# The New York Metropolitan Elder Law Institute

## Elder Law Musings

## April 29, 2014


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I. Demographics and Observations.

A. People are living longer past age 65. Average of 16 years for men, 20 for women. But somewhat longer for our clients, who are more highly educated and have higher incomes.

B. More aggressive attitudes of Boomer children – ages 50 to 70 – in regards to their parents. They often seek out lawyers for their parents who are age 75 and older.

C. Single parent households are increasing.

D. Many people choose not to have children.

E. More non-traditional families.

F. More blended families.

G. Number of people with special needs continues to grow.

H. Less family support. Decline in the number of elderly living near children, fewer children, divorce and the loss of lifetime commitment. Elderly women outliving husbands and siblings, but not moving in with their adult children.

I. More governmental assistance programs that can benefit the elderly – but unlike Social Security, eligibility decisions are not black/white, such as proof of age. E.g. Medicaid payment of long-term care.

J. Increasing ownership of wealth by elderly leads to more concern about asset preservation during life and wealth transfer at death while maintaining an adequate life-style during the long, last years of life.

K. Increasing age means increasing numbers of elderly with dementia or other memory/cognition impairments. Results in the need for assistance, which often requires a lawyer.

L. Relative higher increases in the cost of long-term care. Longer lives, more dementia and increased costs of care combine to create great fear in the elderly and their adult children that accumulated wealth may be spent depleting the estate or that the older person will not be able to afford to live in a dignified and comfortable manner.

M. Increasing acute care costs leads to the need for asset preservation planning or else planning for a reduced estate.

N. Widespread lack of planning.

O. Federal estate tax issues not a concern for many, but state estate taxes may be a concern.

P. Changing role of advisor.

Q. Find out what clients really care about.

II. Client Goals and Values.

A. Preserve autonomy.

B. Effective financial and estate planning for 30+ years.

C. Quality of life.

D. Plan for and promote adequate acute and long-term care if health declines.

E. Create surrogate decision making plans in the event of loss of mental capacity.

F. Decent housing, including assisted or supportive housing.

G. Preserve the value of the estate to the extent possible.

III. Income During Retirement.

A. Social Security.

1. Key ages are 62, 65-67 and 70.

2. Rights of spouse.

(1) May be advisable to claim spousal 50% rate at age 65-67 and wait until age 70 to claim on own record.

(2) Delaying claim of benefits until age 70 may increase surviving spouse benefits.

(3) Divorced spouses have rights to benefits that neither lowers the former spouse's benefits nor those of the present spouse.

B. 401(k) Concerns.

1. At separation of service, the account is typically rolled over into an IRA – but where to invest the IRA?

2. Issues arise with surviving spouse who has to take over the IRA.

3. Issues arise when the IRA owner has diminished capacity.

    a. Continued investment decisions.

    b. Distribution decisions.

4. How to access the principal of the IRA for long-term care needs.

C. Savings.

1. How to convert into income – possible purchase of annuities.

2. Whether to fund a trust for management purposes in case the client suffers mental incapacity.

IV. Long-Term Care.

A. Where to obtain it.

1. In home.

    a. Clients prefer to "age in place."

    b. Very costly and creates risk of abuse or crime by caregiver.

    c. Contributes to social isolation and may put client at risk in case of medical problems.

2. Continuing care retirement communities.

a. Resident must be healthy enough upon entry to live independently and have finances to pay monthly fee for remainder of life.

b. Provide full range of care so that resident never has to move again.

c. Keeps couples in close proximity in case one needs nursing home care or special care due to dementia.

d. High entry cost - hundreds of thousands of dollars – but often mostly refundable upon death, plus a high monthly fee - $6,000 plus and rises annually. Most do not accept Medicaid.

e. Non-refundable entry fee may be partially deductible as cost of medical care under IRC § 213. Represents pre-paid medical care or insurance for possible long-term care.

f. Clients must be sure that they never want to move again. Voluntary departure may not trigger refund of entry fee.

