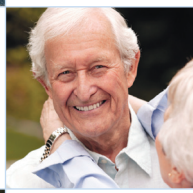
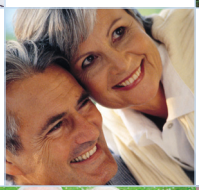
2012 Edition

lookingahead

Estate and Long-Term Care Planning for You and Your Family





By Kenneth M. Coughlin and Harry S. Margolis

ElderLawAnswers

About the Authors

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LOOKING *Ahead*

Estate and Long-Term Care Planning

for You and Your Family

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Introduction

The many obligations we Americans face today – to work, to family, to church and community, and to ourselves – often leave little time and energy for planning for the future, whether for ourselves, our children, our spouses or our parents. Unfortunately, lack of planning can often lead to unnecessary expense and stress upon the death or disability of a family member.

The purpose of this booklet is to help families both plan now in advance of a future need and deal with an impending life event, generally the need for long-term care. A publication of this length cannot be exhaustive in answering all questions, but it will provide an outline and a guide to resources to help with specific situations. This edition reflects the changes in the Medicaid asset transfer rules enacted in February 2006 as part of the Deficit Reduction Act of 2005, and includes Medicaid eligibility figures and other relevant numbers updated for 2012.

The booklet is divided into two major sections – estate planning and long-term care planning – with more specific chapters within the two sections.

PART ONE

Estate Planning: Will Your Wishes Be Carried Out?

1. The Key Elements of an Estate Plan

This chapter explains:

- The importance of estate planning
- Durable powers of attorney
- Wills
- Trusts
- Medical directives

Why Plan Your Estate?

The knowledge that we will eventually die is one of the things that distinguishes humans from other living beings. At the same time, no one likes to dwell on the prospect of his or her own demise. But if you, your parents or other loved ones postpone planning until it is too late, you run the risk that your intended beneficiaries – those you love the most – may not receive all that you would hope.

We should begin a discussion of estate planning with a consideration of what "estate" and "estate plan" mean. An "estate" is simply everything a person owns: bank accounts, stock, real estate, motor vehicles, jewelry, household furniture, retirement plans, life insurance. An "estate plan" is the means by which the estate is passed to the next generation. This can be accomplished through a variety of instruments. Most retirement plans and life insurance policies pass to named beneficiaries, chosen when you take out the policy or at a later date. Property that is jointly owned passes to the surviving joint owner. Trust assets are distributed according to the terms of the trust. Property held in an individual's name alone comes under the instructions laid out in a will, or in the absence of a will, under the rules of "intestacy" set out in state law.

Problems often arise when people don't coordinate all of these methods of passing on their estate. To take just one example, a father's will may say that everything should be equally divided among his children, but if the father creates a joint account with only one of the children "for the sake of convenience," there could be a fight about whether that account should be put back in the pool with the rest of the property.

The Four Leading Excuses for Not Having an Estate Plan

Excuse #1: My estate is too small.

Response: For many individuals, especially those with smaller estates, the most important documents are a durable power of attorney and medical directives. While a will protects your estate after you're gone, a durable power of attorney and medical directives protect you while you're still here.

Excuse #2: Joint ownership of accounts with my children is an adequate plan.

Response: No it isn't, unless there is only one child. It is impossible to keep separate accounts for more than one child equal. This is especially true if the parent becomes incapacitated and no longer has control over the accounts. Trying to save a few dollars by managing an estate in this fashion runs the serious risk of causing discord in a family for generations to come. Why take the chance?

Excuse #3: I don't want to pay a lawyer to draw up the plan.

Response: Software is available that produces most of the estate planning documents an attorney will prepare. The chances are good, however, that such "one size fits all" approaches will prove inadequate in any specific case. In fact, few clients need just a simple will. If there's anything about your situation that's not plain vanilla, you need to see a lawyer (and only a qualified lawyer can tell you if your situation is indeed plain vanilla). The problems you may create by not getting competent legal advice probably won't be yours, but may well be your children's. Don't risk leaving such a legacy.

Excuse #4: I just haven't gotten around to it.

Response: Reading this booklet is the first step towards getting around to it.

A well-drafted estate plan also permits you to save as much as possible on taxes, court costs and attorneys' fees. Most importantly, it affords the comfort that your loved ones can mourn your loss without being simultaneously burdened with unnecessary red tape and financial confusion.

All estate plans should include, at minimum, three important planning instruments: a durable power of attorney, a health care proxy and a will. A durable power of attorney allows you to designate someone to manage your property during your life, in case you are ever

unable to do so yourself. The health care proxy, called a durable power of attorney for health care in some states, appoints another individual to direct your medical care if you are ever unable to do so yourself. The health care proxy should include or be accompanied by a medical directive providing guidance to your health care agent. The will is for the management and distribution of your property after your death.

If you do not have an estate plan, your estate will be distributed under the rules of "intestacy." These direct that what you leave goes to your nearest relatives, whether that's your spouse, your children, or your nieces and nephews. That works for most people, but not for a lot of people – and fewer every day. Less and less do we live in the standard family model of a mother, a father and two or more children. More and more children are raised by single parents, lesbian and gay parents, and by grandparents. Over the last few decades, the number of children raised primarily by grandparents has skyrocketed, and in 2009 was estimated to be nearly 4 million, or 5 percent of all grandchildren. Anyone in an atypical situation needs a carefully considered estate plan.

The Durable Power of Attorney

For many people, the durable power of attorney is the most important estate planning instrument – even more important than a will. A power of attorney allows you to appoint another person – your "attorney-in-fact" – to step in and manage your financial affairs if and when you ever become incapacitated.

What happens if there is no durable power of attorney? Without it, a family must wait for a court to appoint a conservator or guardian to manage the incapacitated person's affairs. That court process takes time, costs money, and the judge may not choose the person that the individual would have preferred. In addition, once a guardianship or conservatorship is in place, the representative may have to seek court permission to take planning steps that she could implement immediately under a simple durable power of attorney.

A power of attorney may be either immediate or "springing." Most powers of attorney take effect immediately upon their execution, even if the understanding is that they will not be used until and unless the grantor becomes incapacitated. However, the document can also

Typical Concerns about Powers of Attorney

I'm afraid that the person I appoint won't manage my affairs properly

Giving someone the potential power to manage your affairs can be frightening. This is why it is important for you to appoint someone you trust to be your attorney-in-fact. She must use your finances as you would for your benefit. Giving someone a power of attorney does not limit your own rights in any way. It simply gives the other person the power to act when or where you cannot act.

Does a power of attorney take away my rights?

Absolutely not. Only a court can take away your right to manage your own affairs, through a conservatorship or guardianship proceeding. An attorney-in-fact simply has the power to act along with you, and as long as you are competent, you can revoke the power of attorney.

I don't have anyone I trust enough to give them power over my affairs

If you do not have someone you trust to appoint, it may be more appropriate to have the probate court looking over the shoulder of the person who is handling your affairs through a guardianship or conservatorship. In that case, you may use a limited durable power of attorney to simply nominate the person you want to serve as your conservator or guardian. Most states require the court to respect your nomination "except for good cause or disqualification."

What if I change my mind?

You may revoke your power of attorney at any time. You need to send a letter to your attorney-in-fact telling her that her appointment has been revoked. From the moment the attorney-in-fact receives the letter, she can no longer act under the power of attorney. If you have recorded the power of attorney with the land records of your county or at the probate court, you must record the revocation as well.

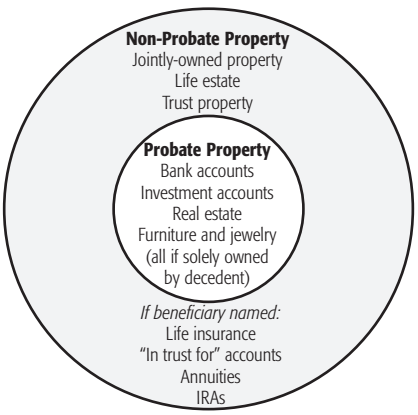
be written so that it does not become effective until such incapacity occurs ("springing"). In such cases, it is very important that the standard for determining incapacity and triggering the power of attorney be clearly laid out in the document itself.

However, attorneys report that their clients sometimes have difficulty in getting banks or other financial institutions to recognize the authority of an agent under a durable power of attorney. A certain

amount of caution on the part of financial institutions is understandable: When someone steps forward claiming to represent the account holder, the financial institution wants to verify that the attorney-in-fact indeed has the authority to act for the principal. Still, some institutions go overboard, for example requiring that the attorney-in-fact indemnify them against any loss. Many banks or other financial institutions have their own standard power of attorney forms. To avoid problems, you may want to execute such forms offered by the institutions with which you have accounts. In addition, many attorneys counsel their clients to create revocable or "living" trusts in part to avoid this sort of problem with powers of attorney.

The Will

Your will is a legally binding statement directing who will receive your property upon your death. It also appoints a legal representative, often called an "executor" or "personal representative," to carry out your wishes. The process by which a person's property is passed to the people or institutions named in the will is called **probate**. However, a will covers only **probate property.** Many types of property or forms of ownership pass outside of probate. Examples of property that pass outside of probate and, thus, are not mentioned in a will, include: jointly-owned property, property in a trust, life insurance proceeds, and property with a named beneficiary, such as IRAs or 401(k) plans.



Filling out the following worksheet will help you make decisions about what to put in your will. The worksheet will also help a lawyer prepare a will that better meets the client's needs and desires.

WILL PREPARATION WORKSHEET

I. Your Estate

List the contents of your estate, including bank accounts, stock, IRAs, real estate, motor vehicles, life insurance, and anything else that you may own, whether by yourself or with another person. For this purpose, an estimate of the value is sufficient.

Bank Accounts

1. _____ $_____
2. _____ $_____
3. _____ $_____
4. _____ $_____

Stocks, Bonds, Treasury Notes, Other Investments

1. _____ $_____
2. _____ $_____
3. _____ $_____
4. _____ $_____

Life Insurance, IRAs, Pension, 401(k)

1. _____ $_____
2. _____ $_____
3. _____ $_____
4. _____ $_____

Real Estate

1. _____ $_____
2. _____ $_____

Tangible Personal Property

This category includes furniture, jewelry or artwork – anything of significant value or that you would like to go to a particular person.

1. _____ $_____
2. _____ $_____
3. _____ $_____
4. _____ $_____

WILL PREPARATION WORKSHEET, PAGE 2

II. Beneficiaries

Here, list the people you would like to receive a part of your estate, including family members, friends, and charities.

Spouse Name _____

Children

1. _____
2. _____
3. _____
4. _____

Other Individuals

Include friends, grandchildren, brothers and sisters, or anyone else to whom you would like to give a part of your estate.

1. _____
2. _____
3. _____
4. _____

Charities

List any religious or other non-profit organizations to whom you would like to make a bequest. This may reduce the taxes on your estate.

1. _____
2. _____
3. _____
4. _____

WILL PREPARATION WORKSHEET, PAGE 3

III. Executor

Name the person or persons you would like to appoint to administer your estate. He or she (called the "executor" or "executrix") will carry out your wishes as stated in your will. Two people may serve together in this role. Also name an alternate in case the first appointed cannot serve for any reason.

Executor, executrix

1. _____
2. _____

Alternate

1. _____
2. _____

IV. Guardian of Children

The most important purpose of a will for most younger people is the appointment of a guardian for their children under age 18. All people with children should have wills for this purpose.

Guardian _____

Alternate _____

Four reasons to have a will

1. A will allows you to direct where and to whom your estate (what you own) will go after your death. When you die intestate (without a will), your estate is distributed according to the laws of your state. In general, those rules provide that your property will be divided among your closest family members. Such distribution may or may not accord with your wishes.
2. Often the probate process can be completed more quickly and at less expense if there is a will. With a clear expression of the deceased's wishes, there are unlikely to be any costly, time-consuming disputes over who gets what.
3. Only with a will can you choose someone to administer your estate and distribute it according to your instructions. This person is called the "executor" (or "executrix" if it is a woman) or "personal representative," depending on the state's statute. If there is no will naming this person, the court will make the choice itself. Usually, the court appoints the first person to ask for the post, whoever that may be. Litigation can arise if family members cannot agree on who should take on this role.
4. One of the most important functions of a will is that it permits parents to appoint the person who will take their place as guardians of their minor children should both parents pass away. In some states, it may also be possible to do this in a separate document.

Trusts

A trust is a legal arrangement through which one person (or an institution, such as a bank or law firm), called a "trustee," holds legal title to property for another person, called a "beneficiary." The rules or instructions under which the trustee operates are set out in the trust instrument. There can be a number of advantages to establishing a trust, depending on the individual situation:

- *Probate avoidance.* Upon the death of the donor (the person creating the trust), the trust either continues for new beneficiaries or terminates, depending on the terms of the trust. In either case, this occurs without requiring probate. This can save time and money for the beneficiaries.

