PLANNING FOR DISABILITY AND LONG TERM CARE:

LEGAL AND FINANCIAL ISSUES

BY

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I. Planning for Disability

Americans are living longer. We all dream of the 'golden years' of retirement: playing golf and tennis in a warm climate, frequent vacations and being surrounded by loving family and friends. However, with increased age, there is an increased risk of chronic and debilitating illnesses. Thirty percent of seniors between ages 65 and 75 need assistance with at least one activity of daily living.[1] By age 75, the percentage increases to 50% and jumps to 75% by age 80.

The cost of long term care is staggering. In the greater New York area, the cost of private care aides ranges from $15 to $25 per hour. The monthly cost of a bed in a skilled nursing facility runs from $13,000 to $20,000. These expenses can quickly deplete the life savings of the average New Yorker. By age 85, there is a 25% chance that an individual will spend some time in a skilled nursing facility.

A well rounded estate plan provides for management of assets and payment of costs in the event of future disability. What would happen if you or a loved one were to suffer a stroke, become the victim of an accident, develop Alzheimer's or Parkinson's disease or another disabling condition? Who will pay the mortgage or rent, handle finances, make financial and health care decisions?

A knowledgeable attorney who practices Elder Law or Trusts and Estates should be able to provide advice about the following planning methodologies:

A. ***Power of Attorney:*** The simplest method of substitute management is the use of a Durable Power of Attorney. A durable power of attorney continues to be effective even after the signer is no longer competent. The principal designates a person called the agent or attorney-in-fact to manage financial and personal affairs. In the absence of a Durable Power of Attorney, only a court appointed guardian will have the authority to access funds which are held in the single name of an incapacitated individual. The legal proceeding to appoint a guardian is expensive, time consuming, unpleasant and may result in the appointment of someone the incapacitated person does not know or would not prefer to act as guardian. Existence of a Durable Power of Attorney avoids the necessity for a guardian in nearly all instances.

An attorney should prepare the Power of Attorney form and supervise its execution. Often financial institutions prefer their own form. Experienced elder law attorneys draft additional powers to the standard form to include gift giving, authority to deal with government agencies and pension plans and other matters. Powers of Attorney signed on or after September 1 2009, must contain a separate gift rider in order for the agent to have powers to make gifts of more than $500 per year. In order to implement Medicaid planning strategies, it may be

[1] Activities of Daily Living ("ADL"s) include feeding, walking, transferring, dressing and toileting.

advisable for the power of attorney to include specific authority for the agent to create and fund trusts, make loans and gift assets, including the ability to make gifts to the agent.

B. ***Joint Ownership:*** Joint ownership allows the joint owner to manage the asset in case of incapacity. However, joint ownership also creates a right of survivorship and a current ownership interest in the asset for the joint owner. Thus, joint ownership must be used cautiously as it may defeat carefully considered testamentary plans for distribution of assets after death. The Medicaid program will generally presume that the applicant for Medicaid benefits owns all of an asset held jointly with another. This presumption can be defeated by showing that the joint owner contributed all or some of the funds held in the account.

C. ***Health Care Proxy/Living Will:*** Just as an individual can name an agent to make financial decisions, she may name an agent to make medical decisions. The health care proxy provides for the orderly management of medical decision making in the event of disability. The health care proxy appoints a health care agent and empowers the agent to make all medical decisions. An individual may name only one agent, however, alternate agents may be named. If an individual wishes the agent to make decisions regarding artificial nutrition and hydration, this must be specifically noted. As a result of changes to the Public Health law in 2002, the health care proxy now includes optional provisions for organ donation.

New York has adopted a standard form for the health care proxy, although no specific form is required. There is no standard form for the living will. A living will is a document which sets forth an individual's intentions concerning health care, particularly with respect to artificial life-sustaining procedures. The living will addresses the type of health care an individual would desire if he or she were seriously ill with no reasonable hope of recovery. In a living will, you can state your intention to forego certain life sustaining measures, such as artificial nutrition or hydration (ie. tube feeding) or mechanical respiration. Other types of treatments that you may decide to forego include cardio-pulmonary resuscitation, antibiotic treatment and saline injections. The document may state that medication to maximize pain relief should be administered even if these medications may expedite death.

