- Chronic Care Medicaid ONLY – Remember, NO penalty period for Home and Community Based Medicaid
- Planning point – For Home and Community Based Medicaid clients, consider the impact of transfers to facilitate Medicaid eligibility should Chronic Care Medicaid be needed during the next five years

Chronic Care Medicaid
Fourth Step: Example for Calculating the Penalty Period

- Applicant has gifted $110,000 during the last 5 years
- Penalty period determined as follows:

$$\frac{\$110{,}000}{10{,}242}$$

- Penalty period = 10.74 months

Chronic Care Medicaid
Fourth Step: Example for Calculating the Penalty Period

- Penalty period begins to run on 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.

Chronic Care Medicaid
Fourth Step: Implications

- If an Applicant satisfies all of the requirements, LCDSS will deny Medicaid benefits as a result of the transfer and impose the applicable penalty period.
- Applicant now has $14,850 (or $89,670 for a married couple), is in a nursing home, and has to wait out the penalty period.

Illustration

- A/R is deemed medically-needy (Step One)
- A/R's cost of care exceeds Applicant's income (Step Two)
- A/R and Spouse are under resource level ($89,670 with exempt assets) (Step Three)
- Penalty Period of 10.74 months imposed (Step Four)
- A/R enters nursing home February 1 and applies for Medicaid asking to start March 1
- A/R doesn't have Medicaid until January 1 of following year (with a partial month penalty imposed for that month of January)
- During that time, A/R and Spouse must private pay

Chronic Care Medicaid Eligibility Secured: Next Steps

- These determinations are critical for planning prior to implementation
- Budgeting computed for when Medicaid starts paying (in above example, at end of penalty period)

Chronic Care Medicaid Income Budgeting: Single Recipient

- For a single person, use countable Medicaid income, deduct $50, and arrive at "spend-down" (income contribution required to be paid toward cost of care)

Chronic Care Medicaid Income Budgeting: Married Recipient

- Community Spouse ("CS") is permitted to retain $3,022.50 of income per month – this is the Minimum Monthly Maintenance Needs Allowance (MMMNA)
  - Health insurance costs are permitted disregards
- If CS has income of his/her own that exceeds $3,022.50 he/she will be asked to contribute 25% of excess toward care of A/R

Chronic Care Medicaid Income Budgeting: Married Couple

MYTH:

The Medicaid required income contribution toward the cost of care will be the same regardless of which spouse needs care.

Chronic Care Medicaid Income Budgeting: CS Excess Income

- Example: A/R (Wife) has income totaling $1,500. CS (Husband) has income totaling $3,775

$1,500 Wife's Income	$3,775 Husband's Income
($50)	($3,022.50)
$1,450 Wife's Contribution to Care	$752.50 Husband's Excess Income

- Husband will be asked to contribute 25% of excess, or 188.13 per month
- Total family contribution = $1,638.13/month

Chronic Care Medicaid Income Budgeting: CS Under Threshold

- In situations where the CS does not have sufficient income to bring her up to the $3,022.50 level
- Example: Husband (Applicant) has $3,775 of income; Wife (CS) has $1,500
  - Wife is allowed to keep up to $3,022.50; her $1,500 is 1,522.50 under the threshold
  - Wife is deemed $1,522.50 of Husband's income
  - Husband contributes $2,202.50 to the cost of his care ($3,775 less $1,522.50 less $50)

Medicaid Extended Coverage for Partnership Policy Owners

- Assets:
  - For a partnership policy owner with a Total Asset Protection ("TAP") policy, A/R retains unlimited assets
  - For a partnership policy owner with a Dollar-for-Dollar ("DFD") policy, A/R retains the then-prevailing asset level (i.e., $14,850 and/or $74,820) PLUS the dollar amount paid by the partnership policy in benefits

Medicaid Extended Coverage for Partnership Policy Owners

- Income:
  - Chronic Care Medicaid: same as traditional Medicaid ($50 for A/R and $3,022.50 for the CS)
  - Home and Community Based Medicaid
    - Single applicant may keep $1,490 per month (up from typical $825)
    - Married applicant may keep $3,022.50 per month (up from typical $1,209)

Spousal Budgeting Issues

- Home and Community Based Medicaid Case
  - Spousal Impoverishment Option
    - One spouse is MLTC or nursing home, or seeking "immediate need" Medicaid, and other is CS not on or seeking Medicaid
    - Assets – Instead of $21,750 for a couple
      - Spouse may keep greater of $74,820 or ½ up to $120,900
      - MLTC spouse may have $14,850 assets – has 30 days after application approved to rearrange assets per these limits