- *Tax savings.* Certain trusts can create estate tax advantages both for the donor and the beneficiary. These are often referred to as "credit shelter" or "life insurance" trusts.
- *Asset protection.* Other trusts may be used to protect property from creditors or to help the donor qualify for Medicaid coverage of nursing home care.
- *Privacy.* Unlike wills, trusts are private documents and only those individuals with a direct interest in the trust have any right to know of trust assets and distributions.
- *Durability.* Provided they are well-drafted, another advantage of trusts is their continuing effectiveness even if the donor dies or becomes incapacitated.

Kinds of Trusts

Trusts fall into two basic categories: revocable and irrevocable.

Revocable Trusts

Revocable trusts give the donor complete control over the trust. He or she may amend, revoke or terminate the trust at any time. The donor can take back the funds he or she put in the trust or change the trust's terms. Thus, the donor is able to reap the benefits of the trust arrangement while maintaining the ability to change the trust at any time prior to death.

Revocable trusts are generally used for the following purposes:

1. **Asset management.** They permit the trustee (the person who manages the trust) to administer and invest the trust property for the benefit of one or more beneficiaries of the trust.
2. **Probate avoidance.** At the death of the person who created the trust, the trust property passes to whomever is named in the trust. It does not come under the jurisdiction of the probate court and its distribution need not be held up by the probate process. However, the property of a revocable trust will be included in the donor's estate for tax purposes.

3. **Tax planning.** While the assets of a revocable trust will be included in the donor's taxable estate, the trust can be drafted so that the assets will not be included in the estates of the beneficiaries, thus avoiding taxes when they die.
4. **Disability planning.** Wills only provide for death. Trusts can help a person have a plan in place in the event of their own illness.

Irrevocable Trusts

An irrevocable trust cannot be changed or amended by the donor. Any property placed into the trust may only be distributed by the trustee as provided for in the trust document itself. For instance, the donor may set up a trust under which he or she will receive income earned on the trust property, but the trust bars access to the trust principal. This type of irrevocable trust is a popular tool for Medicaid planning (see Section II, Chapter 7 below). In addition, irrevocable trusts are often used with life insurance policies as an estate tax planning device.

Testamentary Trusts

A testamentary trust is a trust created by a will. Such a trust has no power or effect until the will of the donor is probated. Although a testamentary trust will not avoid the need for probate and will become a public document as it is a part of the will, it can be useful in accomplishing other estate planning goals. For example, the testamentary trust can be used to provide funds for a surviving spouse that would be protected if she required Medicaid-covered nursing home care, an option that is not available through the use of a revocable or "living" trust.

Special Needs Trusts

For more information on planning for people with special needs, visit www.specialneedsanswers.com

The purpose of a special needs trust is to enable the donor to provide for the continuing care of a disabled spouse, child, relative or friend. The beneficiary of a well-drafted special needs trust will have access to the trust assets and still be eligible for benefits such as Supplemental Security Income, Medicaid and low-income housing. A special needs trust can be created by the donor during life or be part of a will.

Here's what a standard estate plan should include:

- Revocable, or "living," trust to avoid probate
- Will, for personal items and anything not in the trust
- Durable power of attorney, appointing someone you trust to handle your finances, in case you cannot
- Health care proxy, appointing someone to make medical decisions for you, in case you cannot

Medical Directives

Any estate plan should include a medical directive. Just as we need to plan for our eventual demise, we also need to plan ahead for the possibility that we will become sick and unable to make our own medical decisions. Medical science has created many miracles, among them the technology to keep patients alive longer, sometimes seemingly indefinitely. As a result of well-publicized "right to die" cases, states have made it possible for individuals to give detailed instructions regarding the kind of care they would like to receive should they become terminally ill or are in a permanently unconscious state.

These instructions fall under the general category of "health care decisionmaking." This phrase can encompass a number of different documents, including **a health care proxy, medical instructions or directives,** and **a living will.** The exact document or documents depend on the particular state's laws and the choices an individual makes.

The Health Care Proxy

If you become incapacitated, it is important that someone have the legal authority to communicate your wishes concerning medical treatment. Similar to a power of attorney (and sometimes called a durable power of attorney for health care), the health care proxy is a document executed by a competent person (the principal) giving another person (the agent) the authority to make health care decisions for them if they are unable to communicate such decisions.

By executing a health care proxy, you ensure that you have someone to represent you in dealing with health care professionals and to carry out your instructions if you become incapacitated. A health care proxy is especially important to have if family members may disagree about treatment. And, with the strict new health care privacy rules now in force, it's more crucial than ever that everyone consider creating an

advance medical directive that specifically names those persons who are entitled to access to health care information about them. Under the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA), which became effective in April 2003, doctors, hospitals and other health care providers may no longer freely discuss a patient's status or health with spouses or other family members — unless the providers have in hand signed consent forms from the patient. Remember: a general power of attorney for financial matters will not suffice. The instrument must refer specifically to HIPAA.

In general, a health care proxy takes effect only when a physician determines that you are unable to communicate your wishes concerning treatment. How this works exactly can depend on the laws of the particular state and the terms of the health care proxy itself. If you later become able to express your own wishes, you will be listened to and the health care proxy will have no effect.

Since the agent will have the authority to make medical decisions in the event you are unable to make such decisions yourself, the agent should be a family member or friend whom you trust to follow your instructions. Before executing a health care proxy, you should talk to the person you want to name as the agent about your wishes concerning medical decisions, especially life-sustaining treatment.

Once the health care proxy is drawn up, your agent should keep the original document, or at least have access to it if you keep it. You should have a copy and your physician should also keep a copy with your medical records.

If you are interested in drawing up a health care proxy document, you should contact an attorney who is experienced in elder law matters. Many hospitals and nursing homes also provide forms, as do some public agencies.

Accompanying a health care proxy should be a medical directive. Such directives provide your agent with instructions on what type of care you would like. A medical directive can be included in the health care proxy or it can be a separate document. It may contain directions to refuse or remove life support in the event you are in a coma or a vegetative state, or it may provide instructions to use all efforts to keep you alive, no matter what the circumstances. Medical directives can

also be broader statements granting general authority for all medical decisions that are important to you. These broader medical directives give your agent guidance in less serious situations.

Living Wills

If you would like to avoid life-sustaining treatment when it would be hopeless, you need to draw up a living will. Living wills are documents that give instructions to withdraw life-sustaining treatment if you become terminally ill or are in a persistent vegetative state and unable to communicate your own instructions. Like a health care proxy, a living will takes effect only upon your incapacity. Also, a living will is not set in stone; you can always revoke it at a later date if you wish to do so.

A living will, however, is not necessarily a substitute for a health care proxy or a broader medical directive. It simply dictates the withdrawal of life support in instances of terminal illness, coma or a vegetative state.

The Risks of Not Planning

You may wonder whether you need a lawyer to do your estate plan. Maybe yes and maybe no. But why take any chances? A man who recently died apparently had an aversion to lawyers, but not to estate planning. Both in his apartment and in his safe deposit box he left many pieces of paper saying that he wanted all of his estate to go to his favorite niece. These included a trust that he got out of a form book, statements that property in the safe deposit box belonged to his niece, and other papers purporting to be his last will and testament.

Unfortunately for him, and even more for his favorite niece, none of these papers had any legal standing. The trust was not funded. The statement of ownership of assets in the box was not a completed gift to the niece because there never was delivery – the act of giving the assets to her. And, the purported wills were not properly witnessed. So the niece got a third of the estate instead of 100 percent. In a less cooperative family this also could have led to costly litigation, ironically to the benefit of lawyers whom the uncle was trying to avoid.

2. Estate Taxes, and How to Avoid Them

This chapter explains:

- The new rules governing the taxation of estates
- How to reduce an estate through gifts
- Credit shelter planning

Ever since the estate tax was instituted in 1916, whatever an individual owns has been subject to the federal estate tax upon their death – until 2010, that is. The tax law enacted in 2001 gradually reduced the estate tax and eliminated it entirely for 2010. To the surprise of many, Congress failed to enact legislation by the end of 2009 to prevent this from happening. Instead, lawmakers reached an agreement only at the end of 2010, when the estate tax rules were about to revert to the relatively stringent levels that had prevailed in 2001. Under those rules, estates above $1 million would have been taxed at a top rate of 55 percent.

The agreement that Congress finally reached at the end of 2010 cemented the federal estate tax rules for 2011 and 2012. If Congress fails to act before the end of 2012, the rules for 2013 will go back to the 2001 rules. For 2011 and 2012, the tax rate on estates is 35 percent of the excess over $5 million ($5.12 million for 2012). That said, not all estates are taxed:

First, you can leave any amount of property to your spouse free of federal estate tax, provided the spouse is a U.S. citizen.

Second, the federal government allows individuals a tax credit or exemption for gifts made during their lives or from their estates upon their deaths. This exemption amount, based on a "unified credit" used to reduce taxes, is $5 million in 2011 and $5.12 million in 2012, meaning that only those estates valued at more than that amount are subject to tax.

Third, gifts to qualified charities are not taxed.

The tax deal worked out at the end of 2010 gives the heirs of those dying in 2010 the option of applying either the 2010 rules (no federal estate tax) or the 2011 rules ($5 million exemption, 35 percent tax).

Tax Year	Tax Rate	Exemption Equivalent
2010	N/A or 35%	N/A or 5,000,000
2011	35%	5,000,000
2012	35%	5,120,000
2013	55%	1,000,000

For the Heirs of Those Dying in 2010

As noted above, the executors of those dying in 2010 will have a choice of either paying no estate tax or being subject to the new rules applying for 2011. For the heirs of those dying in 2010 with significant wealth, this choice could be important due to the interplay of estate and capital gains taxes.

For 2010 the estate tax was replaced with a capital gains tax on inherited assets that are later sold. Normally someone inheriting property at an individual's death gets a "step-up" in basis in the property. That is, the value of the property for determining the capital gains tax due is calculated at the time it is inherited, not when it was originally bought. (For further explanation of this concept, see the Asset Transfers section of Chapter 7.)

But the law eliminating the estate tax in 2010 also did away with the basis step-up rules. This meant that those inheriting assets would have to pay capital gains taxes on any assets sold based on the original price paid for the asset, after an exemption for the first $1.3 million in capital gains (plus $3 million for assets transferred to a surviving spouse). This potentially placed great administrative burdens on the executors of estates to ascertain the original price paid for inherited assets.

In addition, a period without an estate tax places at particular risk couples who have so-called "credit shelter" or "bypass" trusts that are

designed to allow both spouses to take advantage of their respective estate tax exemptions (see Credit Shelter Planning below).

For these reasons, Congress made the new $5 million estate tax exemption and 35 percent rate retroactive to January 1, 2010, and gave executors of the estates of those dying in 2010 the option of being subject to the new estate tax provisions, including a step-up in the basis of inherited assets, or the "no estate tax" law already in place for 2010. You will need to consult with an attorney to determine which option works best for a particular estate.

Portability

The estate tax law for 2011 and 2012 also makes the federal estate tax exemption "portable" between spouses. This means that if the first spouse to die does not use all of his or her $5 million exemption, the estate of the surviving spouse may use it. So, for example, let's say John dies in 2011 and passes on $3 million to the children he has with his wife, Mary. John has no taxable estate. If at the time of Mary's later death the federal estate tax exemption is still $5 million, she can pass on $7 million free of federal tax — her own $5 million exclusion plus John's unused $2 million exclusion that she "inherited" from him. However, to take advantage of this Mary must make an "election" on John's estate tax return. Check with your attorney.

The new law contains other and unprecedented wealth transfer opportunities for those with substantial estates. For example, the lifetime gift tax threshold has been raised from $1 million to $5.12 million (in 2012) and the "generation-skipping transfer tax" exemption is also $5.12 million. Some taxpayers will now feel freer to make gifts to family members, although most people were never at risk of giving away more than $1 million during their lives.

What About State Estate Taxes?

Nearly half the states also have an estate or inheritance tax, and most have exemption thresholds of $1 million or less. Before the tax laws changed in 2001, taxpayers received a credit against their federal estate tax liability for state estate tax payments, up to certain limits. Many

states simply taxed estates up to the credit available, resulting in no extra cost to estates.

However, this credit, which was a significant revenue source for states, was repealed as of January 1, 2005, totally eliminating the estate tax for such states. To make up for the revenue loss, many states have changed their estate and inheritance tax systems over the last few years and more changes at the state level can be expected as state lawmakers react to the new federal estate tax landscape. This means that some estate planning methods that once resolved all estate tax issues up to a certain size estate are no longer effective at both the state and federal levels and need to be revised; check with your attorney.