II. Payment of Long Term Care Costs

Planning for medical expenses associated with long-term care generally involves four sources of payment: Medicare, private insurance, Medicaid and private payment.

A. *Medicare*

1. *Eligibility*

Most individuals who have reached the age of 65 are eligible for Medicare coverage. Individuals who have not yet attained the age of 65 are eligible for Medicare coverage if they have been entitled to (but not necessarily receiving) Social Security disability benefits for the past 24 months, or if they have suffered permanent kidney failure and need maintenance dialysis or kidney transplants. Medicare provides minimal coverage of long term care costs.

2. ***Nursing Home Coverage***

a. Medicare provides very limited coverage for Skilled Nursing Facility Care (SNF). Medicare does not cover custodial care in a Nursing Home, only skilled care. In order to qualify for coverage, the patient must have been hospitalized for medically necessary inpatient hospital care for at least three (3) consecutive calendar days for the same condition that is to be treated in the SNF; the patient must be admitted to the Nursing Home and receive the needed care within thirty (30) calendar days after the date of discharge from the hospital; and the patient must require and receive daily skilled care. Nursing or skilled rehabilitation services are the most common qualifying services, but they are not mandatory for coverage purposes.

b. Many services are denied initially by the nursing home and Medicare, but are often approved upon appeal. Vigorous advocacy can often obtain up to 100 days of Nursing Home care coverage under the Medicare program. Days 1-20 in the SNF are fully covered if the care is qualified as outlined above. Thereafter, for days 21-100, there is a co-insurance payment of $164.50 per day (2017 rate).

c. In recent years, we have seen an increase in "observation status" hospital stays. As the Medicare program will only pay for a stay in a skilled nursing facility after a three day hospital admission, an individual who is discharged to a nursing home after a hospitalization which has been categorized as for observation only will not receive any Medicare payment for the stay in the nursing home, even if the individual is receiving skilled services in the Nursing Home. New York Public Health Law §2805-w effective April 14, 2014 requires that hospitals provide both written and oral notice to patients within 24 hours if the patient is being held for observation only.

3. ***Home Care Coverage***

Medicare beneficiaries can receive, in theory, an unlimited number of home health care visits, without deductibles or co-insurance, if the following conditions are met: the beneficiary requires and receives intermittent nursing, physical, occupational or speech therapy; the beneficiary is homebound, and a physician certifies the need for home health care. The Medicare program can never provide more than 35 hours of home care per week. As a practical matter, benefits rarely exceed four hours per day for five days per week and even 20 hours per week is unusual. Due to the requirement that skilled care is also needed, most authorizations of Medicare home care services last for only a few weeks after discharge from a hospital or skilled nursing facility.

B. ***Private Insurance***

1. ***Medicare Supplemental Insurance - Medigap***

Medicare supplemental policies, often referred to as "Medigap" policies, should be purchased by all Medicare recipients. These policies provide coverage for services and expenses not covered by Medicare. Examples of expenses which may be covered by Medigap insurance include the hospital deductible, hospital co-insurance for hospital stays exceeding sixty days,

private duty nurses, nursing home co-insurance and deductibles. Federal law requires that all "Medigap" policies be one of ten standard plans which are designated as Plans A through N. Medicare recipients should shop around for the best policy that they can afford. Medigap plans C, D, F, and G cover the nursing home deductible, which is currently $164.50 per day in 2017. Plans K and L offer partial coverage of the nursing home deductible. There is also a high deductible Plan F which requires an out of pocket expenditure of $2,200 (in 2017) but then covers all Medicare out of pocket coinsurance and deductibles.

The federal government offers incentives for Medicare beneficiaries to enroll in Medicare managed care plans. These plans, also known as Medicare Advantage Plans require that the beneficiary enroll in managed care, usually through an HMO. There is often no fee to enroll in a Medicare Managed Care plan and most plans include prescription drug coverage. However, individuals with complex medical conditions and who see specialists who do not participate in the managed care plan may be better off with a standard Medicare supplemental insurance plan. Most nursing homes do not participate in the network of Medicare HMOs. Accordingly, an individual who is enrolled in a Medicare HMO may be required to disenroll from the HMO and switch to standard Medicare with a supplement in order to receive any Medicare coverage for skilled nursing facility care.

