

SUMMER 2009

Message from the Editor

Planning and paying for long-term care is for many persons a matter of life and death. It is the role of the elder law attorney and other advocates for the disabled and elderly to make certain that those individuals in need of health-care services are able to secure them. Toward that goal, information may be critical. In this issue of the *Elder Law Report* we have brought together articles that provide the basics for understanding important aspects of the health-care system: how to qualify for Medicaid home care and nursing-home care; understanding Medicare; how and when to use pooled-income trusts and supplemental-needs trusts; the use and value of durable powers-of-attorney, etc. In the months ahead we will be reporting on other subjects relevant to disabled and elderly persons, including housing options, veterans' benefits, long-term-care insurance, reverse mortgages, and annuities. ■



Free Program Now Available

The law firm is now offering a seminar, **MEDICAID 2009!**, for professionals only, to be presented at social-service agencies, nursing homes, adult-day-care centers, hospital and assisted-living facilities. There is no charge for this program which is presented by Martin Petroff. Topics to be covered include new Medicaid transfer-of-assets rules, look-back and penalty periods, pooled-income trusts, supplemental needs trusts for disabled persons, and primary residence rules.

To schedule a presentation at your office or to reserve a place for the same program at the law offices of Martin Petroff & Associates at 270 Madison Avenue, between 39th & 40th Streets, please call (212) 679-5800. ■

Pooled Income Trusts & Medicaid Home Care

Disabled persons of any age receiving community Medicaid services – including home care, adult-day care and prescription drugs – are now able to use virtually all of their income to pay for their living expenses by participating in a pooled-income trust. It is no longer necessary for consumers to contribute their “excess” income to the Medicaid system as a “spend-down.” The pooled trust is proving to be a popular planning tool for persons in need of long-term health-care services for whom the excess-income option did not work because it would not allow them sufficient money to live in the community and qualify for Medicaid. The program works as follows:

- Suppose Mr. Smith has a monthly income of \$1,787 in Social Security and pension income and is utilizing Medicaid home care and adult day-care services. Under present (2008) Medicaid guidelines he is only allowed to keep \$787 of that income.

- Currently his monthly surplus is \$1,000 ($\$1,787 - \$787 = \$1,000$). He is sending a check each month for that amount to the appropriate health-care provider as a contribution toward the cost of his care.

- After Mr. Smith joins the pooled-income trust his \$1,000 check will be sent to the trust office. He will keep \$787 as he does now. Mr. Smith's expenses for rent, food, utilities, clothing, etc. will be paid by the trust according to instructions from Mr. Smith or his representative. Mr. Smith's Medicaid services will not be affected.

The pooled-income trust contains the assets of a number of disabled individuals and is managed by a non-profit organization that maintains separate accounts for each individual. It is effectively a program that receives the beneficiary's monthly income and redistributes it on his behalf as directed by the beneficiary or his representative without affecting his Medicaid eligibility. ■

2009 Medicaid Update – The Essentials

Individuals in need of home care or nursing-home care should understand that despite recent changes made in the Medicaid eligibility rules, they do not have to spend down their savings to qualify for Medicaid services. The Deficit Reduction Act of 2005 made significant changes in the Medicaid law, nevertheless, a number of valuable planning options have been left in place and they are outlined here.

Home Care & Assisted Living

There continues to be no penalty period for transferring assets to become eligible for non-institutional Medicaid! The virtually-free Medicaid services include home care; adult-day care; private-duty nursing; the Consumer Directed Personal Assistance Program; community managed long-term care; the Assisted Living Program and more.

Nursing Home Care

Under the old and new law an individual who transfers assets to qualify for Medicaid institutional services may incur a penalty period during which time the individual will not qualify for Medicaid coverage in a nursing home. **However, it is never too late to conserve life-time savings. An individual who has resources in excess of the Medicaid limits and faces placement in a nursing home, or who is already a resident there, may still protect a substantial portion of his resources and ultimately qualify for Medicaid!** Note that there is no penalty period if assets are transferred to a spouse; the individual's child under age 21; a blind or disabled child of any age; or a trust established for the sole benefit of any disabled person under the age of 65.

The Home

An individual's home – a house, cooperative or condominium apartment – **remains an exempt asset for purposes of determining initial Medicaid eligibility.** However, ultimately, Medicaid may impose a lien on the sales proceeds of the property for all it spent on behalf of the Medicaid recipient. **The transfer of the home will not incur a penalty period for nursing-home eligibility if the transfer is made to a spouse; a child who is blind, disabled or under age 21; a brother or sister who has an equity interest in the house and resided there for at least one year before the individual was institutionalized; or a “caretaker” child who resided in the home for at least two years before the person was institutionalized and provided care to maintain the person at home.**

Spousal Refusal

Consumers should not be misled by the words “spousal refusal” as it occurs in the process of filing a Medicaid application for home care or nursing-home care. Without the submission to Medicaid of a spousal-refusal letter, a well spouse's income and assets will be imputed to the unwell spouse and that unwell spouse may then not qualify for Medicaid.