Making Gifts: The $13,000 Rule

One simple way to reduce estate taxes (or to shelter assets in order to qualify for Medicaid coverage of nursing home costs) is to give some or all of your estate to your children (or anyone else) during your life in the form of gifts. Certain rules apply, however. There is no actual limit on how much you may give during your lifetime. But if you give any one individual more than $13,000 in a calendar year, you must file a gift tax return reporting the gift to the IRS. The amount above $13,000 will be counted against the new $5.12 million ($10.24 million for married couples) lifetime tax exclusion for gifts (in 2012). Each dollar of gift above $13,000 to any one individual also reduces the amount that can be transferred tax-free in your estate.

Provided the gift to any one person during a calendar year is for no more than $13,000, it does not need to be reported as a gift. Thus, for example, a grandparent may give $13,000 to each of his or her children, their spouses, and his or her grandchildren (or to any number of other people he or she chooses) each year without reporting these gifts to the IRS. Married couples can duplicate these gifts. For example, a married couple with four children can give away up to $104,000 a year to them with no gift tax implications. In addition, the gifts will not count as taxable income to their children (although the earnings on the gifts if they are invested will be taxed to the gift recipient).

(Most people with less than $5.12 million don't need to worry

about gift taxes because they can't give away enough money to incur a tax. And the penalty for not reporting gifts in excess of $13,000 is a percentage of the gift tax owed. Since a percentage of $0 is $0, in effect, there's no penalty. The one caveat, however, is that Congress could lower the threshold to $1 million again in 2013.)

There are some downsides to gifting. One is the loss of stepped-up basis if capital gain property is being gifted (for an explanation of this concept, see the Asset Transfers section of Chapter 7). Another is the loss of use and control of the gifted property. Trusts can often be used instead to accomplish more effective tax savings. Finally, as is explained in Chapter 7, gifts of assets can have consequences for Medicaid eligibility, triggering a penalty period before benefits can be received.

Credit Shelter Planning

Although you can give an unlimited amount to your spouse when you die, in prior years the second spouse to die has been limited to her own estate tax exemption upon her death. In other words, without proper planning the exemption of the first spouse to die is lost. The way to preserve both spouses' exemptions has been to create a "credit shelter trust" (also called an A/B or bypass trust).

The currently high federal estate tax exemption, coupled with the portability feature that allows the first spouse to die to pass his exemption to the surviving spouse, might suggest that this planning strategy is needless unless you are a multi-millionaire. But there are still reasons for those of more modest means to do this kind of planning, and one of the main ones is state taxes. As noted above, many states have an estate or inheritance tax and the thresholds are usually far lower than the current federal one.

Let's say that a couple lives in State X, which has retained an estate tax on all estates over $1 million (this is the state's exemption). Looking at just the federal exemption of $5.12 million and the ability for the first spouse to die to transfer his or her unused credit to the other spouse, it would appear that the couple would have no tax issues if their estate is under $10.24 million. However, if the first spouse on

death passes everything to the surviving spouse, she may end up with an estate well over the state's $1 million threshold and be subject to a substantial state tax upon her own death. In effect, the couple has lost the state's unified credit of the first spouse to pass away.

Standard estate tax planning is to split an estate that is over the prevailing state or federal exemption amount between spouses and for each spouse to execute a trust to "shelter" the first exemption amount in the estate of the first spouse to pass away. While the terms of such trusts vary, they generally provide that the trust income will be paid to the surviving spouse and the trust principal will be available at the discretion of the trustee if needed by the surviving spouse. Since the surviving spouse does not control distributions of principal, the trust funds will not be included in her estate at her death and will not be subject to tax. This way, in State X the couple can protect up to $2 million from estate taxation while still making the entire estate available to the surviving spouse if needed.

The rising federal estate tax exemption means that many older trusts drawn up for married couples contain outdated estate-splitting provisions that may cost them dearly in state or federal taxes, or both. Couples would do well to have their revocable trusts that contain credit shelter provisions reviewed by a competent professional.

Even if your state has no estate or inheritance tax, there are other reasons to have a credit shelter trust. Here are a few: it shields funds in trust from creditors; it protects children's inheritance if the surviving spouse remarries; it helps avoid administrative headaches; and, we never know what Congress will do down the road.

3. The Probate Process: What to Do Following a Death

This chapter explains:

- The necessary steps to take upon the death of a parent or other relative
- The general rules for administering an estate

First Steps

The emotional trauma brought on by the death of a close family member often is accompanied by bewilderment about the financial and legal steps the survivors must take. The spouse who passed away may have handled all of the couple's finances. Or perhaps a child must begin taking care of administering an estate about which he or she knows little. And this task may come on top of commitments to family and work that can't be set aside. Finally, the estate itself may be in disarray or scattered among many accounts, which is not unusual with a generation that saw banks collapse during the Depression.

Here we set out the steps the surviving family members should take. These responsibilities ultimately fall on whoever was appointed executor or personal representative in the deceased family member's will. Matters can be a bit more complicated in the absence of a will, because it may not be clear who has the responsibility of carrying out these steps.

First, secure the tangible property. This means anything you can touch, such as silverware, dishes, furniture, or artwork. You will need to determine accurate values of each piece of property, which may require appraisals. Later, you will distribute the property as the deceased directed. If property is passed around to family members before you have the opportunity to take an inventory, this will become a difficult, if not impossible, task. Of course, this does not apply to gifts the deceased may have made during life, which will not be part of his or her estate.

Second, take your time. You do not need to take any other steps immediately. While bills do need to be paid, they can wait a month or two without adverse repercussions. It's more important that you and your family have time to grieve. Financial matters can wait.

When you're ready, but not a day sooner, meet with an attorney to review the steps necessary to administer the deceased's estate. Bring as much information as possible about finances, taxes and debts. Don't worry about putting the papers in order first; the lawyer will have experience in organizing and understanding confusing financial statements. Just bring all the information and papers you have to the meeting.

The Probate Process

Probate is the process by which a deceased person's property (the "estate") is passed to his or her heirs and legatees (people named in the will). Strictly speaking, "probate" only includes property owned by the deceased in his or her individual name, not joint property, living trusts, life insurance or retirement accounts that pass automatically at death. But the term is often used to encompass the entire estate, including both probate and non-probate property. While the legal process, supervised by the probate court, usually takes about a year, substantial distributions from the estate can be made in the interim.

The exact rules of estate administration differ from state to state. In general, they include the following steps:

1. **Filing the will and petition** at the probate court in order to be appointed executor or personal representative. In the absence of a will, next of kin must petition the court to be appointed "administrator" of the estate. In many states in the absence of a will, not only family but any "interested party," including creditors, may be appointed.

2. **"Marshaling," or collecting, the assets.** This means that you have to find out everything the deceased owned. You need to file a list, known as an "inventory," with the probate court. It's generally best to consolidate all the estate funds to the extent possible. Bills and bequests should be paid from a single checking account, either one

you establish or one set up by your attorney, so that you can keep track of all expenditures. The account needs to be a new account in the name of the estate, not the continuation of an account previously owned by the decedent.

3. **Paying bills and taxes.** A federal estate tax return generally must be filed if the estate exceeds the estate tax exemption equivalent applying in the year when the individual died. Many states have lower taxation thresholds. The return must be filed within nine months of the date of death. If you miss this deadline and the estate is taxable, severe penalties and interest may apply. If you do not have all the information available in time, you can file for an extension and pay your best estimate of the tax due. In any case, estate tax returns should be prepared by an experienced probate attorney.

4. **Filing tax returns.** You must also file a final income tax return for the decedent and, if the estate holds any assets and earns interest or dividends, an income tax return for the estate. If the estate does earn income during the administration process, it will have to obtain its own tax identification number in order to keep track of and properly report such earnings.

5. **Distributing property to the heirs and legatees.** Generally, executors do not pay out all of the estate assets until the period runs out for creditors to make claims, which can be as long as a year after the date of death. But once the executor understands the estate and the likely claims, he or she can distribute most of the assets, retaining a reserve for unanticipated claims and the costs of closing out the estate.

6. **Filing a final account.** The executor must file an account with the probate court listing any income to the estate since the date of death and all expenses and estate distributions. Once the court approves this final account, the executor can distribute whatever is left in the closing reserve, and finish his or her work.

Some of these steps can be eliminated by avoiding probate through joint ownership or trusts. But whoever is left in charge still has to pay all debts, file tax returns, and distribute the property to the rightful heirs. You can make it easier for your heirs by keeping good

records of your assets and liabilities. This will shorten the estate administration process and reduce the legal bill.

Should You Avoid Probate?

The answer is "yes." But don't worry too much about it. Lawyers and others selling "living" and "loving" trusts paint a grim picture of the horrors of probate. While the stories are no doubt true, they are not typical. The probate process involves some expense and can take up to a year, or even longer in some cases. It involves the probate court, which can be cumbersome. And your finances become a public record. These are the downsides. The upside is that court supervision can help make certain that your estate is passed on properly as you direct.

While probate is not usually the nightmare predicted by some, it is an added expense and burden for your heirs that can be avoided. If you have more than one child, the best mechanism to avoid probate is a revocable trust, often referred to as a "living" trust. There is some expense to establishing the trust, and it provides no benefit unless you actually go to the trouble of retitling your assets so that the trust is funded. If you want one heir to receive everything, and you are not concerned that he or she may abscond with your funds (and there's no risk of bankruptcy, divorce or need for financial aid), you can simply put his or her name on your accounts and real estate as a joint owner.

Additional advantages of a revocable trust are that they provide for management of your assets if you become incompetent and they can continue for the benefit of one or more of your heirs if you do not think it wise to give them funds outright.

PART TWO

Long-Term Care Planning: Getting the Care You Deserve at a Price You Can Afford

The Need for Planning

One of the greatest fears of older Americans is that they may end up in a nursing home. This not only means a significant loss of personal autonomy, but also a tremendous financial price. Depending on location and level of care, nursing homes cost between $50,000 and $250,000 a year. In 2011, the average cost of a private room in a nursing home was $87,235 a year, according to MetLife.

Most people end up paying for nursing home care out of their savings until they run out. Then they can qualify for Medicaid to pick up the cost. The advantages of paying privately are that you are more likely to gain entrance to a better quality facility and it eliminates or postpones dealing with your state's welfare bureaucracy – an often demeaning and time-consuming process. The disadvantage is that it's expensive.

Careful planning, whether in advance or in response to an unanticipated need for care, can help protect your estate, whether for your spouse or for your children. This can be done by purchasing long-term care insurance or by making sure you receive the benefits to which you are entitled under the Medicare and Medicaid programs. Veterans may also seek benefits from the Veterans Administration.

4. Alternatives to Nursing Home Care

This chapter explains:

- How to plan for in-home care of an older person
- Help for in-home caregivers
- Three alternatives to nursing homes

Staying Home

Studies show that older Americans prefer to stay in their own homes if they possibly can – not a surprise. As a result, most care is provided at home, whether by family or by hired help. This has many consequences, some of which may be quite unexpected.

To begin with, family members shoulder most of the burden of caring for the elderly at home. Being the primary caretaker for someone who requires assistance with activities of daily living, such as walking, eating and toileting, can be a consuming and exhausting task. One important consideration when one family member has the sole responsibility of caring for a parent or other older relative is the question of equity with other family members. For example, is the child being fairly compensated for her work? If the older person is living with a child, does the elder help pay for the house? If the care is taking place in the elder's home, should the child have an ownership interest in the house?

For parents with only one child, such arrangements may not be so complicated, but if the parent has more than one child, it can be difficult to know what's fair. An arrangement that seems equitable today may not seem that way after a child has devoted, say, five years to the care of the parent. And if a plan is set up that is fair for five years of care, what happens if the parent suddenly moves into a nursing home during the first year? With no planning for such eventualities, the care of an older person can foster resentment and guilt among family members. Fortunately, most elder law attorneys are skilled in helping families devise creative solutions to such problems.

To find a qualified elder law attorney, go to www.elderlawanswers.com

Getting Outside Help

State and federal government officials are slowly recognizing that home care is more cost-effective than institutional care. This means that, depending on the state, financial or other assistance may be available for those who choose to remain in their homes despite declining capabilities.

Public and private agencies offer a variety of home care services that may be available:

- Home health care, either part-time or 24-hour care
- Personal care and homemaking services, such as shopping, cooking and cleaning
- Services delivered to the home, such as meals programs, transportation and home repair
- Adult day care centers that offer more intensive services than senior centers. There are more than 4,600 such centers around the nation, according to the National Adult Day Services Association, and they are often affiliated with churches or non-profit community agencies.
- Money management.
- Respite services. These programs provide caretakers a periodic break. A home care professional or aide substitutes for the caretaker for a specified period of time.

Medicare and Medicaid provide some coverage of the medical portion of home health care. Although the coverage is often inadequate, when combined with other resources available to the client and his family, it may be enough to keep a fragile older person at home for a longer period of time.