2. ***Long Term Care Insurance Overview***

a. While you are healthy, you should consider purchasing Long Term Care insurance. Long Term Care policies may pay for skilled, intermediate or custodial care in a nursing home. The better policies will also cover home care services, although the daily rate for home care services is sometimes a percentage of the amount paid for nursing home care.

b. Criteria to look for in a Long Term Care Policy include the following: If you are expecting the Long Term Care Policy to pay the bulk your long term care expenses, the daily benefit should be high enough, when combined with other income, to pay all or most of the cost of a nursing home and should include an inflation rider. (In the greater NYC area, nursing home costs average from $13,000 to $20,000 per month.) The policy should cover care in a nursing home, assisted living facility or in the home. Premiums should be level with a waiver of premium once the policy holder is receiving benefits from the plan. The company should be rated A+ by Best or equivalent rating agency. Most policies have either a maximum benefit amount or a maximum period of coverage.

c. Think carefully about whether to purchase inflation protection. Inflation protection will add substantially to the cost of the policy. However, health care costs tend to increase at much higher rates than other consumer services. Most policies offer compounded or simple inflation protection. Depending upon your age when the policy is purchased, it may not be necessary to purchase compounded inflation protection. However, simple inflation protection is generally advisable.

d. An individual who has already been diagnosed with Alzheimer's disease or dementia will not be able to obtain coverage. Moreover, underwriting requirements have become much more stringent over the past few years and many applicants will be unable to obtain coverage or face higher premiums due to age or health conditions such as advanced

arthritis. A diagnosis of cancer will generally preclude purchase of a long term care insurance policy until such time as the individual has been in remission, without any treatment, for at least two years. Annual premiums are based on age at the time of application. Starting in 2013, women who apply for policies may pay more for coverage than men. Furthermore, all policies contain limitations and exclusions, such as preexisting condition limitations, deductibles or waiting periods, exclusions for mental illness, intentionally self-inflicted injuries, substance abuse or chemical dependency.

e. Compare the costs and benefits of the New York State Partnership Insurance plans with other types of long term care insurance. The policies generally provide for from two to four years of nursing home coverage and up to six years of home care services, or a combination thereof. Individuals who purchase a "Total Asset Protection" policy and then exhaust the coverage under the policy, are entitled to Medicaid coverage without regard to their resources, or any transfers of resources. However, the Medicaid rules regarding the treatment of income will be followed. Especially given the drastic new provisions regarding Medicaid treatment of transfers of assets (discussed below), the Partnership Policies deserve serious consideration. New "dollar for dollar" plans enable individuals to purchase less than three full years of nursing home coverage and still have "dollar for dollar" resource protection for Medicaid once the benefits under the policy have been exhausted. (For example, an individual can purchase $200,000 worth of long term care coverage and protect $200,000 of resources once the benefits under the plan have been paid.)

f. New hybrid universal life insurance policies with guaranteed long term care benefits have been recently introduced. Initially, these policies required a single premium but this year, new policies have been introduced which can be funded within 3, 5, 7 or 10 years. The policies are guaranteed refundable after a period of 5 or 6 years, and guarantee a death benefit to the policy beneficiaries, unless the policy value is reduced by loans or payments made for long term care.

C. ***Medicaid***

1. ***Introduction***

Medicaid, a joint Federal and State funded program, was established by Federal Law in 1965. It is a needs-based program originally conceived to provide health care for the poor. Over the years it has come to be a major payor of the costs of long term health care, especially nursing home costs for the middle class.

2. ***Eligibility for Medicaid payments to a skilled nursing facility***

In order to meet the financial eligibility rules for Medicaid, income and resources must be spent down to levels established by federal and state regulations. In New York, during 2017, an institutionalized Medicaid applicant may keep only $14,850 in personal assets. Except for exempt resources such as the home and automobile, assets in excess of these amounts have to be spent or otherwise unavailable at the time of application in order for the individual to be eligible for Medicaid.