For example: Mary Smith has \$100,000. Frank, her husband is ill and requires nursing-home care. He is financially eligible for Medicaid except for the fact that half of his wife's resources will be counted by Medicaid as if they belong to him. Mary must sign the letter refusing to support her husband but she remains responsible for the cost of his Medicaid services.

Spousal refusal allows the unwell spouse to access Medicaid but the refusing spouse must understand that she/he remains liable for the unwell spouse's Medicaid charges. Proper Medicaid planning with an elder-law attorney will reduce the financial vulnerability of the well spouse. ■

Medicare 2009 in a Nutshell

Editors' Note: It is important to remember that purely custodial care (the type of care that most persons at home or in nursing homes require) is not covered by Medicare or Medigap policies. The only home-care or nursing-home services that Medicare covers are for skilled nursing or rehabilitation. Long-term-care insurance or Medicaid are the major alternative sources for paying for custodial-care services.

Introduction

The Medicare program is a system of health insurance for the aged and disabled. It is administered by the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration. It consists of two basic units: Part A provides coverage for the costs incurred by eligible beneficiaries for inpatient hospital care, inpatient care in a skilled-nursing facility following a hospital stay, home-health-care and hospice services; Part B is a voluntary program in which eligible beneficiaries who pay a monthly premium are entitled to reimbursement for physician and other medical services and supplies. Parts C and D are reviewed below.

Eligibility

Primary Medicare eligibility is linked to Social Security retirement and disability benefits. Disabled persons and disabled widows/widowers under age 65 may also be eligible for Medicare. Some persons who are 65 years of age or older, but not otherwise eligible, may purchase this insurance by applying to Social Security.

Enrollment

The initial enrollment period begins three months prior to the month of the 65th birthday and continue for three months after that. (There are substantial penalties for late enrollment.) A special enrollment period is available for the working aged and their spouses who delay enrollment because of primary, employer-based insurance.

Medicare Part A - Hospital Insurance

Inpatient Hospital Coverage: Medicare Hospital Insurance (Part A) will pay for all medically necessary inpatient hospital care for the first 60 days minus a deductible of \$1,068 (2009) for each benefit period. For the remaining days a beneficiary must pay substantial co-payments, which may be covered under a Medigap policy (see discussion below). Major in-hospital services covered by Medicare Part A include a semi-private room, all meals, special-care units including the intensive-care and coronary-care units, regular nursing services and drugs furnished by the hospital during the patient's stay.

Skilled Nursing Facility Care: Medicare will also pay for up to 100 days in a skilled-nursing facility. The first 20 days are covered, but for days 21 through 100 a \$133.50 (2009) daily co-payment is required. The patient must have been hospitalized for at least three days and be admitted to the facility generally within 30 days after leaving the hospital.

Home Health Care: Medicare also provides home-health-care services for a beneficiary who is under a physician's plan of care, requires skilled-nursing care and is essentially confined to home. Physical, occupational and speech therapy and the services of a home-health aide are available. A prior hospital stay is not required.

Hospice Care: Medicare's hospice program includes both home care and inpatient care, when needed, and a variety of services not otherwise provided by Medicare. To be eligible, a Medicare beneficiary must be certified by a physician as terminally ill with a life expectancy of approximately six months or less. Those who choose hospice care receive non-curative medical and support services for their terminal illness. Regular Medicare continues to pay for medical treatments not related to the terminal illness.

Part B - Medical Insurance

Medicare Medical Insurance (Part B) covers a variety of medical services of particular importance to Medicare beneficiaries, including physician services in and out of the hospital, durable medical equipment, out-patient hospital services, physical, occupational and speech therapy and ambulance transportation. Part B coverage is voluntary. Most Medicare

beneficiaries decide to enroll in the program with their monthly premiums deducted from their Social Security checks. There is a monthly Part B standard premium of \$96.40 (2009). Persons who file an individual tax return with annual income above \$85,000 (or \$170,000 for a married couple filing a joint tax return) will pay a Part B premium higher than \$96.40. There is an annual deductible of \$135 (2009) which must be paid before Medicare benefits are reimbursed. Medicare pays 80% of the approved charges for services and the beneficiary is responsible for the 20% co-payment. Some Medicare supplemental insurance policies cover these charges. See Medigap Insurance below.

Limiting Charge

There is a cap imposed on the amount doctors may charge their Medicare patients for each service. In New York, doctors may not charge more than 5% above the Medicare-approved rate for most services.

Excluded Services under Part A and Part B

Some services not covered by Medicare Part A are private-duty nursing and, generally, a private room. Other services excluded under Medicare Part B are routine physical checkups, immunizations with some exceptions, eyeglasses and contact lenses, most dental care and hearing aids, and most out-patient prescription drugs that do not require administration by a physician. Generally, Medicare will not pay for hospital or medical services abroad or for physician services on ship cruises beyond the territorial waters of the United States.