3. Assisted living.

a. Custodial care in small, usually studio apartments.

b. Three meals a day, supportive assistance but not licensed to provide medical care.

c. Good alternative to a nursing home for many elderly.

d. Generally cannot stay if not ambulatory.

e. Often have special dementia units that are designed to prevent resident “elopement” from the facility.

f. Typically cost about ½ as much as a nursing home or $4,000 to $8,000 a month depending on the where located, quality of care, and degree of luxury provided. Cost could be higher if private duty nurses are needed due to deteriorating condition.

4. Nursing homes.

a. Medical, institutional setting that provides 24 hour care.

b. Due to Medicaid reimbursement requirements, usually feature two (sometimes, more) residents to a room.

c. A few nursing homes are trying to create a less institutional, hospital-like setting.

d. Very few do not accept Medicaid and so offer a very expensive, but more comfortable form of care.

e. The "standard" nursing home is very expensive - $7,000 to over $10,000 a month. In some major metropolitan areas, this cost can exceed $15, 000 a month.

B. Paying for long-term care.

1. Medicare – federal subsidized health care insurance.

    a. Eligible at age 65, on SSDI or end-stage renal failure.

    b. Eligibility tied to eligibility for Social Security but do not have to be taking Social Security benefits to qualify for Medicare.

    c. Divorced spouse from a marriage that lasted at least 10 years is eligible on prior spouses Medicare entitlement.

2. Medicare Part A.

    a. No monthly premium – paid for by 2.9% tax on wages.

    b. Pays for hospitalization, though there are deductibles, co-pays and limits on the number of consecutive days that are covered.

    c. Pays for hospice care.

    d. Limited skilled nursing home care – after 3 days in hospital, 20 days coverage and then 80 more days with daily co-pay of $152.

3. Medicare Part B.

    a. Eligibility if qualify for Part A and pay monthly premium of $104.90 for adjusted gross income up to $85,000. Higher premiums as income rises up to maximum of $335.70.

    b. Pays for doctors and some outpatient services.

    c. Annual deductible of $147 and patient must pay 20% of doctor fee.

d. Medicare only pays for “reasonable charges” as determined by “approved” Medicare charge. If doctor does not “participate” may charge more than approved rate and the patient must pay the difference. Participation is mandatory in several states.

4. Medicare Advantage are health plans offered by private companies that contract with Medicare to provide all Part A and B benefits, and which typically offer Part D prescription drug benefits.

    a. Requires enrollment in both Part A and B, and then joining a specific plan.

    b. Cannot use Medigap policy to pay for any plan deductibles.

5. Medicare Part D – prescription drug benefits.

    a. Offered by private insurance plans.

    b. Consists of 4 stages of payment.

        (1) Initial deductible of $310.

        (2) Plan pays 75% of prescription up to $2,850.

        (3) 50% coverage for brand name drugs up to $4,750 – gap or “donut hole.”

        (4) Plan pays 95% of all costs above $4,550.

    c. Enrollee pays 47.5% or the cost of brand-name drugs and 79% of the cost of generic drugs. Gradually reduced each year until it reaches 25% in 2020.

6. Medicaid.

    a. Nationwide pays for about half of all nursing home costs.

    b. Joint federal-state program with federal government paying about 57% of the cost though the percentage varies by state. Richer states pay a higher percentage.

    c. To get the federal dollars, states have to meet the minimum eligibility standards in the federal law.

d. Medicaid does not pay the "private pay" rate, but rather a lower rate that the state determines to be sufficient – the rate varies across the state.

e. Most elderly who qualify for Medicaid do so as "Medically needy." Meaning that they cannot afford the cost of their care.

f. To qualify, an unmarried individual must essentially spend all his resources and devote all his income to the cost of care. Medicaid will pay the resulting shortfall.

g. A married applicant must spend all of his income for his care, but the community spouse's income is not counted and that income is not considered available for the support of the institutionalized spouse.

h. In "income cap" states, to be eligible the applicant's income cannot exceed 300% of the monthly Supplemental Security Income (SSI), which is $721.

i. A married couple may preserve some resources for the spouse

   (1) The family home (maximum equity value of either $543,000 or $814,000 depending on the state.)