3. ***Protection of Spouse***

a. ***Treatment of Resources***

(1) The Medicaid program contains special rules which protect the income and resources of spouses of institutionalized Medicaid recipients. The general rule is that when one spouse is institutionalized and applies for Medicaid, the total value of the assets held by either spouse is computed. Regardless of which spouse holds title to the assets, one-half of the total will be considered to be held by each spouse. This is the so-called "Spousal Share." The Community Spouse is allowed to retain assets up to the "Resource Allowance". In 2017, the Spousal Resource Allowance is a minimum of $74,820 to a maximum of $120,900. The Resource Allowance can be increased by court order or agency decision but only if the spouse can show extreme financial hardship.

(2) **There is an important exception to the above rule. The Community Spouse has the right to refuse to contribute resources for the institutionalized spouse's care when the Community spouse has resources in excess of the Community Spouse Resources Allowance. This is a very important right.** The Institutionalized Spouse cannot be denied Medicaid under the following circumstances: (a) Community Spouse who is retaining more than his or her "Community Spouse Resource Allowance" refuses to contribute to the institutionalized spouse's costs of medical care; and (b) the Institutionalized Spouse executes an assignment of support from the Community Spouse in favor of the Department of Social Services; or (c) the Institutionalized Spouse is physically or mentally impaired and cannot assign the right to sue for support, or (d) denial of assistance would create undue hardship. This right of refusal can also be exercised in Medicaid home care cases.

(3) Spousal refusal is frequently misunderstood. If the Community Spouse exercises his or her refusal right, the Department of Social Services has a right to bring an action or proceeding to recover from the Community Spouse the cost of the spouse's health care. The ability of the refusing spouse to contribute to the cost of care provided by the Medicaid program is negotiated on an individual basis, based upon the extent of the assets and the age and health status of the refusing spouse. The aggressiveness of the local Department of Social Services in negotiating these spousal support claims varies from county to county. If a settlement is not reached, the County bring a spousal support court action. As the Medicaid program generally pays far less for the cost of care in a nursing home than the nursing home would charge to a private pay resident, spousal refusal is generally a good option to reduce the cost of the care, even if it is likely that the refusing spouse may have to reimburse the Medicaid program for all or most of the care. For home care, the difference between the Medicaid rate for the care and the private care rate may not be as substantial. It is critical that a spouse who has assets in excess of the Resource Allowance retain the assistance of an experienced elder law attorney to assess the likelihood of a spousal recovery proceeding before deciding whether to proceed with the filing of a Medicaid application.

b. ***Interspousal Transfer of Assets***

In addition, the law allows unlimited transfers from the institutionalized spouse to the community spouse. (The community spouse could then refuse to use those assets to pay for the institutionalized spouse's care.)

c. ***Treatment of Income***

All but $50 per month of the income of the institutionalized individual must be applied towards the cost of skilled nursing facility care. The Community Spouse (the spouse of an institutionalized individual) can retain all of his or her income and need not contribute any of the income toward the cost of care of his or her spouse. In addition, the Community Spouse is allocated a minimum monthly maintenance needs allowance of $3,022.50 in 2017 and will be allocated the income of the Institutionalized Spouse necessary to bring the Community Spouse's income to this level. This income allowance can be increased by Fair Hearing or Family Court Order if extraordinary circumstances are established. It is also adjusted each year for inflation. In addition, there is a family allowance which can be deducted from the Institutionalized Spouse's monthly income for each dependent family member.

d. ***Treatment of Retirement Assets***

There are special rules which govern the treatment of retirement assets. An IRA, 401(k) or other retirement plan which is in "periodic payment" status, will not be counted towards the assets of the institutionalized individual. In some counties, the retirement account will be considered to be in "periodic payment" status if the Medicaid applicant is taking Required Minimum Distributions from the retirement account, in accordance with the IRS tables. However, in most counties, the Medicaid applicant must take distributions which comply with life expectancy tables promulgated by the Social Security Administration.

4. ***Transfer of Assets***

a. ***Interspousal Transfers***

The Institutionalized Spouse is allowed to transfer resources to the Community Spouse without limit or penalty. Gifting of assets may result in adverse estate and capital gains tax consequences and should only be done upon consultation with a qualified financial planner or attorney.

b. ***The Look Back Period***

The federal Medicaid program imposes periods of disqualification for institutional care services (i.e. nursing home coverage) for individuals who give away assets to anyone other than a spouse during the "look back period." Prior to February 8, 2006, the federal government imposed a "look back period" of thirty-six months for individuals who made outright gifts of their assets and applied for institutional care Medicaid. Legislation enacted in 2006, extended

this "look back period" to sixty months. For many years, the law has provided for a "look back period" of sixty months for assets placed into a trust.

