Long Term Care Planning

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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.

In Alabama, the annual cost of nursing home care ranges from approximately $47,450.00 to over $120,000.00, and it is climbing each year! That is approximately $130.00 to $328.00, 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 $15 to $30 per hour for home health aides. In some cases, people pay over $150,000 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.

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

MEDICARE

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 in 2016 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 $1,288.00 (total) for the first 60 days and a co-payment of $322.00 per day for the remaining 30 days, and an additional one-time, lifetime benefit of 60 days, with a co-payment of $644.00 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 $161.00 per day for 80 days (maximum of 100 days).

**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”. 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.

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. With the Medicare Trust Fund currently projected to fail in approximately 2018, gaps in coverage are widening rapidly.

**Medicare Part D (Prescription Drug Coverage)**

Medicare includes 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 monthly premium for the Medicare Part D plan varies by company, and the basic plan costs up to $25 per month, while the more comprehensive plans costs between $50 and $100 per month. 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.

**PAYING YOUR OWN LONG-TERM CARE EXPENSES**

**Self – Insuring**

“Self-insuring,” or paying your own way, may be an option. However, you can expect to pay approximately $47,450.00 to $120,000.00 per year for nursing home care, and more for better facilities.
Home care can be even more expensive, with 24/7 care costing in excess of $150,000 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?

**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. 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.

**PRIVATE LONG-TERM CARE INSURANCE**

Most folks 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.

Benefits to look for in an LTC insurance policy include: nursing home and home care coverage; sufficient daily payouts ($150.00/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.

Counseling clients on the use of Long-Term Care Insurance is a critical component 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. Please contact us for our brochure “Questions and Answers on Long-Term Care Insurance,” or to schedule an appointment for a consultation.

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.

Income & Resource Limits

An individual applying for Medicaid in a nursing home can have only $2,000.00 in total assets, plus a burial fund or policy of $5000 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 $30.00 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 $500,000, 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 $25,000.00 (or one-half of a couple's resources up to a maximum of $119,220.00) in assets, in addition to the home. The spouse in the nursing home is entitled to keep only a $30.00 per month allowance while the “community spouse” is allowed a minimum income of $1,991.00 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.

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.

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 for transfers to trusts, 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 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 Alabama Medicaid Agency determines this “average” each year. In 2016, that number is $5,800.00.

For example, if a person transferred $75,600.00 in 2015 and applied for Medicaid in March, 2016 the penalty period for that transfer would be 13.03 months ($75,600.00 divided by the average monthly cost of $5,800).

When does the penalty period begin to run?

The penalty period begins when the applicant meets three conditions: (1) he or she needs nursing home care; (2) he or she has $2,000.00 or less in assets; and (3) he or she applies for Medicaid. With proper planning, penalty time can be avoided. 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.

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.

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”.

**VETERANS BENEFITS**

Few seniors or their families are aware of remarkable financial benefits that are available to U.S. military veterans in the form of Veterans Administration low-income pension benefits. Of those Americans who are aware of veterans pensions, even fewer of the large numbers of veterans or their widows or widowers who are eligible, or who could become eligible with proper planning by an elder law attorney, have done the planning and application to receive their federal benefits. Veteran pensions are available to large numbers of seniors age 65 or older, or who have other non-service-connected disabilities, and are financially eligible. The rules consider seniors age 65 and older automatically “disabled” for purposes of pension benefit eligibility. Additional criteria can raise the veteran’s pension benefit above the basic independent pension if the veteran is “housebound” or in need of “aid and attendance” for certain activities of daily living.

Veterans who have service-connected disabilities may be eligible for benefits that are classified as Disability “Compensation”. However, many more veterans have non-service-connected disability needs, so this article is focused on the low-income pension benefits available to this much larger portion of America’s population of veterans and their widows or widowers.

The numbers below are maximum pension figures. They are the maximum one can receive after considering other income minus recurring medical-related costs. Deductible medical-related costs include a range of expenses too diverse to discuss in the space available in this article. They can include in-home caregiver costs or the costs of an assisted living facility, but the documentation must be presented properly in order for the costs to be deductible.

In 2016, the basic low-income pension benefit for an independent veteran with no dependents is $1,072.00 per month. The benefit for an independent veteran with one dependent is $1,404.00 per month. If the veteran with no dependent is “housebound”, the monthly benefit increases to $1,310.00, whereas the housebound pension benefit for a veteran with a dependent is $1,642.00 per month. If the veteran with no
dependent needs “aid and attendance” for certain activities of daily living, the pension available is $1,788.00 per month. If the veteran has a dependent, the monthly benefit is $2,120.00 in 2016. For all of the above categories, each additional dependent child raises the monthly benefit by $183.00.

Pension benefits are also available for widows and widowers of veterans. In 2016, the basic low-income pension benefit for a widow or widower of a veteran without dependents is $719.00 per month, whereas the widow or widower with a dependent is $941.00 per month. If the widow or widower is housebound, the benefit is $878.00 per month, and if he or she is housebound and has a dependent, the monthly benefit is $1,100.00. Again, the aid and attendance benefit is the highest for the widow or widower of a veteran: Without a dependent, the benefit is $1,149.00 per month; and with a dependent the benefit is $1,371.00 per month. As for the veteran above, each additional dependent child raises the monthly benefit by $183.00.

These VA pension benefits can make a huge difference in the ability of the veteran, or widow or widower to afford basic costs of living, in-home caregivers in order to be able to stay at home, or to afford to live in an assisted living facility of his or her choice without Medicaid. Planning for eligibility for veteran’s pension benefits is somewhat similar to, but less complicated than the intricate planning often necessary for Medicaid eligibility. A very worrisome concern is, however, that the simpler rules for VA pension benefit eligibility may entice seniors or their agents under Powers of Attorney to carry out transactions that will cause later Medicaid ineligibility if either the veteran or the veteran’s spouse, widow or widower should require Medicaid benefits within five years.

It is crucial not to preclude later Medicaid eligibility. Because of this, VA pension eligibility planning needs be done with careful analysis of its implications for eventual Medicaid eligibility for the veteran or his or her spouse. Veteran Service Organizations exist to provide no-cost assistance in preparing and filing applications for veterans benefits, but they are not qualified to assist veterans or their families with eligibility planning. Furthermore, they are not qualified to counsel veterans or their families in regard to Medicaid eligibility and the sometimes-conflicting standards and techniques that apply to the two sets of eligibility rules. Such planning requires the careful guidance and assistance of an experienced elder law attorney.

**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.)

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. It is 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 booklet. As with any planning, a good way to begin is to seek competent advice from a qualified professional. At Dempsey Steed we are dedicated to helping you find solutions to your long-term care concerns. Please call (205) 803-6724 for a consultation, or visit us on the web at www.elderlawadvocates.com.

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