   (2) One car.

   (3) Prepaid burial contract.

   (4) Some states allow retirement accounts to be preserved if they are in "payout" status.

   (5) The community spouse resource allowance - not to exceed $117,240 and at least $23,448.

   (6) Community spouse has right to income from institutionalized spouse to bring community spouse up to the Minimum Monthly Maintenance Needs Allowance - MMMNA - $2,931.

j. Estate recovery permits the state to make a claim against the house at the death of the community spouse or at the sale of the house to recover amounts spent on nursing home care of institutionalized spouse. If the state has adopted expanded

estate recovery, the state also can make claims against other assets including non-probate assets.

k. Gifting – is a "no no." Any gifts within five years of the application for Medicaid can cause a period of ineligibility.

(1) Number of months of ineligibility is value of gift divided by average monthly cost of nursing home in state - as declared by the state. In some states the penalty rate varies from region to region within the state.

(2) Penalty does not begin until the applicant is "otherwise eligible," meaning she is out of assets and her monthly income is not enough to pay the monthly nursing home cost of care. The claimant must be in nursing home and must apply for benefits.

l. Using resources to buy annuities payable to the community spouse appears to be a good way to reduce countable resources (an annuity creates community spouse income that is not counted towards the cost of care of the institutionalized spouse) while increasing the income for the community spouse. But annuities have to meet certain requirements.

(1) Not paid out longer than the actuarial life of the annuitant.

(2) Be paid in equal installments and no balloon payment at end.

(3) Paid to state after death of annuitant to the extent that the state has paid Medicaid benefits for institutionalized spouse.

m. To deal with five year look-back, many are placing assets in irrevocable trust, with income to grantor. Wait five years before applying for Medicaid so that the transfer to the trust corpus does not count as a disqualifying transfer.

(1) Requires care in drafting trust and selection of trustees.

(2) Possibly turn-off of income if grantor enters nursing home.

(3) Often used to protect the house from estate recovery.

7. Long-Term Care Insurance.

a. Insurance that covers some portion of the cost of long-term care.

b. Pays benefits according to the policy requirements, which are usually:

   (1) Insured has at least two deficits of “activities of daily living” such as bathing and dressing.

   (2) If the insured has a cognitive impairment - most often dementia.

c. Benefits are paid when necessary care is paid for - whether in a nursing home, assisted living or as home health care.

d. Benefits are a daily dollar amount, such as $200/day not to exceed actual cost of daily care. Multiply total maximum days paid by daily rate to determine total benefits. E.g. $200/day for 3 years = $219,000.

e. Usually pay higher premium and have daily benefit rise by an annual compounded percentage such as 5% per year to reflect rising cost of care.

f. Benefits are paid either for a limited period of time, such as for 3 years, or for life. Most policies are reimbursement policies that pay only if the insured has out-of-pocket costs of care with the benefit payment not to exceed the cost of such care. Some are indemnity policies that pay a set benefit amount without regard to the actual cost of care so long as the claimant meets the criteria that trigger benefits, typically two deficits in activities of daily living. Elimination period - benefits not paid for a set number of the first days – often 30 or 90 days.

g. Premiums are set by age of purchaser – do not increase due to rising age, though insurer can request permission to raise rates for a group of policy holders because premiums are inadequate to pay benefits.

h. High rates of un-insurability – estimated to be 25%.

i. Usually not sold to individuals age 80 or older.

j. State partnership policies.

(1) Permit insured to retain assets equal to insurance benefits paid by policy.

(2) Policy must be "tax-qualified" as defined in IRC § 7702B(b).

(3) Tax qualified policies benefits are tax free up to daily dollar limit or the cost of care. Premiums are deductible as IRC § 213 medical expense (subject to the limitations of that section) up to limit based on age. Amounts adjusted annually for inflation.

k. Industry undergoing massive changes.

l. Higher rates for women.

m. Hybrid products.