Assets which have been transferred for less than fair market value during the "look back period" create a period of disqualification for nursing home Medicaid benefits, as discussed below.

c. ***Calculation of the transfer for gifts made after 2006.***

The Deficit Reduction Act of 2006 ("DRA") was passed by Congress and signed by President Bush on February 8, 2006. The law enacted sweeping changes in the manner in which the transfer penalty will be calculated. Under the new law, the "look back period" for transfers of assets after the effective date of the legislation is sixty months (not thirty-six months) for all transfers, whether outright or in trust. Moreover, the transfer penalty will only begin to run once an individual is receiving institutional level of care **and** has applied for Medicaid. Gifts made during the look-back period are aggregated and the total is divided by a "regional rate" which is modified annually. The Medicaid program divides the state into seven different regions for purposes of calculating the Medicaid transfer penalty. In 2017, the regional rate for individuals who reside in nursing homes in Westchester County is $12,198. The regional rate for individuals residing in a nursing home in New York City is $12,157.

Example: If Mary Smith made total gifts of $120,000 during the five years prior to her admission to a nursing home in White Plains in 2017, those gifts would create a transfer penalty of Medicaid disqualification of 9.84 months. Moreover, the penalty will not begin to run until Mary's assets are spent down to the Medicaid resource limit, currently $14,850.)

d. ***Medicaid Treatment of the Primary Residence***

The primary residence has always been treated as an exempt asset for Medicaid purposes. However, a lien may be placed on the home if the Medicaid recipient is residing in a nursing home, is over the age of 55 and the home is not occupied by a spouse or a minor or disabled child. Moreover, the Department of Social Services can recover the value of Medicaid provided to an individual who is over age 55 from the applicant's estate.

Under the Deficit Reduction Act, a primary residence will no longer be an exempt asset if the equity in the residence is more than $500,000 and the home is not occupied by a spouse, or a minor or disabled child. States have the option of increasing the cap on home equity and New York has done so. In 2017 the maximum home equity value for a home in New York State is $840,000. An individual whose home is worth more than the equity cap may apply for a home equity loan or reverse mortgage, utilize the proceeds to pay privately for care and then apply for Medicaid once the home equity has been reduced, through expenditure of the proceeds.

Transfers of the homestead are treated the same as transfers of other non-exempt assets, even if the homestead was exempt at the time of the transfer, unless the homestead is transferred (1) to the spouse; (2) to a child who is under 21 or certified blind or certified

permanently and totally disabled; (3) to a sibling with an equity interest in the home who was residing in the home for at least one year immediately before the date of the institutionalization, or (4) to an adult (non-disabled) child commonly known as the "caretaker child", who was residing in the home for at least two years immediately prior to the date of institutionalization and who has provided care which permitted the parent to reside in the home rather than in an institution. Transfers of the homestead to one of these individuals will not result in any period of ineligibility for Medicaid. However, such a transfer may cause problems in the distribution of the estate or with taxes.

e. ***Home Care***

Currently, New York State provides extensive home care benefits to Medicaid recipients. Eligibility for Medicaid home care is not subject to the transfer of assets rules which apply to applicants for institutional care. However, there have been periodic proposals to extend the transfer of assets penalties to community Medicaid recipients. In appropriate cases, it is possible to obtain round the clock live-in home care attendants through the community Medicaid program. Although it is theoretically possible to obtain two twelve hour shifts of home attendant care per day, this is extremely difficult and will only be authorized in extreme cases and will always require expert legal advocacy. Most care is delivered through Managed Long Term Care (MLTC) programs which contract with licensed home care agencies to provide services to Medicaid recipients. However, the Consumer Directed Personal Attendant Program (CDPAP) permits “self-directed” Medicaid recipients to hire and fire their own aides and to perform some complex medical tasks which personal attendants are generally not able to perform. Regardless of whether care is provided through an agency, or the CDPAP program, the worker must be paid “on the books” and must be a citizen or have a valid green card which permits employment.