Spousal Budgeting Issues

- Home and Community Based Medicaid Case
  - Spousal Impoverishment Option
    - Income Budgeting – Basic Rules
      - Normally, couple can keep $1,229/month combined income – excess is spend-down
      - With SI budgeting, couple can keep up to:
        - $3,022.50/mo – Community Spouse Monthly Income Allowance for CS
        - $384.00/mo – Personal Needs Allowance for A/R
        - $3,406.50/mo = Total combined income PLUS $668.00/mo. Family Member Allowance (if applicable)

Spousal Budgeting Issues

- Home and Community Based Medicaid Case
  - If Spousal Impoverishment does not help the client, Applicant may apply as a single person
  - May be the case if the Community Spouse has income higher than the Community Spouse Monthly Income Allowance
  - GIS 14 MA/025 gives choice of using Spousal Impoverishment or, if not favorable, to be budgeted as a single person without spouse's income being counted
  - A/R is then budgeted as single, using SSI-related Home and Community Based budgeting. Spend-down of net income in excess of $825/month.
    - Consider use of a pooled trust for excess income.

Special Medicaid Rules

MYTH:

My annuities and IRAs are treated the same as my other assets, such as bank accounts, stocks, etc., by Medicaid.

Special Medicaid Rules

Treatment of Annuities

- See 06 OMM/ADM-5
- Requires A/R to disclose a description of any interest the A/R or spouse has in an annuity, regardless of whether it is irrevocable or treated as an asset
- A/R purchases an annuity after 2/8/2006, NYS must be named as remainder beneficiary in first position or purchase will be deemed a transfer of assets
  - If Community Spouse or disabled child, NYS must be named in second position

Special Medicaid Rules

Treatment of Annuities

- If annuity is purchased by or on behalf of A/R, purchase will be treated as transfer of assets for less than fair market value unless:
  - It is an annuity described in subsection (b) or (q) of Section 408 of the IRC
  - It is purchased with the proceeds from an account described in subsection (a), (c), (p) of Section 408 of the Code; a simplified employee pension (within the meaning of Section 408(k) of the Code); or a Roth IRA described in 408A of the Code; or

Special Medicaid Rules

Treatment of Annuities

- The Annuity is:
  - Irrevocable and non-assignable;
  - Is actuarially sound; and
  - Provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made
- Applies to transactions on or after 2/8/2006
  - Transactions include: any action to change the course of payment or that changes the treatment of the income or principal; additions of principal; elective withdrawals; requests to change the distribution of the annuity, elections to annuitize the contract, etc.

Special Medicaid Rules

Treatment of Annuities

- Fair Hearing#7259544N, Erie Co., June 7, 2016
  - A/R purchased an annuity on June 3, 2011 for $80K with irrevocable monthly payments of $584.39
  - Agency said to be actuarially sound, payment should have been $738.28/month
  - $153.89 (difference between $738.28 and $584.39) x 12 = $1,846.68/year x 9.03 life expectancy for total transfer of $16,675.52
  - Agency decision upheld.

Special Medicaid Rules

Treatment of IRAs

- IRAs – considered an available asset unless in “pay-out” status
- Value is the amount that may be withdrawn
- If there is a penalty for early withdrawal, the value is the amount available after the penalty
- If in pay-out status, the distributions are considered as income and the full value of the account will not be countable as a resource
- No deduction for ordinary income taxes due

Special Medicaid Rules

Treatment of IRAs

- Applicant is required to maximize the pay-out schedule
  - IRS vs. SSA
  - Disparity in application across NYS
- Periodic retirement benefits are payments made to an individual at some regular interval (i.e., monthly, quarterly, annually)

Special Medicaid Rules

Treatment of IRAs

- Non-periodic distributions = conversion of an exempt resource and not countable as income
- Periodic distributions must be made from all accounts
- Community Spouse – accounts in pay-out status also a disregarded resource, but distributions are income subject to income limitations
  - GIS 06MA/004 – if CS is not receiving periodic payments from an available retirement fund, then it is considered a countable resource

Special Medicaid Rules

Treatment of IRAs

- Fair Hearing#7225195R, Oneida Co., June 3, 2016
  - Facts: Community Spouse puts IRA in pay-out but did not maximize; irregular withdrawals made.
  - Decision: CS made non-periodic withdrawals from IRA, considered conversion of a resource and not countable income. Lump sum withdrawal does not satisfy requirement for exemption. A/R must maximize benefits as a condition of eligibility. IRA countable if CS is not receiving periodic payments.