V. Use of Trusts.

A. Non-tax reasons.

B. Drafting issues.

C. Distribution issues.

VI. Health Care Decision Making

A. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . ." Justice Cardozo, *Schloendorff v. Society of N.Y. Hospital, 105 N.E. 92 (N.Y. 1914)*

B. Competent patient must give informed consent to medical care – understand the benefits, burdens and alternatives to proposed treatment.

C. Competent patient can refuse or terminate life-sustaining medical treatment – artificial nutrition and hydration are forms of medical treatment.

D. Mentally incapacitated patient.

1. Patients are presumed to have capacity but that is a rebuttable presumption. Capacity is situational and varies according to the decision to be made.

2. Realistically the patient may have capacity even though does not understand the larger issues and not the more complex details.

E. Surrogate decision making for the mentally incapacitated patient.

1. Have a guardian of the person appointed with express authority to make medical decisions, including termination of life-sustaining treatment.

2. Living wills. Patient attempts to control future end-of-life care by advance instructions. Frequently this document is not observed by the treating physician because the family insists on treatment despite instructions to the contrary in the living will.

3. Appointment of a surrogate decision maker.

    a. Preferred to a living will as it identifies a person who the doctor can consult about treatment options. State law may limit when applicable e.g. when patient is terminal.

    b. Can contain precatory language about treatment preferences or mandated instructions.

    c. Need for naming of successor surrogates.

    d. Need for surrogate to understand the wishes of the patient in order to employ substitute judgment, i.e. do what the patient would have done if the patient had capacity.

4. Many states have statutes that appoint a default surrogate decision maker.

    a. Authority of surrogate begins when the physician determines that the patient lacks capacity.

    b. Automatic, no court action required.

    c. Statutes begin with spouse acting as surrogate, and then list possible surrogates, from adult children, parents, sibling etc. May list "close friend."

    d. Authority of surrogate determined by state law. May be more circumscribed than a surrogate appointed by the patient.

F. POLST – Physician Orders for Life-Sustaining Treatment, aka POST & MOLST.

1. A form created by a physician in consultation with the patient that details the kind of treatment the patient wants toward the end of life. Intended to be placed with patient's medical records and be binding on all who provide medical treatment to the patient, e.g. physicians, nurse practitioners, nursing homes, hospices, home health providers, and emergency medical services.

2. In most states, the POLST is printed on pink paper so that it will be noticed.

3. May be created by the patient's surrogate, but state law may limit the authority of the surrogate to refuse health care unless the patient is "soon to die."

4. Not a substitute for an advance health directive but a means of implementing the patient's wishes.

5. Can be updated, revised or withdrawn to reflect changes in patient's treatment.

VII. Common Issues.

A. Differences in spousal ages, health, planning needs and attitudes.

B. The need for separate discussions may be very important.

C. Need to plan for financial future and autonomy of second to die spouse.

1. Surviving spouse may need to pay for care that she provided for free to her husband.

2. Good planning anticipates possible dementia, physical frailty and social isolation.

3. Plan for possible remarriage of surviving spouse.

D. Second marriage with children of hers, his and ours.

1. Make sure both spouses are comfortable with how the children of various parents are treated.

2. "Children" are likely age 50 or older. Consider how this affects the plan. Does it argue for non-tax based generation skipping? If so grandchildren may be age 25 or older. Should the skip be down to the great-grandchildren?

3. Tangled families suggest the use of trusts and professional trustees.

E. Plan for possible incapacity.

1. Physical.

a. Frailty, loss of stamina, and decline in memory.

b. Loss of vision or hearing.

c. Identify those who can assist client including financial advisors and children who may or may not act under a power of attorney.

2. Mental.

a. Asset protection.

(1) Durable power of attorney, joint accounts and joint signature accounts.

(2) Inter-vivos trusts – revocable and irrevocable.

(3) Family partnerships and LLCs.

b. Care and protection of the person.

(1) Advance health care directive that focuses on end-of-life care.

(2) Nominate a possible guardian of the person.

(3) Consider "life care planning" to assure proper level of care is delivered by proper caregivers.

c. Discuss desires as to care with children and others.