Individuals who receive Medicaid in the community are permitted to have income of $825 per month, a $20 monthly income disregard, plus an amount sufficient to pay monthly health insurance premiums. Individuals who have income over the permitted income threshold are required to pay their “surplus” or “excess” income on medical expenses, before the Medicaid program will pay. For example, if a Medicaid home care recipient has “surplus income” of $250 per month, he or she would ordinarily be required to “spend down” the surplus amount of $250 per month by paying it to the home care agency.

Medicaid recipients who are certified to be disabled by the Social Security Administration, or the NYS Department of Health, can instead deposit their monthly “surplus income” amount to a Supplemental Needs Trust. The amounts deposited to the trust will then be available to pay other household expenses instead of being required to be “spent down” on necessary medical care. Individuals who are under the age of 65 can create their own Supplemental Needs Trust and appoint a trusted friend or family member as Trustee of that Trust. Individuals who are over the age of 65 can only use a “pooled” Supplemental Needs Trust run by a not for profit agency.

NEW DEVELOPMENT-- MANAGED LONG TERM CARE: Since late 2012 in NYC and the spring of 2013 in Westchester, Suffolk and Nassau County, most[1] individuals who apply for Medicaid home care services are now required to join a Medicaid Managed Long Term Care Plan ("MLTC") which will assess the need for care services and arrange for all care. MLTC enrollment is now mandatory throughout New York State. MLTC plans are paid a flat rate for each person they serve (currently between $4,500 and $5,000 per month.) Currently, we are very successful in obtaining live-in home care authorizations for our clients from several of the MLTC programs. However, vigorous advocacy is often required. Medicaid recipients should carefully research the track-records of the available MLTC programs before choosing a plan. An experienced elder law attorney can provide advice on how to choose a plan and advocate for the maximum appropriate home care authorization.

NEW DEVELOPMENT—OPTION FOR MARRIED COUPLES TO UTILIZE ENHANCED SPOUSAL BUDGETING: In 2014, the Department of Health issued directives which permit individuals who receive home care services through a Managed Long Term Care Plan to utilize spousal impoverishment budgeting rules which are ordinarily limited to married individuals who receive Medicaid payments for nursing home care. This will allow the spouse enrolled in the Medicaid program to divert income to the well spouse up sufficient to bring the spouse's income up to the MMMNA of $3022.50 per month. However, if this option is used, the Medicaid applicant cannot divert the remainder of his or her income, if any, to a pooled trust.

D. ***Private Payment of Long Term Care***

1. If you are paying privately for long term care, be aware of the potential to take significant medical deductions on your tax returns. Individuals who are over the age of 65 may deduct medical expenses from income to the extent they exceed seven and a half per cent (7½%) of adjusted gross income. (As of 2013, younger tax payers may only deduct medical expenses which exceed 10% of adjusted gross income.) Qualified long term care services are deductible as medical expenses. Skilled nursing home costs should be fully deductible since the primary purpose of nursing home care is medical. Home care and assisted living expenses may be partially or totally deductible depending on the nature of the services provided. You should consult with your attorney or tax advisor regarding which assets should be used to pay for long term care. With proper planning, excess income generated by withdrawals from retirement assets and sale of highly appreciated assets can be offset by maximizing use of medical expense deductions.

2. If the person receiving the long term care services cannot utilize the medical deduction because of insufficient income, his or her children may be able to utilize the deduction. If the parent is a US citizen and the child pays for more than one-half of the parent's support for the calendar year, the parent would qualify as a dependent under I.R.C. §152, and if

[1] Enrollment in an MLTC program is not required for individuals who receive services from the Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver, a Waiver program operated through the Office for People with Development Disabilities, individuals receiving hospice services at the time of Medicaid long term care approval or individuals who are under the age of 18.

the child paid for the long term care services, the child could take the deduction under I.R.C. §151.

3. Payment of long term care cost from principal will reduce the estate and eliminate potential costly New York or federal estate taxes. After calculating the after tax cost of paying privately, it may be determined that private payment of long term care, with full utilization of any tax benefits is a preferable alternative to Medicaid planning. As Medicaid planning generally involves gifting out of assets, some of which may be highly appreciated, Medicaid planning strategies may have adverse capital gains consequences.