Medicare-Covered Home Health Benefits

If the beneficiary qualifies, Medicare will cover home health benefits entirely and with no limit on the length of time you are covered. Beneficiaries are entitled to Medicare coverage of their home health care if they meet the following requirements:

- They are confined to their home (meaning that leaving it to receive services would be a "considerable and taxing effort").

- Their doctor has ordered home health services for them.
- At least some element of the services they receive is "skilled" (intermittent skilled nursing care, physical therapy or speech therapy).

Congress severely cut back these benefits as part of the Balanced Budget Act of 1997. Some of what was available before then has been restored, but Visiting Nurse Associations are still playing a zero sum game. The more they provide one beneficiary, the less they can provide others. That said, for an individual beneficiary, energetic advocacy can often mean more benefits.

Medicaid-Covered Home Health Benefits

Medicaid offers very little in the way of home care except in New York State, which provides home care to all Medicaid recipients who need it. Recognizing that home care costs far less than nursing home care, a few other states – notably Hawaii, Oregon and Wisconsin – are pioneering efforts to provide services to those who remain in their homes.

Home Health Care Providers

There are thousands of private home care agencies around the nation. About half of these are Medicare or Medicaid Certified Home Care Agencies, meaning that these two federal programs will reimburse for services provided by the agency if the services are covered. Such certification also means that the agency has met certain minimum federal standards regarding patient care and finances. Home care agencies can also gain accreditation from private accrediting organizations. The three major accrediting groups for home care agencies are the Community Health Accreditation Program (www.chapinc.org); the Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org); and the National Association for Home Care & Hospice (www.nahc.org).

Other Services

Non-medical services are also available to help older persons remain independent. The Older Americans Act funds more than 10,000 senior centers and makes grants to State and Area Agencies on Aging to provide services to seniors that include Meals-on-Wheels, transportation,

To find Area Agencies on Aging programs across the country, visit the Eldercare Locator Web site at (www.eldercare.gov) or call the nationwide, toll-free Eldercare Locator at 1-800-677-1116. In many cases, these agencies offer case management and coordination services.

respite care, housekeeping and personal care, money management, and shopping. Services are usually free but staffing may be limited.

Private Geriatric Care Managers

The new profession of "private geriatric care manager" has evolved to help coordinate services for seniors. Private geriatric care managers usually have a background in either social work, nursing, or psychology and they are experts in helping older persons and their families assess what the best care and living arrangement is for a senior needing assistance and in carrying out that plan. These care managers evaluate an older person's needs, review the options available, and monitor care once it is being delivered. Their services can be invaluable. Finding the right care for an aging parent may be a once-in-a-lifetime burden for the children, but it's what geriatric care managers do every day. They have the experience and knowledge of local resources that cannot be duplicated.

Geriatric care managers can be especially important when children live far from their parents. The geriatric care manager can act as a surrogate parent, making visits to home or to a nursing facility, and reporting back to family members.

To find a qualified geriatric care manager in your area, visit the Web site of the National Association of Professional Geriatric Care Managers at www.caremanager.org.

Alternative Living Arrangements

The reality is that it's sometimes impossible or too expensive for an elderly person in poor health to remain at home. Other seniors may simply wish to live with others rather than be isolated. Fortunately, over the last two decades there has been an explosion of supportive housing alternatives for seniors, and the options are no longer limited to an agonizing choice between staying at home or moving to a nursing home. If a loved one does not require round-the-clock skilled nursing care, one of these supportive housing alternatives may be just right.

Board and Care Facilities

These are group residences that can range in size from as few as two residents to more than 200. They may also be referred to as residential care facilities, homes for the aged, or community-based residential facilities. Such facilities provide room, board, and 24-hour supervision, as well as help with some of the six activities of daily living, often referred to as ADLs (eating, dressing, bathing, using a toilet, transferring from one position to another, continence), and the instrumental activities of daily living or IADLs (preparing meals, walking outdoors, taking medications, shopping, housekeeping, using the telephone, handling money).

Such facilities generally do not provide any medical services. These homes may be unlicensed, and even licensed homes may rarely be monitored by the state. Costs can range from $350 to $3,500 a month. For those with very limited incomes, Supplemental Security Income (SSI) may help pay the cost of these homes. Medicaid may also reimburse the monthly fee, depending on the state and the resident's Medicaid eligibility.

Assisted Living Facilities

The assisted living industry has experienced tremendous growth over the past 10 years. There are now as many as 38,000 assisted living residences in the United States (the precise number depends on the definition).

These facilities offer basically the same services as board and care homes, but in a more "upscale" and private environment. Housing is often in small apartments and there is generally more space, more privacy and more recreational options. A premium is placed on retaining as much independence in living as possible, and care is more individualized. Despite the emphasis on independence, twenty-four hours a day supportive services are available to meet residents' needs. There also may be more medical supervision than in a board and care home, depending on the facility.

While costlier than board and care homes, assisted living facilities nevertheless are usually less expensive than a nursing home. Assisted living facility residents agree to pay a monthly rent, which averaged $3,477 a month in 2011, according to the MetLife Market Survey of

A number of Web sites list assisted living facilities; here are three:
Senior Housing Net (www.seniorhousingnet.com)
SeniorLiving.net (www.assistedlivinginfo.com)
Assisted Senior Living (www.assistedseniorliving.net)

For state assisted living regulations, visit www.ahcancal.org/ncal/resources/Pages/AssistedLivingStudies.aspx

Assisted Living Costs. This rent may cover all services or there may be charges for services above the monthly fee on a per-use basis. Residents generally pay the cost of medical care from their own financial resources, although some costs may be reimbursed by an individual's health insurance program or long-term care insurance policy. Many state Medicaid programs now provide some type of funding for elderly residents who qualify for the Medicaid program.

However, assisted living facilities are an emerging industry and not all states regulate such centers to protect residents from substandard care or questionable business practices. Even when these facilities are regulated, there are no common standards for assisted living across the United States. "Assisted living" can mean different things in different states. In addition, most states authorize facilities to evict residents when the facility's services do not meet a resident's needs. Asking specific questions can help you gauge the quality of a facility, what sort of medical care is provided (if any), and under what circumstances a resident may be discharged. A national non-profit organization, the Assisted Living Consumer Alliance (ALCA), has been formed to advocate for stronger consumer protections for assisted living residents. Visit www.assistedlivingconsumers.org.

Continuing Care Retirement Communities (CCRCs): "Aging in Place"

Continuing Care Retirement Communities, "CCRCs," guarantee a life-long place to live. Assisted living and even skilled nursing facilities make no such guarantees, and in fact they may ask a resident to leave if they believe they cannot provide the care the person requires.

CCRCs offer the entire residential continuum – from independent housing to assisted living to round-the-clock nursing services – under one "roof." Such settings allow seniors to "age in place." Residents pay an entry fee and an adjustable monthly rent in return for the guarantee of care for the rest of their life.

Because CCRCs maintain an assortment of on-site medical and social services and facilities, residents can enter the community while still relatively healthy and then move to more intensive care as it becomes necessary. Nursing care is often located within the CCRC or at a related facility nearby. In addition to health care services, CCRCs also typically provide meals, housekeeping, maintenance, transportation, social activities, and security. Communities range in size from about 100 to 500 living units

CCRCs are so diverse in their offerings and personality that the saying in the industry is that "if you've seen one CCRC, you've seen one CCRC." The physical plants of CCRCs run the gamut from urban high-rises to garden apartments, cottages cluster homes, or single-family homes. Some CCRCs offer units that are designed for people with special medical needs, such as Alzheimer's disease.

The downside of CCRCs is the cost, which can be more than those with low or moderate income and assets can afford. Prices depend on the amount of care provided, the type of contract, and the unit's size and geographic location. Entry fees run from $80,000 to more than $750,000, with monthly charges ranging from $500 to more than $4,000. (A number of different fee arrangements are available, depending on the facility.) Often seniors use the proceeds from the sale of their home to make the initial investment in the retirement community.

As with assisted living facilities, the regulation of CCRCs is spotty. These institutions are strictly regulated in some states, while not at all in others, and there is no overarching federal agency that watchdogs retirement communities. A private non-profit organization, the Continuing Care Accreditation Commission (CCAC), accredits CCRCs. The CCAC accreditation process is voluntary, and its high cost and the length of time it takes to complete means that accreditation is a good indicator of a facility's quality.

Nevertheless, a CCRC's lack of accreditation should not necessarily be taken as a bad sign. One of the most important considerations is the financial soundness of the facility, particularly in a weak economy. In selecting a community, experts recommend choosing a "mature" facility, one that has been in business a number of years. Also, know who the CCRC's sponsor is.

The CCAC's Web site lists all CCRCs that have been accredited. Go to: www.carf.org

Most CCRCs are operated by non-profit groups. The Religious Society of Friends (Quakers), for example, has been in the CCRC business for quite a while and its facilities are reputed to be excellent.

CCRC Entry Requirements

Most CCRCs require that a resident be in good health, be able to live independently when entering the facility, and be within a certain age range. As a prerequisite to admission, facilities may also require both Medicare Part A and Part B, and perhaps Medigap coverage as well. A few are now even making long-term care coverage a prerequisite. Of course, applicants will have to demonstrate that they have the means to meet the required fees.

For a checklist of questions to ask assisted living facilities and CCRCs, see www.elderlawanswers.com/reliable_sources/check_livingcare.asp

CCRC residents usually fund their care out of their own pockets. However, Medicare, and at times Medicaid, can be used to pay for certain services, and most CCRCs accept either Medicare or Medicaid. Although Medicare does not generally cover long-term nursing care, it often covers specific services that a CCRC resident might receive, such as physician services and hospitalization. Very few CCRC residents are eligible for Medicaid.

How to Evaluate a Facility and Contract

Deciding on a CCRC is a once-in-a-lifetime choice, and it is a decision that should be made carefully. Many communities allow prospective residents to spend some time in residence on a temporary basis to experience life at the facility. Each community has an agreement or contract that lays out the services provided. Potential residents should make sure they understand the contract before signing, and they are well advised to seek legal or financial counsel before entering into any agreement.

LeadingAge is the national association for the non-profit CCRCs. Go to www.leadingage.org

5. Nursing Homes: Placement and Resident Rights

This chapter explains:

- How to evaluate a nursing home
- How to talk with family members about placement
- The rights of nursing home residents
- How to resolve disputes with the nursing home

While no one ever wants to move to a nursing home, a lot of people end up there anyway. There are 15,500 nursing homes in the United States caring for approximately 1.4 million residents. Of these residents, 90 percent are over age 65 and about half are over age 85. By definition, they are little able to care for themselves and need all the protection provided them under law and by families and friends.

Choosing and Evaluating a Nursing Home

Can there be a more difficult job than finding a nursing home for a parent or spouse? They serve as institutions of last resort when it's impossible to provide the necessary care in any other setting. And, typically, the search takes place under the gun – when a hospital or rehabilitation center is threatening discharge or it's no longer possible for the loved one to live at home. Finally, in most cases, finding the right nursing home is a once-in-a-lifetime task, one you're taking on without the experience of having done it before.

That said, there are a few rules of thumb that can help you:

1. **Location, location, location.** No single factor is more important to quality of care and quality of life of a nursing home resident than visits by family members. Care is often better if the facility knows someone's watching and cares. Visits can be the high point of the day or week for the nursing home resident. So, make it as easy as possible for family members and friends to visit.

For a checklist of factors to consider when selecting a nursing home, go to www.elderlawanswers.com/reliable_sources/check_nursing.asp

2. **Get references.** Ask the facility to provide the names of family members of residents so you can ask them about the care provided in the facility and the staff's responsiveness when the resident or relatives raise concerns.
3. **Check certifying agency reports.** Is the facility certified by Medicare and Medicaid? How long has the facility been certified? Free nursing home performance comparisons are available online from Medicare (visit www.medicare.gov/NHCompare/home.asp). To help consumers compare nursing homes more easily and identify areas about which to ask questions, Medicare has created a Five-Star Quality Rating System. The ratings are based on a facility's performance in three areas: quality measures, nurse staffing levels and health inspection reports. Medicare's Web site explains the strengths and limitations of the rating system.
4. **Talk to the nursing home administrator or nursing staff** about how care plans are developed for residents and how they respond to concerns expressed by family members. Individual care plans must be implemented for each resident. How often is the care plan reviewed and changed? What is the protocol for handling problems? A resident of a nursing home must be under the care of a licensed physician. The physician must evaluate the resident's needs and prescribe a program of medical care, including therapy, diet restrictions, and medication. Make sure you are comfortable with the response. It is better that you meet with and ask questions of the people responsible for care, not just the person marketing the facility.
5. **Tour the nursing home.** Try not to be impressed by a fancy lobby or depressed by an older, more rundown facility. What matters most is the quality of care and the interactions between staff and residents. See what you pick up about how well residents are attended to and whether they are treated with respect. Also, investigate the quality of the food service. Eating is both a necessity and a pleasure that continues even when we're unable to enjoy much else.