3. Take special care to discuss the issues with clients in late life second marriages. Is the new spouse to make the decisions or children of prior marriage?

VIII. Effective estate planning requires life planning for the final years of life.

A. Consider how to pay for adequate housing, which may give rise to state death tax issues if client changes state of residence, e.g. to move near children.

B. Plan for long-term care and how to pay for it without depleting the estate. – possible move to a Continuing Care Retirement Community.

C. Consider long-term care insurance or 2nd to die life insurance to avoid estate depletion.

D. Identify where to obtain assisted living or nursing home care – where living or where a child lives?

E. Consider loss of capacity of one or both spouses and how that will affect the estate.

1. Inability to handle investments.

2. Inability to act as a trustee.

3. Cannot exercise power of appointment.

4. Cannot amend estate plan to deal with changing needs and life situations of heirs.

5. May need a guardian – how will the guardian interact with other fiduciaries such as trustees?

F. Selection of surrogate health care decision maker is important because that person may choose the form and cost of long-term care provided for aging client as well as the cost of end-of-life care.

1. If client develops dementia, where does the client want to live?

2. If client develops severe dementia, what kind of life-sustaining treatment is acceptable, e.g. feeding by hand?

3. Does client believe cost of care should enter into housing and medical care decisions?

This outline is based on an outline prepared by Lawrence Frolik and Bernard A. Krooks for their presentation at the 47th Annual Heckerling Institute on Estate Planning.

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 1

## Graying of America

- 40 million Americans over age 65
  - 13% of the population
- By 2030, expected to increase to 88.5 million
  - 20% of the population
- Seniors will need more help accessing quality health care and advice re: payment therefor

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## Financial Concerns of Clients

- Households with more than $250K in investable assets
  - Health care costs
  - Job security
  - Protecting current wealth
  - Minimizing taxes
  - Economy

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## Client Concerns

- Cost of health care may impact ability to gift or create family legacy
- Estate taxes not a concern for many
  - Less than 4,000 estate tax returns showing a tax due expected to be filed this year
  - Shift in focus to state estate taxes and income tax planning

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## Long-Term Care

- Strategies for paying for long-term care
  - Private pay
    - Tax issues
  - Medicare
  - Medicaid
  - Long-term care insurance
  - VA benefits
  - Reverse mortgages

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## What is Long-Term Care?

- Acute v. chronic illness
- Heart attack v. Alzheimer's disease
- No expectation of recovery
- Who is affected by this?
  - Seniors
  - People with special needs
  - Others

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## Long-Term Care

- Most Americans are in for sticker shock if they or a loved one ever requires long-term care




## The Problem

*The United States has **no** health insurance system for long-term care*





## Medicare

- Federal program
- Administered by CMS
- Short-term rehabilitation
- Prior hospital stay required
- Deductibles and co-pays
- Does not cover custodial care

## LBJ - 1965

- "Every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years"




## 2014 Medicare Part A

| | |
|---|---|
| Hospital deductible: | $1,216 |
| Hospital co-insurance amounts: | $304 per day for days 61-90, $608 per day for days 91-150 (lifetime reserve) |
| Skilled nursing facility co-insurance amount: | $152 per day for days 21-100 |




## 2014 Medicare Part B

- $147 annual deductible
- $104.90 premium per month
- Above 85K annual income, premium increases until income exceeds 214K
- $335.70 per month
- 2012 modified adjusted gross income
- Medigap policies

## Medicare

- No improvement necessary
  - Critical inquiry is whether the services are needed not whether person will improve
- Maintain condition or slow deterioration
- Applies to home health, outpatient therapy and skilled nursing facilities
- Observation status




## Long-Term Care Insurance

- Evaluate existing policies
- Suggest healthy clients/family consider
- Determine Need
  - Client goals
  - Asset risk
- Work with reputable agents
- Assist in policy design and benefit level
- Determine payment source
- Third party lapse notification