Special Medicaid Rules

Treatment of Irrevocable Income-Only Trusts

- When were assets transferred?
- Treatment of income?
- Post-eligibility planning with Trust-owned assets
  - Financial and Tax Implications

Special Medicaid Rules

Treatment of Irrevocable Income-Only Trusts

- Benefits beyond asset protection in Medicaid context
  - Retention of income for use and taxation purposes
  - Life use and occupancy of real property
  - Retained tax exemptions
  - Some aspects of retained control (with proper drafting)
    - Choice of Trustee
    - Choice of Beneficiaries
  - Step-up in cost basis at death
  - Probate avoidance

Special Medicaid Rules

MYTH:

If my mother gives me her money, and I spend it on things for her, there will be no impact on her Medicaid eligibility.

Special Medicaid Rules

Return of Assets

- Transferred assets considered returned if the person to whom they were transferred uses them to:
  - Pay for skilled nursing facility services; or
  - Provides the A/R with an equivalent amount of cash or other liquid assets

Special Medicaid Rules

Return of Assets

- See Matter of Weiss v. Suffolk Cty Dep't of Soc. Svcs., et al. 121 A.D.3d 703, App. Div. 2d Dep't, Oct. 1, 2014.
  - Department of Health determination is supported by substantial evidence
  - Returned assets were not used to pay for applicant's skilled nursing facility care per the Dept. of Health ADM
  - Plain language of the ADM defines return of assets ONLY as return to applicant of "an equivalent amount of cash or other liquid assets" or use by transferee to pay the applicant's "nursing facility services."

Planning Options

Advance Planning

- Legal Planning
  - Use of Trusts
  - Advance Directives
- Financial Planning
  - Consideration of investments
    - Qualified vs. Non-qualified
    - Annuities
- Insurance Planning
  - Impact of life insurance and long-term care insurance

Planning Options

- The 5 Year Plan
  - Accounting for resources, income, and expenses
  - Retain enough to pay or calculated "fall-short"
  - Married couple – planning underway for both spouses
  - For longer plans, avoids the technicalities of Gift/Note plan

Planning Options

- The 5 Year Plan (continued)
  - Consider
    - Income is high
    - Cost of care is low
    - Assets are sizeable
    - Issues in past transactional history
    - Combination of factors

Planning Options

- The calculated spend-down
  - Especially for a married couple
    - New vehicle
    - Home improvements
    - Pre-paid funeral plans for both

Planning Options

- Exempt Transfers
  - Transfers between spouses
  - Transfers to a disabled child
  - Transfers to a trust established for sole benefit of disabled person under 65
  - Transfer to sibling with equity interest in home
  - Transfer of home to caretaker child
- Post-eligibility planning by the CS
  - Otherwise non-exempt transfers only impact CS's (future) eligibility

Planning Options

- Exempt Transfers
  - Transfers made for purpose other than qualifying for Medicaid
    - Very fact-specific
  - Undue Hardship
    - A/R is otherwise eligible to receive Medicaid
    - Unable to have transferred assets returned
    - Denial of care would endanger the A/R

Planning Options

- Spousal Refusal
  - Otherwise responsible spouse refuses to contribute assets or income to A/R spouse
  - May retain assets and income beyond threshold levels
  - Deferral of payment option, since DSS will pursue repayment at Medicaid rate (less than private pay)

Planning Options

MYTH:

Unless I plan years in advance, there are no planning options available to preserve assets or address my eligibility for Medicaid if I need care now.

Planning Options

- Crisis Planning with Gift/Note Plan
  - Use of a compliant promissory note in conjunction with gifting/transfers
  - Only an available option to someone already receiving skilled nursing facility level of care
  - Accounts for the payment of individuals long-term care expenses for a specified term
  - Protects assets to the greatest extent possible given circumstances
  - Sets plan in motion towards Medicaid eligibility at earliest possible time

Planning Options

9 Pieces of Information Needed for a Gift/Note Plan:

1. Medicare Cut-Off Date
2. Assets
3. Prior Transactions Review
4. Income
5. Cost of Care
6. Outstanding Liabilities
7. Need for Retained Assets
8. Liquidity of Assets
9. Penalty Period Divisor

Thank You!

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