Talking With Family About Placement

The difficulty of deciding on a nursing home can be compounded when family members disagree on whether the step is necessary. This is true whether the person disagreeing is the person who needs help, his or her spouse, or a child.

We recommend the following steps to make the process less difficult:

1. **Include all family members in the decision.** Let them know what is happening to the person who needs care and what providing that care involves. If possible, have family meetings, whether with the family alone or with medical and social work staff, where available. If you cannot meet together, or in between meetings, use the telephone, the mail or e-mail.

2. **Research other options.** Find out what care can be provided at home, what kind of day care options are available outside of the home, and whether local agencies provide respite care to give the family care providers a much-needed rest. Also, look into other residential care options, such as assisted living and board and care homes. Local agencies, geriatric care managers, and elder law attorneys can help answer these questions.

3. **Follow the steps above for finding the best nursing home placement available.** If you and other family members know you've done your homework, the guilt factor can be assuaged (at least to some extent).

4. **Where necessary, hire a geriatric care manager to help.** While hospitals and public agencies have social workers to help out, they are often stretched too thin to provide the level of assistance you need. In addition, they can have dual loyalties – to the hospital that wants a patient moved as well as to the patient. A social worker or nurse working as a private geriatric care manager can assist in finding a nursing home, investigating alternatives either at home or in another residential facility, in evaluating the senior to determine the necessary level of care, and in communicating with family members to facilitate the decision. See Chapter 4 for more on these specialists and how to find one.

Resident Rights

While residents in nursing homes legally have no lesser rights than anyone else, the combination of an institutional setting and the disability that put the person in the facility in the first place often results in a loss of dignity and the absence of proper care.

As a result, in 1987 Congress enacted the Nursing Home Reform Law that has since been incorporated into the Medicare and Medicaid regulations. In its broadest terms, it requires that every nursing home resident be given whatever services are necessary to function at the highest level possible. The law gives residents a number of specific rights, among them:

1. Residents have the right to be free of unnecessary physical or chemical restraints.
2. When a resident experiences any deterioration in health, or when a physician wishes to change the resident's treatment, the facility must inform the resident, and the resident's physician, legal representative or interested family member.
3. Facilities must inform residents of the name, specialty, and means of contacting the physician responsible for the resident's care. Residents have the right to participate in care planning meetings.
4. The resident has the right to gain access to all his or her records within one business day, and a right to copies of those records at a cost that is reasonable in that community.
5. The facility must provide a written description of legal rights, explaining state laws regarding living wills, durable powers of attorney for health care and other advance directives, along with the facility's policy on carrying out these directives.
6. At the time of admission and during the stay, nursing homes must fully inform residents of the services available in the facility, and of related charges.
7. The resident has a right to privacy, which is a right that extends to all aspects of care, including care for personal needs, visits with family

and friends, and communication with others through telephone and mail. Residents thus must have areas for receiving private calls or visitors so that no one may intrude and to preserve the privacy of their roommates.

8. Residents have the right to share a room with a spouse, gather with other residents without staff present, and meet state and local nursing home ombudspersons or any other agency representatives. Residents may leave the nursing home, or belong to any church or social group. Within the home, residents have a right to manage their own financial affairs, free of any requirement that they deposit personal funds with the facility.

9. Residents also can get up and go to bed when they choose, eat a variety of snacks outside meal times, decide what to wear, choose activities, and decide how to spend their time. The nursing home must offer a choice at main meals, because individual tastes and needs vary. Residents, not staff, determine their hours of sleep and visits to the bathroom. Residents may self-administer medication.

10. Residents may bring personal possessions to the nursing home, such as clothing, furnishings and jewelry.

11. Nursing home residents may not be moved to a different room, a different nursing home, a hospital, back home or anywhere else without advance notice, an opportunity for appeal and a showing that such a move is in the best interest of the resident or necessary for the health of other nursing home residents.

12. The resident has a right to be free of interference, coercion, discrimination, and reprisal in exercising his or her rights. Being assertive and identifying problems usually brings good results, and nursing homes have a responsibility not only to assist residents in raising individual concerns, but also to respond promptly to those concerns.

Resolving Disputes

The nursing homes that live up to the ideal of what we would want for our parents or ourselves are few and far between. The question is how far you can push them towards that ideal, what steps to take in pushing, and at what stage does the care become not only less than ideal, but so inadequate as to require legal or other intervention. This can be a hard determination to make and in some cases needs the involvement of a geriatric care manager who can make an independent evaluation of the resident and who has a sufficient knowledge of nursing homes to know whether the one in question is meeting the appropriate standard of care.

Following is a list of the interventions a family member may take, in ascending order of degree. Move down the list as the severity of the problem increases or the facility does not respond to the less drastic actions you take. In all cases, take detailed notes of your contacts with facility staff and descriptions of your family member and his or her care. Always note the date and the full name of the person with whom you communicate.

1. **Talk to staff.** Let them know what you expect, what you care about and what your family member cares about. This may easily solve the problem.

2. **Talk to a supervisor,** such as the nursing chief or an administrator. Explain the problem as you see it. Do it with the expectation that the issue will be favorably resolved, and it may well be.

3. **Hold a meeting with the appropriate nursing home personnel.** This can be a regularly scheduled care planning meeting or you can ask for a special meeting to resolve a problem that wasn't resolved more informally.

To find the ombudsperson nearest to you, contact the Ombudsman office in your state, which can be found at www.ltcombudsman.org

4. **Contact the ombudsperson assigned to the nursing home.** He or she should be able to intervene and get an appropriate result.

5. If the problem constitutes a violation of the resident rights described above, **report it to the state**

licensing agency. This should put necessary pressure on the facility.

6. **Hire a geriatric care manager to intervene.** An advocate for you who is not as personally involved as you and who understands how nursing homes function as institutions can help you determine what is possible to accomplish and can teach the facility to make the necessary changes.

7. **Hire a lawyer.** While a lawyer may be necessary to assert the resident's rights, the involvement of an attorney may also escalate the dispute to a point where it is more difficult to resolve. This is why we have listed this as one of the last options. But when all else fails, a lawyer has the tools to make the facility obey the law.

   The National Senior Citizens Law Center's guide, *20 Common Nursing Home Problems — and How to Resolve Them*, offers clear explanations of relevant law and careful instructions on how a resident, family member or advocate should proceed. For more, go to: www.nsclc.org/index.php/store/books/

8. **Move your relative.** If nothing else works, move your family member to a better facility. This may be difficult, depending on the situation, but it may be the only solution. It does not prevent you from pursuing legal compensation for any harm inflicted on the nursing home resident while at the earlier facility.

9. **Sue the facility.** If your relative is injured in the facility, whether through negligence, abuse, or no one's fault, make sure the incident is recorded in his or her medical records and consult with an attorney. The lawyer can help you to decide whether a suit should be brought against the facility. Don't avoid dealing with a problem, whether it's an injury or not, because you are afraid of reprisal against your family member. Your attorney can work with you to make sure your relative is protected. This may involve the relative moving to another facility prior to making any claim.

6. Alternatives to Medicaid Coverage of Nursing Home Care

This chapter explains:

- What Medicare pays for
- Long-term care insurance
- Rules for purchasing a good long-term care insurance policy
- The tax-deductibility of long-term care insurance premiums

Medicare

Don't look to Medicare to cover much, if any, nursing home care. Medicare Part A covers only up to 100 days of care in a "skilled nursing" facility per spell of illness. The care in the skilled nursing facility must follow a stay of at least three days in a hospital. And for days 21 through 100, you must pay a co-payment of $144.50 a day (in 2012). (This is generally covered by Medigap insurance.) In addition, the definition of "skilled nursing" and the other conditions for obtaining this coverage are quite stringent, meaning that few nursing home residents receive the full 100 days of coverage. As a result, Medicare pays for only about 17 percent of nursing home care in the United States.

That said, all Medicare beneficiaries should make sure they get their full benefit. Typically, after a certain amount of time in a skilled nursing facility, the facility informs the patient's family that he or she is no longer making progress with physical therapy or other skilled treatment and that the Medicare coverage will end. To be effective, the notice must be in writing. It is a misconception that a patient must be making progress to merit Medicare coverage. Any benefit from the treatment, even if it simply slows down deterioration, merits its continuation and the continuation of Medicare coverage. Family members should advocate for continued physical or other therapy for the patient both due to the benefit of the treatment and to extend Medicare coverage.

If the institution insists on terminating coverage, the written notice will give the patient or family member the opportunity to ask for a review. There's no cost for the review, so there's no reason not to request it. While the fiscal intermediary – the insurance company under contract to administer the Medicare program – conducts its review, the patient does not have to pay for his care. However, if the fiscal intermediary agrees with the termination of benefits, the patient will be responsible for the cost of care back to the date of the termination notice. Further appeals are possible but should be done with the help of a lawyer.

Long-Term Care Insurance

If you can afford the premiums and you are insurable, the best solution to the prospect of significant long-term care costs is long-term care insurance. Most long-term care insurance policies today pay for home care and assisted living as well as for nursing home care. The problem is choosing a good policy and being able to afford it.

Long-term care insurance is a contract between an insurance company and a policyholder to pay for certain types of coverage under certain conditions. In general, long-term care policies are sold to policyholders by insurance agents, although group policies are becoming increasingly available as an employee benefit, through membership organizations like AARP, and from health maintenance organizations. Despite the wide range of policy options, there are a few rules of thumb for purchasing a policy. Following these rules tends to drive up the insurance premium, but if you are going to invest in long-term care coverage, you should buy a good policy.

1. **Buy enough coverage for what you want to cover.** While nursing homes are increasingly expensive, more alternatives to nursing homes exist than ever before. If you cannot afford to purchase sufficient coverage to pay for nursing home care (including anticipated inflation), you may be able to cover the cost of home care or assisted living.

2. **Most advisors recommend purchasing five years of coverage.** After moving to a nursing home or assisted living facility, you may want to

Here's a formula for figuring out how much long-term care coverage to purchase: the average daily cost of a nursing home today times 2, minus your monthly income divided by 30, equals the amount of coverage to purchase. For instance, if the average nursing home in your area costs $200 a day and your projected retirement income is $2,400 a month ($80 a day), you should buy coverage of $320 a day ($400 – $80 = $320). Somewhat less coverage can be purchased if an inflation rider is bought (meaning that the insurer's payments rise with inflation) or if you are prepared to contribute some of your savings to the cost of care.

transfer assets to your children, or to whomever you would like to benefit, if you haven't done so already. As explained in the discussion of Medicaid in the next chapter, Medicaid looks as far back as five years to identify asset transfers that could result in a period of ineligibility. After that five-year look-back period has passed, you can qualify for Medicaid to pay your nursing home costs (provided the assets remaining in your name do not exceed Medicaid's limits).

3. **Buy a home care option or rider.** One of the problems with Medicaid is that although it pays for nursing home care, in most states it pays for only limited home care. (New York State is a notable exception.) Thus people often feel financially compelled to move to a nursing home, where the state will pick up the cost. Until there is a change in the law, most home care will have to be paid for out-of-pocket or by insurance. It doesn't make much sense to pay insurance premiums to replicate what Medicaid covers – nursing home care but not home care.

   Some long-term care insurance agents have begun to refer to long-term care insurance as "avoid nursing home" insurance, since the availability of home care coverage can help the beneficiary avoid moving to a nursing home.

Every fall, MetLife releases an annual survey of long-term care costs in metropolitan areas around the nation. Go to: www.metlife.com and click on "About MetLife," then on "Press Room."

4. **Fill out the application truthfully and make sure the insurance company evaluates it before issuing the policy.** If in completing your application for insurance you fail to tell the insurer about an illness or a doctor's visit, the company

may refuse you coverage at the time benefits are needed. It is better to be denied a policy and to be able to plan knowing that coverage is not available than to believe that coverage will be forthcoming, only to have it denied when it is needed. Likewise, you should make sure that you purchase from an insurance company that evaluates – or, in insurance company parlance, "underwrites" – the policy from day one. If not, the company could refuse you coverage when it evaluates the application at a later date.

5. **Compare insurance companies and rates.** Make certain that the insurer is rated A or A+ by A.M. Best or another service that rates insurance companies. Your coverage will not be very effective if the insurer goes out of business. In addition, rates charged by insurance companies in the long-term care field tend to vary widely. Compare different companies' rates and offerings before making a decision. Unfortunately, each company offers slightly different benefits and coverage definitions, which makes comparison difficult. The best bet is to work with a qualified long-term care insurance broker (see below).

Which spouse gets the coverage?