## Long-Term Care Insurance

- Massive changes
  - Fewer companies
  - 10 of top 20 companies (by sales) have exited the LTC market in past 5 years
  - High capital requirement
  - Less profitable
  - Uncertainty regarding future claims
  - Low interest rates
  - Low lapse rate

## Long-Term Care Insurance

- More conservative underwriting
- Tougher approval process
  - More scrutiny re: existing medications
  - Tougher to qualify for best rates
- Higher costs
  - Especially for women
    - Historically gender neutral
    - Live longer
    - No caregiver at home
    - Now as much as 40% higher

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## Long-Term Care Insurance

- Sex discrimination lawsuit
  - National Women's Law Center
- Women own 58% of policies but account for 67% of claims
- ACA bars sex discrimination in health care
- Some states require unisex pricing
  - Colorado and Montana

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## Long-Term Care Insurance

- Hybrid products
  - Hedge your bet
  - Annuities
  - Life insurance
  - So far, very little claims-paying history
- Partnership policies
  - Available in 40 states
  - Dollar for dollar
  - Total asset protection
  - Income not protected

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## Deductibility of LTCI Premiums

- Age 40 or less $370
- Over 40-50 $700
- Over 50-60 $1,400
- Over 60-70 $3,720
- Over age 70 $4,660
- State tax credit or deduction
- 10% medical expense threshold
  - 7.5% if 65 or older (until 2017)
- C corporation




## Tax Treatment of Benefits

- Benefits received under a qualified LTC policy are not considered taxable income
- Tax-free cap of $330/day applies to indemnity policies




## LTC Strategies

- Self insure
- Insure part of the cost/Medicaid planning
- Create an income stream
- Avoid family disputes
- Purchase LTCI for parents
  - Parents can stay at home
  - Tax benefits
- Reverse mortgage
- Second to die life insurance

## LTC Strategies

- Accelerated life insurance benefits
  - State regulated
  - Monthly or lump-sum
  - Insured must be terminally ill or suffering from long-term chronic illness
  - Usually done when life expectancy is short
  - Not subject to federal income tax
- Life and viatical settlements
  - Sale to a third party




## Medicaid

- Look-back period
- Estate planning gifts
- Married persons
  - Spousal transfers
  - Pre-nuptial agreements
  - Divorce
- Estate recovery
- Home care
- Pooled trusts




## Trusts

- Use of trusts for non-tax reasons
  - Death, divorce, spendthrift, creditor protection
  - More trusts, greater duration
- Be clear about wishes
  - Family values statement
  - Statement of intent/wishes
  - Gives creators more peace of mind
  - Can be written after trust is created
  - Does not override trust agreement

## Trust Distributions

- HEMS
  - PhD or adult education class on meditation
- Style to which they have grown accustomed
  - New BMW every year
- Be flexible in trust drafting to account for changing circumstances in future




## American Taxpayer Relief Act

- Portability made permanent
  - Federal estate tax purposes only
  - Bypass trusts
    - State estate taxes
    - Creditor protection
    - Second marriage
    - Subsequent appreciation
  - Disclaimer planning
  - Medicaid look-back




## Trust Tax Rates

- 39.6 percent rate – income over $12,150
- Single individual – income over $406,750
  - 20% capital gains and dividend rate
- Additional Medicare tax – additional 3.8%
  - Applies to capital gains and dividends
  - Revenue goes to general fund of US Treasury not Medicare Trust Fund
- Medicaid trusts
- Special needs trusts

## Medicaid Trusts

- Irrevocable
- Income-only
- Limited power of appointment
- Sprinkling provision
- Change trustee
- Tax considerations
  - Income
  - Gift
  - Estate




## Special Needs Trusts

- First party SNT
- Pooled trusts
- Third party SNT
  - Inter-vivos
  - Testamentary
  - Contingent SNT
- Tax issues
- Insurance planning and SNTs
- Investment issues for SNTs




## Advance Directives

- Durable Power of Attorney
  - Springing power
  - Immediately effective power
- Advance health care directives
- Selection of surrogate
- Who makes decisions re: type and cost of long-term care?
- Second marriage issues

# Thank You!

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