E. ***Medicaid Planning Strategies***

With the passage of the Deficit Reduction Act in 2006, the federal government has imposed drastic new restrictions on individuals who transfer assets in order to qualify for Medicaid. Individuals who transfer assets to trusts or their children are now disqualified from receiving Medicaid benefits for a period of up to five years. An experienced Elder Law attorney can still implement Medicaid planning strategies after the passage of the Deficit Reduction Act. However, the greatest savings are generally available to individuals who adopt a Medicaid plan well in advance of the need for long term care.

For most middle class families, the home is the most valuable and most highly appreciated asset. However, a home with a value in excess of $840,000 may disqualify an individual from receiving Medicaid, even if there are no other assets! Moreover, the Medicaid program may have the right to place a lien against a home and seek repayment of the full value of Medicaid services after the Medicaid recipient dies.

1. **Medicaid Planning Trust**: The most common Medicaid planning strategy is to place the home and any other assets not needed for day to day living expenses over the next five years into a Medicaid Planning Trust, also known as an Irrevocable Income Only Trust ("IIOT.") The funding of the trust will create a five year disqualification for Medicaid nursing home coverage, provided the applicant's other assets are below the maximum permitted resource threshold (currently $14,850.) However, after the five year penalty period has expired, the house and any other assets in the trust will be fully protected against a lien or estate recovery in the event that a nursing home stay is required. A ***properly drafted trust*** has the following important features:

   - The owners who created the trust have a life time right to reside in the house. The trustees cannot force them to move or sell the house without their consent.
   - A house placed into the Trust will still enable the grantors to qualify for the STAR, Enhanced Star and Veteran's tax exemptions.
   - The owners who created the trust will still qualify for the $250,000 per person exemption from payment of capital gains taxes if the house is sold during the owners' lifetimes.

- The value of the house will qualify for a "step-up" in basis to the market value at the time of death, if the house is not sold until the owners have died.
- The initial funding of the trust will not be treated as a taxable gift and a gift tax return will not have to be filed.
- The house will be protected as an inheritance for the owners' family members and will not be subject to a Medicaid lien or estate recovery.
- The grantors cannot retain the right to use of any of the trust principal, although the trust may require the trustees to distribute any net income from trust investments to the grantors.

It is important that the grantors understand that once the residence is placed into the trust, they may not be able to obtain a mortgage, home equity line or reverse mortgage for the property, although there are a limited number of mortgage brokers who will loan to an irrevocable trust.

2. **Gift and Loan or Annuity:** In many instances, an elderly client who is placed into a nursing home may be able to gift as much as half, or more, of the non-exempt assets to family members. The gifting strategy is generally combined with the use of a loan secured by promissory note or an annuity which is used to pay privately for the care in the nursing home during the period of Medicaid disqualification caused by the gift.
3. **Personal Services Contract:** Another strategy may involve paying family members for caretaking services through the use of a carefully drafting Personal Services Contract. However, recent fair hearing decisions and New York court decisions have severely limited the utility of this strategy for individuals who are receiving care in a skilled nursing facility. As the nursing home is required by law to provide for nearly all of the care needs of the resident, payments to family caregivers have been found to be duplicative of the services provided by the Medicaid program.

As Medicaid rules are complicated and ever changing, it is very important to seek assistance from an experienced elder law attorney before implementing any Medicaid planning strategy.

BIOGRAPHY OF FRANCES M. PANTALEO

Frances M. Pantaleo is a partner at Bleakley Platt & Schmidt LLP, and the head of its Elder Law and Special Needs Planning Group. Her practice is concentrated in the areas of Elder Law, Trust and Estates, Medicaid Planning, Special Needs Planning, Guardianship and legal issues affecting individuals with disabilities and their families. She is a Past Chair of the Elder Law and Special Needs Section of the New York State Bar Association and a member of its Special Needs Planning Committee. She is a member of the National Academy of Elder Law Attorneys and has previously served as Chair of the Elder Law Committees of the Westchester County Bar Association and Westchester Women's Bar Association.

Ms. Pantaleo has been recognized as a "Best Lawyer" and a "Super Lawyer" in the area of Elder Law and was named one of the top twenty-five attorneys in Westchester County in 2011 and 2012. She has received an AV rating (the highest available) from Martindale-Hubbell.