The American Association for Long-Term Care Insurance has a useful page on insurer ratings. Visit: www.aaltci.org/long-term-care-insurance/learning-center/company-ratings.php

Often, a married couple will be able to afford coverage for only one spouse. Looking at statistics alone, the wife should purchase the policy. In our society women tend to live longer than men and to provide more care than men. The result is that women are much more likely than men to end up in a nursing home for a long period. In addition, the Medicaid rules provide some protection for the spouse of a nursing home resident. For these reasons, the best bet for most couples who can afford the premiums for only one long-term care insurance policy is to purchase it for the wife. Couples should bear in mind, however, that this is playing the odds and is not a sure thing. And your own health history and that of family members is more relevant than statistics for the general population. A 'shared care' policy might give both spouses more coverage for less money. With this kind of policy, you buy a pool of benefits that you can split between you and your spouse. For example, if you buy a five-year policy, you will have a total of 10 years between you and your

Purchasing Tip: Some newer long-term care insurance policies are "guaranteed" – that is, if the stated benefit amount is not used during the insured's lifetime, the policies will pay out the benefit amount upon the insured's death.

spouse. If your spouse uses two years of the policy, you will have eight years left.

Can you afford long-term care insurance?

A rule of thumb is that payment of the long-term care insurance premium should not affect your standard of living. Thus, premiums are affordable if they are paid with money that you would otherwise set aside to add to savings. An alternative would be to purchase an annuity that pays sufficient benefits to cover the long-term care insurance premiums.

The tax deductibility of long-term care insurance premiums

"Qualified" long-term care insurance policies receive special tax treatment. To be "qualified," policies issued on or after January 1, 1997, must adhere to specific requirements. Among the requirements are that the policy must offer the consumer the options of "inflation" and "nonforfeiture" protection (you get some money back if you let the policy lapse), although the consumer can choose not to purchase these features.

The policies must also offer both activities of daily living (ADL) and cognitive impairment triggers for coverage and may not offer a medical necessity trigger. "Triggers" are conditions that must be present for a policy to begin paying out. Under the ADL trigger, benefits may begin only when the beneficiary needs assistance with at least two of six ADLs. The ADLs are: eating, toileting, transferring, bathing, dressing or continence. In addition, a licensed health care practitioner must certify that the need for assistance with the ADLs is reasonably expected to continue for at least 90 days. Under a cognitive impairment trigger, coverage begins when the individual has been certified to require substantial supervision to protect him or her from threats to health and safety due to cognitive impairment.

Premiums for "qualified" long-term care policies will be treated as a medical expense and will be deductible to the extent that they, along with other unreimbursed medical expenses (including "Medigap" insurance premiums), exceed 7.5 percent of the insured's adjusted gross income. However, the taxpayer's age determines the maximum long-

term care insurance premium that is deductible, as outlined in the chart below (the limits will be adjusted annually with inflation):

Age attained before the end of the taxable year	Amount allowed as a medical expense in 2012
40 or under	$ 350
41–50	660
51–60	1,310
61–70	3,500
71 or older	4,370

As you can see, the tax incentive is relatively small for most people. It should not be a reason for purchasing long-term care insurance, but certainly the deduction should be taken if available.

Consult With a Certified Agent

Long-term care insurance has attracted much media attention, and many insurance agents are now selling it. However, long-term care insurance is a complex product, and insurance agents and brokers marketing these policies need to be highly trained and know how to recommend the right coverage based on a client's finances and objectives.

The Corporation for Long-Term Care Certification's professional designation "Certified in Long-Term Care" (CLTC) offers a rigid program that meets these criteria. The Corporation for Long-Term Care Certification is dedicated to training agents to solve clients' long-term care needs. Moreover, the Corporation for Long-Term Care Certification's program is "third party," meaning that it is not affiliated with any insurance company or supported financially by the long-term care insurance industry. When it comes to choosing an agent, you will want one who represents a number of insurance carriers so you can choose from a variety of policies.

For a directory of CLTC-designated agents in your area, visit the CLTC Web site at www.ltc-cltc.com

7. Medicaid Coverage of Nursing Home Care

This chapter explains:

- The difference between Medicare and Medicaid
- Medicaid planning
- The new Medicaid rules for transferring assets
- Advance and crisis Medicaid planning

Lacking access to alternatives like long-term care insurance or Medicare, most people pay out of their own pockets for long-term care until they become eligible for Medicaid. Since few people have long-term care insurance or can afford to pay the high cost of nursing home care out-of-pocket, most people eventually qualify for Medicaid. By default, it has become the primary source of funding for nursing home care and the long-term care insurance of the middle class, paying for 43 percent of the $125 billion spent on nursing home care in 2006. Medicare covered 17 percent of these costs.

Although their names are confusingly alike, Medicaid and Medicare are quite different programs. Medicare is an "entitlement" program, meaning that everyone who reaches age 65 and is entitled to receive Social Security benefits also receives Medicare. Medicaid, on the other hand, is a form of welfare – or at least that's how it began. To be eligible for Medicaid, you must become "impoverished" under the program's guidelines. Also, unlike Medicare, which is totally federal, Medicaid is a joint federal-state program. Each state operates its own Medicaid system, but this system must conform to federal guidelines in order for the state to receive federal money, which pays for about half the state's Medicaid costs. (The state picks up the rest of the tab.)

This complicates matters, since the Medicaid eligibility rules are somewhat different from state to state, and they keep changing. (The states also sometimes have their own names for the program, such as "Medi-Cal" in California and "MassHealth" in Massachusetts.) Both the federal government and most state governments seem to be continually

tinkering with the eligibility requirements and restrictions. This has most recently occurred with the passage of the Deficit Reduction Act of 2005 (the "DRA"), which was enacted February 8, 2006, and significantly changed the rules governing the treatment of asset transfers and homes of nursing home residents. The implementation of these changes will proceed state-by-state over the next few years. To be certain of your rights in your particular state, consult an elder law attorney. He or she can guide you through the complicated rules of the different programs and help you plan ahead.

The most significant difference in the realm of long-term care planning, however, is that Medicaid covers nursing home care, while Medicare, for the most part, does not, as explained in Chapter 6. It is also worth noting that, spurred by incentives from the federal government, state programs are spreading aimed at keeping Medicaid long-term care recipients in the community and out of nursing homes for as long as possible.

Qualifying for Medicaid

While two-thirds of nursing home residents are covered by Medicaid, at root it is a health care program for the poor. The definition of "poor" has become quite complex in the area of nursing home coverage. In order to be eligible for Medicaid benefits, a nursing home resident may have no more than $2,000 (in most states) in "countable" assets. The spouse of the nursing home resident – called the "community spouse" – is limited to one half of the couple's joint assets up to $113,640 (in 2012) in countable assets. (In some states the community spouse may keep all of the couple's assets up to $113,640, not just half up to that amount.) This figure, called the community spouse resource allowance (CSRA), changes each year to reflect inflation. In addition, the community spouse may keep the first $22,728 (in 2012), even if that is more than half of the couple's assets. This figure is higher in some states, up to the full $113,640 as mentioned above.

All assets are counted against these limits unless the property falls within the short list of "noncountable" assets. These include:

1. Personal possessions, such as clothing, furniture, and jewelry.

To find a qualified elder law attorney, go to www.elderlawanswers.com

2. One motor vehicle of any value as long as it is used for transportation.

3. The applicant's principal residence, provided it is in the same state in which the individual is applying for coverage. In most states, the home has not been considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident intended to return home. Under the DRA such houses may be deemed noncountable only to the extent their equity is less than $525,000, with the states having the option of raising this limit to $786,000. In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.

4. Prepaid funeral plans (many states limit the value), up to $1,500 set aside in a specified burial account, and a small amount of life insurance.

5. Assets that are considered "inaccessible" for one reason or another.

6. Business property that produces income essential for self support.

Case Study

After her husband, George, moved to a nursing home, Alice came with her daughter, Joyce, to consult with an elder law attorney. Alice had been caring for George for years at home as his Alzheimer's disease progressed. Eventually, she had to be hospitalized for minor surgery, and Joyce and her two siblings were able to convince Alice that it was time for George to move to a nursing home.

Alice and her daughter provided the attorney with the following financial information: Alice and her husband owned their home, which had a fair market value of approximately $300,000 and an outstanding home equity loan of $15,000. They had $150,000 in savings and investments. George received $1,200 a month in Social Security benefits and an additional pension of $300. Alice received $700 a month from Social Security. The nursing home charged $6,000 a month.

The attorney advised Alice and her daughter that in their state Alice could keep half of the couple's combined savings – $75,000 – and George could keep $2,000, for a combined total of $77,000.

They would have to spend down $73,000 before Medicaid would begin to pick up the tab for George's nursing home care. He advised them that any spending is allowed – even encouraging Alice to take a much-needed vacation – but that giving away assets would be penalized by one month of ineligibility for every $5,000 transferred.

After much discussion (and overcoming Alice's aversion to spending large sums), Alice, Joyce and the attorney came up with the following plan to spend down $73,000:

$15,000	Pay off home equity loan
+6,000	One month of nursing home care
+27,000	Purchase an immediate annuity for Alice's benefit
+10,000	Trading in Alice's car for a new one
+ 5,000	Painting Alice and George's house
+10,000	Prepaying George and Alice's funerals
$73,000	

With this plan, Alice was able to preserve the bulk of the couple's savings by spending it in ways that kept its value for her.

Medicaid's Treatment of Income

The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. Medicaid pays nursing home costs that exceed the resident's income. But in some states, known as "income cap" states, eligibility for Medicaid benefits is barred if the nursing home resident's income exceeds $2,094 a month (for 2012), unless the excess above this amount is paid into a "(d)(4)(B)" or "Miller" trust. If you live in an income cap state and require more information on such trusts, consult an elder law specialist in your state.

For Medicaid applicants who are married, the income of the community spouse is not counted in determining the Medicaid applicant's eligibility. Only income in the applicant's name is counted. Thus, even if the community spouse is still working and earning, say, $5,000 a month, she will not have to contribute to the cost of caring for her spouse in a nursing home if he is covered by Medicaid. In some states, however, if the community spouse's income exceeds certain levels, he

or she does have to make a monetary contribution towards the cost of the institutionalized spouse's care. The community spouse's income is not considered in determining eligibility, but there is a subsequent contribution requirement.

What if most of the couple's income is in the name of the institutionalized spouse, and the community spouse's income is not enough to live on? In such cases, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. How much the community spouse is entitled to depends on what the Medicaid agency determines to be a minimum income level for the community spouse. This figure, known as the minimum monthly maintenance needs allowance or MMMNA, is calculated for each community spouse according to a complicated formula based on his or her housing costs. The MMMNA may range from a low of $1,838.75 to a high of $2,841 a month (for 2012; the first figure will rise by July 1, 2012). If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income (but see a possible alternative under Increased Resource Allowance below).

Case Study

After Alice and George (see Case Study on page 54) spent down so that George qualified for Medicaid coverage of his nursing home care, the state Medicaid agency calculated Alice's MMMNA to be $1,900 a month, based on her housing expenses and the utility costs in the state. Since her own monthly income was only $700 from Social Security, she had a shortfall of $1,200 a month. George was permitted to pay this amount from his own income over to Alice each month rather than pay all of his income to the nursing home. His "patient pay amount," the amount he had to pay the nursing home each month, was determined to be $240, calculated as follows:

$1,500	George's total monthly income
- $1,200	Income allowance to Alice
- 60	Personal needs allowance (cash George could keep)
$ 240	Patient pay amount

Asset Transfers

For a calculator of the MMMNA for a particular person, go to www.elderlawanswers.com/reliable_sources/mmmna_calc.asp

Why not qualify for Medicaid coverage of nursing home care by simply transferring assets out of your name? Because Congress does not want you to move into a nursing home on Monday, give all your money to your children (or whomever) on Tuesday, and qualify for Medicaid on Wednesday. So it has imposed restrictions on the ability of people to transfer assets before applying for Medicaid coverage without receiving fair value in return. These restrictions, already severe, have been made even harsher by enactment of the DRA.

The restrictions impose a penalty for asset transfers — a period of time during which the person transferring the assets (and his or her spouse) will be ineligible for Medicaid. The period of ineligibility is determined by dividing the amount transferred by what the state Medicaid agency determines to be the average private pay cost of a nursing home in your state. For example, if you live in a state where the average monthly cost of care has been determined to be $5,000, and you give away property worth $100,000, you will be ineligible for benefits for 20 months ($100,000 ÷ $5,000 = 20).

However, for transfers made prior to enactment of the DRA on February 8, 2006, state Medicaid officials would look only at transfers made within the 36 months prior to the Medicaid application (or 60 months if the transfer was made to or from certain kinds of trusts). But for transfers made after passage of the DRA the so-called "look-back" period for all transfers is 60 months.

The second and more significant major change in the treatment of transfers made by the DRA has to do with when the penalty period created by the transfer begins. Under the prior law, the 20-month penalty period created by a transfer of $100,000 in the example described above would begin either on the first day of the month during which the transfer occurred, or on the first day of the following month, depending on the state. Under the DRA, the 20-month period will not begin until (1) the transferor has moved to a nursing home, (2) has spent down to the asset limit for Medicaid eligibility, (3) has applied for Medicaid coverage, and (4) has been approved for coverage but for the transfer.

For instance, if an individual in our example transfers $100,000 on April 1, 2010, moves to a nursing home on April 1, 2011, and spends down to Medicaid eligibility on April 1, 2012, that is when the 20-month penalty period will begin, and it will not end until December 1, 2013. The implementation of this change has differed from state to state.

Transfers should be made carefully, with an understanding of all the consequences. People who make transfers must be careful not to apply for Medicaid before the five-year lookback period elapses without first consulting with an elder law attorney. This is because the penalty could ultimately extend even longer than five years.

Also, bear in mind that if you give money to your children, it belongs to them and you should not rely on them to hold the money for your benefit. However well-intentioned they may be, your children could lose the funds due to bankruptcy, divorce or lawsuit. Any of these occurrences would jeopardize the savings you spent a lifetime accumulating. Do not give away your savings unless you are ready for these risks. In addition, transfers can affect grandchildren's eligibility for financial aid and have bad tax consequences for children receiving the funds. Moreover, the transfer of appreciated property to your children during your life can mean that your children will not get a step-up in basis in the property by inheriting it from you at your death.

Here's how that works: Say you purchased stock for $10 a share 30 years ago and today it's worth $100 a share. The $10 purchase price is your basis. If you sell the stock today, you will have a capital gain of $90 a share, the difference between the basis and the selling price, on which you will have to pay taxes. If you give the stock to your children, they will have the same basis as you and have to pay the same taxes if they sell it. On the other hand, if they inherit the stock at your death, the stock's basis gets "stepped up" to the value on your date of death. If that is $100 and your children sell the stock for $100, then there's no gain and no tax. (However, as explained in Chapter 2, this does not necessarily apply for those dying in 2010.)

In any case, as a rule, never transfer assets for Medicaid planning unless you keep enough funds in your name to (1) pay for any care needs you may have during the resulting period of ineligibility for Medicaid; and (2) feel comfortable in doing it and have sufficient resources to maintain your present lifestyle.

Permitted Transfers

Remember: You do not have to save your estate for your children. The bumper sticker that reads "I'm spending my children's inheritance" is a perfectly appropriate approach to estate and Medicaid planning.

While most transfers are penalized with a period of Medicaid ineligibility, certain transfers are exempt from this sanction. Even after entering a nursing home, you may transfer any asset to the following individuals without having to wait out a period of Medicaid ineligibility:

- Your spouse (but this may not help you become eligible since the same asset limit on both spouses' assets will apply);
- Your child who is blind or permanently disabled; or
- Into trust for the sole benefit of anyone under age 65 and permanently disabled.

In addition, you may transfer your home to those listed above, as well as to the following individuals:

- Your child who is under age 21 (rather unusual for nursing home residents);
- Your child who has lived in your home for at least two years prior to your moving to a nursing home and who provided you with care that allowed you to stay at home during that time (often referred to as the "caretaker" child);
- A sibling who already has an equity interest in the house and who lived there for at least a year before you moved to a nursing home.

Case Study

Emily and Ira go to visit an elder law attorney. They are quite concerned about their father, Frank, and their brother, Samuel. Samuel, now 54 years old, is mentally retarded and has lived with his parents his whole life. Since his mother's death seven years ago, Samuel has been living only with his father. Frank is 85 years old and recently had a stroke. He is receiving care in a rehabilitation facility, but it is unlikely that he will be able to come home. He certainly will not be able to care for Samuel any longer.

Since his father's stroke, Samuel has been staying alternately with Emily and Ira. His presence, along with tending to Frank, has greatly disrupted their family and work lives. This fill-in arrangement is not

working for anyone. But Emily and Ira do care a great deal about Samuel, showing his picture to the attorney, and explaining how his presence in the house had been at least as much a comfort for their parents as it was a burden.

Fortunately, they have located a group home that looks like a good setting for Samuel. Unfortunately, it costs $3,000 a month. Once Medicare coverage ends, Frank's nursing home expense will be $6,000 a month. Frank's estate, including the value of his house, is approximately $500,000. While Emily and Ira are not seeking an inheritance themselves, they see their parents' estate being depleted over the next several years and their having to support Samuel themselves, or find publicly-funded care that may not be what they want for their brother.

They are much relieved when the elder law attorney advises them that Frank can create a trust to hold his estate for the sole benefit of Samuel, allowing Frank to immediately qualify for Medicaid coverage of his nursing home care. With the cost of care suddenly $3,000 rather than $9,000 a month, the trust fund will be able to pay for Samuel's care indefinitely, even footing the bill for extras that will enhance his life.

Is Transferring Assets Against the Law?

You may have heard that transferring assets to achieve Medicaid eligibility is a crime. Is this true? No. But what about a professional advising someone to engage in asset transfers for Medicaid planning? That is a crime, at least in the statute books. However, it has been ruled to be an unconstitutional violation of the First Amendment. Nevertheless, it remains on the books.

As part of a 1996 health care bill, Congress made it a crime to transfer assets for purposes of achieving Medicaid eligibility. Congress repealed the law as part of the 1997 Balanced Budget bill, but replaced it with a statute that made it a crime to advise or counsel someone for a fee regarding transferring assets for purposes of obtaining Medicaid. This meant that although transferring assets was again legal, explaining the law to clients could have been a criminal act.

In 1998, then-Attorney General Janet Reno determined that the law was unconstitutional because it violated the First Amendment protection of free speech, and she told Congress that the Justice

Department would not enforce the law. Subsequently, a U.S. District Court judge in New York said that the law could not be enforced for the same reason. See *New York State Bar Association v. Reno* (N.D.N.Y., No. 97-CV-1760, April 7, 1998). Accordingly, the law remains on the books, but it will not likely be enforced. In theory, however, a federal prosecutor in any state other than New York could seek to enforce the law. And, of course, Janet Reno is no longer attorney general. Another attorney general could see things differently from her.

Trusts

The problem with transferring assets is that you have given them away. You no longer control them, and even a trusted child or other relative may lose them. A safer approach is to put them in an irrevocable trust. The different kinds of trusts are explained in Chapter 1.

Whether trust assets are counted against Medicaid's resource limits depends on the terms of the trust and who created it. Medicaid considers the principal of revocable trusts (that is, the funds held in the trust) to be assets that are countable in determining Medicaid eligibility. Thus, revocable trusts are of no use in Medicaid planning.

The funds in most irrevocable trusts are counted as available to the applicant for Medicaid if the trust was created by the applicant or his or her spouse. The funds in most trusts created and funded by someone else are not considered available. However, there are some exceptions to these general rules. For instance, Medicaid, does not count the principal of an "irrevocable, income-only" trust as a resource, even if created by the Medicaid applicant or his or her spouse, provided the trustee cannot pay principal to or for the benefit of the nursing home resident or his or her spouse. That is, only the income from the trust is payable.

Another exception to the general rules, in the case of a trust created by someone other than the nursing home resident or his or her spouse, is when the trust document obligates the trustee to make distributions of trust property. In such a case, the trust funds will be considered available to the extent of such obligation.

Testamentary Trusts

As explained in Chapter 1, testamentary trusts are trusts created under a will. The Medicaid rules provide a special "safe harbor" for testamentary trusts created by a deceased spouse for the benefit of a surviving spouse. Unlike a trust created during life for a spouse, the assets of these trusts are treated as available to the Medicaid applicant only to the extent that the trustee has an obligation to pay for the applicant's support. If payments are solely at the trustee's discretion, they are considered unavailable to the Medicaid applicant.

While totally illogical, if one spouse creates a trust during his life for his spouse, the funds will be considered available should she apply for Medicaid benefits. On the other hand, should the first spouse create the same trust with the same funds, but through his will, the funds will be considered unavailable.

Therefore, these trusts can allow a healthy spouse living in the community (a "community spouse") to leave funds for their surviving institutionalized husband or wife that can be used to pay for services that are not covered by Medicaid. These may include extra therapy, special equipment, evaluation by medical specialists or others, legal fees, visits by family members, or transfers to another nursing home if that becomes necessary.

Safe Harbor Trusts

The Medicaid rules provide for three "safe harbor" trusts that are exceptions to the general trust rules. The first, referred to as a "(d)(4)(A)" or "pay-back" trust, must be created by a parent, grandparent, guardian or court for the benefit of a disabled individual under age 65. It may be funded with the disabled individual's own funds, and the trust property will not be considered available in determining the disabled individual's eligibility for Medicaid benefits as long as the trust provides that at the beneficiary's death the state will be reimbursed out of any remaining trust funds for Medicaid benefits paid on behalf of the beneficiary during his or her life.

The second safe harbor trust, often referred to as a "(d)(4)(B)", "Miller" or "Income" trust, permits nursing home residents in states

with an "income cap" (described above) to shelter excess income and still qualify for Medicaid benefits.

The third safe harbor, often referred to as a "(d)(4)(C)" or "pooled" trust, is similar to a (d)(4)(A) trust. The differences are as follows: (1) It must be administered by a not-for-profit corporation for the benefit of more than one beneficiary, though it can set up separate accounts for each beneficiary; (2) The disabled individual himself or herself may fund the trust, as well as his or her parent, grandparent or guardian, or a court; (3) An alternative to reimbursing the state for Medicaid expenditures made on the beneficiary's behalf upon his or her death is to have the funds remain in the trust for the benefit of its other beneficiaries.

Estate Recovery

The rules described above limit who may receive Medicaid coverage of nursing home care. But they are not the whole story. Once someone receives Medicaid benefits, whether for nursing home care or for any other health care cost after the age of 55, the state will seek reimbursement from his or her estate after death. However, no recovery can take place until the death of the recipient's spouse, or as long as there is a child of the deceased who is under 21 or who is blind or disabled. (How this deferral of estate recovery works in practice depends on the state in question.)

In most cases, Medicaid beneficiaries do not have any estate to speak of; otherwise they would not have been eligible for Medicaid in the first place. However, in many states, Medicaid beneficiaries can keep their homes. They also could inherit money unexpectedly (or through poor planning) or be the beneficiary of a personal injury claim, leading them to have money at the end of their life despite being impoverished before then.

In those cases, whether the state will successfully recover against the Medicaid beneficiary's estate depends on how the property is held and on the particular state's laws. All states seek recovery against the probate estate of the deceased Medicaid beneficiary. Some also seek recovery against non-probate property in which the deceased had an interest, such as jointly-held real estate, life insurance and trust property (see

Chapter 1 for a discussion of the difference between the probate and non-probate estate). With proper planning, most individuals can avoid recovery against their estates.

Medicaid liens are often confused with estate recovery. While estate recovery only occurs at death, typically if the Medicaid beneficiary is permitted to keep his or her home the state will place a lien on it to be paid back if the house is sold while the beneficiary is alive. Exceptions to the lien exist, substantially paralleling the exceptions to the transfer penalty for giving away the home. Thus, no lien may be applied if a spouse, disabled or minor child, or caretaker child is living there. People often confuse these exceptions as protecting the house from estate recovery as well. They do not. To assume they will can be a costly error. While there is a deferral of estate recovery during the life of a surviving spouse or until a minor child reaches age 21, as described above, this only delays the estate recovery. States, however, are supposed to waive estate recovery in the case of "hardship," which they are free to define.

Advance Medicaid Planning

Planning to become eligible for Medicaid to cover the cost of nursing home care generally takes place in one of two circumstances. In the first – advance planning – the individual or couple is planning ahead for the possibility that they may need long-term care in the future. In the second – crisis planning – a spouse, child or other family member is seeking to preserve as much of the assets as possible in the face of a costly nursing home placement that has occurred already or that is imminent.

While the crisis situation is the most difficult, planning steps are often more clear-cut, since the feared event has happened. In advance planning, one hopes the need for long-term care will never occur. And some of the steps one could take to plan ahead are difficult or even ill-advised, such as giving away assets.

Following is a discussion of the advance planning steps you might take while healthy, understanding that each is a trade-off and only you can decide what makes the most sense for you in your situation.

Long-Term Care Insurance

The best advance plan, unless you are so affluent that the cost of long-term care is not an issue, is long-term care insurance. The biggest questions are whether you can afford it and whether you are insurable (meaning that the insurance company doesn't reject your application due to a preexisting condition). (See discussion in Chapter 6 above.)

The next question is when you should purchase a policy. More and more companies are offering long-term care insurance as an employee benefit, often at a reasonable cost. If possible, take advantage of one of these offerings. If not, in our opinion it's time to buy long-term care insurance when you no longer need term life insurance – that is, when your children (if any) have completed their schooling and you have saved enough so that your spouse (if any) will be able to have a comfortable retirement if you predecease him or her. When you no longer need life insurance for these purposes, begin using those premium dollars for long-term care insurance. (Of course, if you can afford both types of insurance at the same time, then don't wait.)

Giving Assets Away

An initial question is who are you protecting assets for: yourself and your spouse, your children and grandchildren, someone else, or a combination of the above? If the reason you saved during your life was simply to provide for your old age and that of your spouse, if any, then keep your savings and use them for the rainy day, when and if it arrives. If you would like to be sure to pass your savings on to your children, and you cannot afford long-term care insurance or are not insurable, the best way to be sure they get what you want them to inherit is to give it to them now.

Of course, there are a lot of problems with that, as outlined in the section above on Asset Transfers. If, despite these warnings, you still decide to begin transferring your estate to your children, remember that the transfer can cause you and your spouse to be ineligible for Medicaid benefits for up to 60 months. Make sure that you keep enough funds for your needs, whatever they may be, during that entire ineligibility period. Another alternative is to purchase long-term care

insurance with the intention of holding it only for the five-year look-back period following the transfer.

Income-Only Trusts

It is possible to transfer assets out of your name for Medicaid purposes but still receive some benefit from them by putting them in an irrevocable trust if it is drafted to say that while the income is payable to you for life, the principal cannot be touched during your life. At your death the principal is paid to your heirs. This way, the funds in the trust are protected and you can use the income for your living expenses. However, if you do move to a nursing home, the trust income will have to go to the nursing home. (At least one state – Hawaii – takes the position that the principal in such a trust will be counted.)

You should be aware of the drawbacks to such an arrangement. First, it is very rigid, so you cannot gain access to the trust funds even if you need them for some other purpose. Think of it as the proverbial "lock box." Second, as noted above, the potential ineligibility period for transfers to trusts can be five years. For this reason, you should always leave an ample cushion of ready funds outside the trust.

This type of trust has three advantages over a direct transfer to children: First, you continue to receive the income. Second, the funds are not at risk, as they would be if placed in a child's name. Third, at your death, your children will receive the funds with a step-up in basis, as described above.

You may also choose to place property in a trust from which even payments of income to you or your spouse cannot be made. Instead, the trust may be set up for the benefit of your children, or others. These beneficiaries may, at their discretion, return the favor by using the property for your benefit if necessary. However, there is no legal requirement that they do so.

Case Study

Lynne and Oliver consult with an elder law attorney about Oliver's mother, who is deteriorating. The family has hired some help for her, but they see some nursing home care in her future. She has sold her house to move to an assisted living facility. Oliver reports that his mother has about $400,000 in savings, of which $150,000 is in certificates of deposit and bank accounts and $250,000 is in highly-appreciated stock.

Lynne and Oliver discuss with the attorney the possibility of transferring half of this amount, meaning that she could not apply for Medicaid coverage for the subsequent five years, but leaving her with enough funds to pay for her care during this time. The problem is which funds to transfer. If they transfer the stock, Oliver and his siblings will receive it with their mother's basis, meaning that when and if they sell it they will have to pay a large tax on capital gains. This would not be the case if they inherited it from their mother, because the basis would be stepped up to its value on her date of death.

The attorney explains that an alternative would be to transfer the funds into an irrevocable trust drafted so that the children would receive a step-up in basis on their mother's death.

As you can see, especially when you mix Medicaid and tax planning, matters can get quite complicated. Consulting with a qualified elder law attorney is an absolute necessity.

Protecting the House From Estate Recovery

As is explained above, after a Medicaid recipient dies the state must attempt to recoup from his or her estate whatever benefits it paid for the recipient's care. Given the rules for Medicaid eligibility, the only probate property of substantial value that a Medicaid recipient is likely to own at death is his or her home. However, states that have not opted to broaden their estate recovery to include non-probate assets may not make a claim against the Medicaid recipient's home if it is not in his or her probate estate.

For many people, setting up a "life estate" is the simplest and most appropriate alternative for protecting the home from estate recovery.

A life estate is a form of joint ownership of property between two or more people where they have the right to possess the property for different periods of time. The person holding the life estate possesses the property currently and for the rest of his or her life. The other owner has a future or "remainder" interest in the property. He or she has a current ownership interest but cannot take possession until the end of the life estate, which occurs at the death of the life estate holder. In all but a few states, once the house passes to the person with the remainder interest, the state cannot recover against it for any Medicaid expenses the person holding the life estate may have incurred. Still, as with any transfer, the deed into a life estate within five years of an application for Medicaid can trigger an ineligibility period. Elderly parents may pass assets to children by purchasing a life estate in the child's home and moving in with the child. However, under the DRA, the purchase of a life estate within the five years prior to applying for Medicaid benefits will be considered a disqualifying transfer unless the Medicaid applicant lives in the property for at least a year.

Another method of protecting the home from estate recovery is to transfer it to an irrevocable trust very similar to the income-only trust described above. Once the house is in the trust, it cannot be taken out again. Although it can be sold, the proceeds must remain in the trust. This can protect more of the value of the house if it is sold than might be the case with a life estate.

Beware that these standard planning devices may not work in states that have elected to seek estate recovery of non-probate as well as probate property.

Crisis Medicaid Planning

As likely as not, if you or a family member is facing the high costs of long-term care, you have not taken any of the planning steps described above. But whether or not you have planned ahead, generally there's more you can do to protect at least some of your savings, even at the last minute, should you or a family member require nursing home care. Following are the principal strategies.

1. The "Half a Loaf" or "Rule of Halves" Strategy

One of the prime planning techniques used prior to the enactment of the DRA, often referred to as "half a loaf," was for the Medicaid applicant to give away approximately half of his or her assets. It worked this way: before applying for Medicaid, the prospective applicant would transfer half of his or her resources, thus creating a Medicaid penalty period. The applicant, who was often already in a nursing home, then used the other half of his or her resources to pay for care while waiting out the ensuing penalty period. After the penalty period had expired, the individual could apply for Medicaid coverage.

Case Study

Mrs. Jones had savings of $72,000. The average private-pay nursing home rate in her state is $6,000 a month. When she entered a nursing home, she transferred $36,000 of her savings to her son. This created a six-month period of Medicaid ineligibility ($36,000 ÷ $6,000 = 6). During these six months, she used the remaining $36,000 plus her income to pay privately for her nursing home care. After the six-month Medicaid penalty period had elapsed, Mrs. Jones would have spent down her remaining assets and be able to qualify for Medicaid coverage.

While you could generally give away approximately half your assets, the exact amount depended on a variety of factors, including the cost of care, the transfer penalty in your state, income, and possible other expenses. One of the main goals of the DRA was to eliminate this kind of planning. To determine whether it is still an available strategy in your state as it implements the DRA, you will have to consult with a local elder law attorney.

2. Spending Down

While there's a penalty for giving savings away, there's no limit on how applicants for Medicaid and their spouses may spend their money. You may protect savings by spending them on any items or services that benefit you. These may include:

- paying off a mortgage or other loan;

- making repairs to a home;
- replacing an old automobile;
- updating home furnishings;
- paying for more care at home;
- buying a new home; or
- taking a vacation (although we have yet to see a community spouse spend down funds for this purpose).

In the case of married couples in states with a minimum community spouse resource allowance below $113,640 (in 2012) it can be important that any spend-down steps be taken only after the unhealthy spouse moves to a nursing home if this would affect the community spouse's resource allowance.

3. Immediate Annuities

The purchase of immediate annuities can be an ideal planning tool for the spouses of nursing home residents. For single individuals, they are less useful. In its simplest form, an immediate annuity is a contract with an insurance company under which the consumer pays a certain amount of money to the company and the company sends the consumer a monthly check for the rest of his or her life. In most states the purchase of an annuity is not considered to be a transfer for purposes of eligibility for Medicaid, but is instead the purchase of an investment. It transforms otherwise countable assets into a non-countable income stream. As long as the income is in the name of the community spouse, it's not a problem since there is no limit on the community spouse's income.

In order for the annuity purchase not to be considered a transfer, it must meet four basic requirements: (1) It must be irrevocable; you cannot have the right to take the funds out of the annuity except through the monthly payments; (2) You must receive back at least what you paid into the annuity during your actuarial life expectancy. For instance, if you have an actuarial life expectancy of 10 years, and you pay $60,000 for an annuity, you must receive annuity payments of at least $500 a month ($500 x 12 x 10 = $60,000); (3) If you purchase an annuity with a term certain (see below), it must be shorter than your actuarial life expectancy; and (4) under the DRA the state

must be named the remainder beneficiary up to the amount of Medicaid paid on the annuitant's behalf.

You can purchase immediate annuities that will pay for as long as you live, whether that's one more month or three more decades, or ones with a term certain – a guaranteed payment period no matter how long you live. In the case of the term certain annuity, if you die before the end of the term, the future payments will be made to whomever you name as beneficiary.

Immediate annuities are a very powerful tool in the right circumstances, but of little or no use in other cases. They must also be distinguished from deferred annuities, which have no Medicaid planning purpose. The use of immediate annuities as a Medicaid planning tool is under attack in some states and in others the annuity must satisfy specific requirements. Be sure to consult with a qualified elder law attorney in your state before pursuing this strategy.

Case Study

After Mr. White moves to a nursing home, Mrs. White tallies the couple's countable assets and finds that they total $160,000. In her state, her community spouse resource allowance will be half that, or $80,000. Mrs. White takes the other $80,000 and purchases an immediate annuity that will pay her $800 a month for the rest of her life, or for 10 years, whichever is longer. She then applies for Medicaid coverage of her husband's care, qualifying him for immediate coverage.

The only drawback to this approach is that more of Mr. White's income will have to be paid to the nursing home. Since Mrs. White's income will be increased by the monthly annuity payment, she will no longer have a right to a share of Mr. White's income to supplement hers and bring it up to her minimum income allowance as determined by the state. However, this is a small price to pay for guaranteeing that Mrs. White will receive the increased income for the rest of her life, no matter how long she survives Mr. White.

4. Spousal Refusal

Federal Medicaid law permits the community spouse to keep all of his or her assets by simply refusing to support the institutionalized spouse as long as the institutionalized spouse assigns his or her rights to spousal support to the state. This portion of the law, usually referred to as "just say no" or "spousal refusal," is generally not used except in New York and Florida, where the states have adopted the federal law in this area. In addition, in 2005 a federal appeals court upheld the right of the wife of a Connecticut nursing home resident to refuse to support her husband. The husband was able to qualify for Medicaid coverage, and assets that he had transferred to his wife were not counted in determining his eligibility.

After awarding Medicaid benefits to the institutionalized spouse, the Medicaid agency then has the option of beginning a legal proceeding to force the community spouse to support the institutionalized spouse. However, this is rarely done, and when such cases do go to court, courts in New York generally allow the community spouse to keep enough resources to maintain her former standard of living. So far, Florida has not pursued refusing spouses for recovery. This spousal refusal strategy sometimes is used in other states in second-marriage situations where the healthy spouse truly refuses to support the nursing home spouse or where the spouses have separated but are not divorced.

5. Increased Resource Allowance

Under rules described earlier in this chapter, if the community spouse's income is below an amount determined by the state Medicaid agency to be the minimum he or she needs to live on, the community spouse can receive a share of the institutionalized spouse's income to bring his or her income up to this minimum level. For instance, if the state determines that the community spouse needs $2,000 a month to live on, and her own income is only $800 a month, she will be entitled to $1,200 of her husband's income each month. That amount will not have to be paid to the nursing home.

If the institutionalized spouse's income added to the community spouse's income is still not sufficient to reach the minimum income level, the community spouse may keep additional assets above the

standard community spouse resource allowance (CSRA) (see "Qualifying for Medicaid" earlier in this chapter) to generate additional income. For instance, in the example above if the husband's income is less than $1,200, the difference may be made up by permitting the community spouse to keep additional savings and investments. The states differ on how this will be calculated. This increased CSRA cannot be granted at the time of the Medicaid application. Typically, the application for benefits is denied for excess assets and the community spouse must appeal it, seeking the increased CSRA at an administrative hearing. In some states, the practice is to seek a court order to obtain an increased CSRA.

The Attorney's Role in Medicaid Planning

Do you need an attorney for even "simple" Medicaid planning? This depends on your situation, but in most cases, the prudent answer would be "yes." The social worker at your nursing home assigned to assist in preparing a Medicaid application for you knows a lot about the program, but maybe not the particular rule that applies in your case or the newest changes in the law. In addition, by the time you're applying for Medicaid, you may have missed out on significant planning opportunities.

The best bet is to consult with a qualified professional who can advise you on the entire situation. At the very least, the price of the consultation should purchase some peace of mind. And what you learn can mean significant financial savings or better care for you or your loved one. As described above, this may involve the use of trusts, transfers of assets, or the purchase of annuities.

If you are going to consult with a qualified professional, the sooner you do so the better. If you wait, it may be too late to take some steps available to preserve your assets.

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