Medigap Insurance

Medicare beneficiaries generally decide to buy supplemental insurance (Medigap). At present, there are 12 standard Medigap policies that may be offered by insurance companies. Plan A is a policy with core benefits that are included in the 11 other plans. For further information, request a copy of the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* by calling Medicare (800) 633-4227 or Social Security (800) 772-1213 or visit the Medicare website at www.medicare.gov/publications.

Part C - Medicare Advantage Plans

Medicare Advantage plans are managed-care programs that are sometimes called coordinated care or prepaid plans or health maintenance organizations (HMOs). They might be thought of as a combination of insurance company and doctor/hospital. Like insurance companies, they cover health-care costs in return for a monthly premium which may be waived. Generally, the plans have 'lock-in' requirements. This means that an enrolled member is locked into receiving all covered care from the doctors, hospitals and other care providers who are affiliated with the plan. In most cases, if the enrollee goes outside the plan for services, neither the plan nor Medicare will pay. The enrollee will be responsible for the entire bill.

Part D - Medicare Prescription Drug Plans

Medicare pays, in part, for out-patient prescription drugs. All Medicare beneficiaries have the opportunity to enroll in a Medicare prescription drug plan sponsored by a private-sector company. New York has more than 50 different plans available to beneficiaries from the companies.

Part D plans charge a monthly premium. Many have a deductible to meet and co-payments or coinsurance requirements as well. Overall, there should be savings of 25-50% depending on the person's drugs and the plan's price and co-pays. After a period of shared drug costs are met, where the plan pays 75% of the costs, an enrollee goes into a period of non-coverage (nicknamed the "donut hole") where he is responsible for

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NEWS BRIEFS

Nearly One-Third of New York City Residents in Medicaid: Nearly one-third of New York City's residents are enrolled in Medicaid and account for 66% of beneficiaries in the program statewide, according to a report published by the United Hospital Fund. City residents' enrollment in the program increased by 55% from 2.8 million in 2000 to 4.3 million in 2005, the report found. The report attributed the statewide increase to policy changes and an effort to enroll more eligible residents in the program.

Assisted Living White Paper: Assisted living provides an attractive option for people who need or desire care services yet want to live in a more community-like setting than a nursing home, however, the rates are often prohibitive. To date, in New York State, assisted living has only been an option for those with substantial means to pay. The Long Term Care Community Coalition has developed a series of recommendations for ways the State can make assisted living affordable to all New Yorkers, irrespective of income. The full paper is available on www.ltccc.org or by request to LTCCC, 242 West 30 St., New York, NY 10001.

Are Payments to Assisted Living Facilities Tax Deductible? As suggested immediately above, the costs for assisted living may create significant financial hardship for residents and their families. In 1996, Congress passed the Health Insurance Portability and Accountability Act which may ease this burden by permitting tax deductions for qualified long-term-care services. Certain payments to assisted-living facilities may be deductible under the provisions of this law. All residents of these facilities and their families should be aware of the potential tax deductions associated with long-term-care services.

Hospital Language Support Assistance: New communication assistance regulations are in effect for all private and public hospitals throughout New York State. The new rules are intended to improve access to health care and protect patients from medical harm arising from failed communication. Anyone, regardless of immigration status, whose ability to communicate in English is limited, or is hearing- or vision-impaired, has a right to free communication assistance. NY Immigration Coalition, (212) 627-2227 or www.thenyic.org.

Transfer-on-Death Registration Act provides a form that extends to New York State residents an important estate planning tool with regard to securities. The new law provides for the administrative transfer of certain assets to a beneficiary without having the property subject to the probate delays and expense. It also avoids the risk of problems arising from joint and survivor security titles. Forms are available through brokerage firms.

A Guide to Burial Assistance and Funeral Planning for New Yorkers in Need compiled by Volunteers of Legal Services is a 56-page compendium covering government and religious agencies, organizations for foreign-born persons, and non-profit offices that will provide funding and support. Available at www.volspobono.org. Single copies of the Guide may be obtained by sending a stamped (\$1.99), self-addressed 9x12 envelope to VOLS, 54 Greene St., New York, NY 10013-2306.

The link between genetics and Alzheimer's disease will be the subject for a distinguished panel of scientists on September 17th at the annual chapter meeting of the Alzheimer's Association. For information on registration, please contact Karen Holland at (646) 744-2926 or kholland@alzny.org or visit www.alzny.org.

The non-sectarian Doula to Accompany and Comfort Program at the Jewish Board of Family and Children Services trains volunteers who provide companionship and comfort to people in New York City whose life expectancy is less than 18 months. For further information contact Judith Kahn at (212) 399-2685, ext. 220, jkahn@jbf.org or visit www.shirarusky.org.

For a free subscription to the **Elder Law Report**, please call the law offices of Martin Petroff at (212) 679-5800 or write to Martin Petroff at 270 Madison Avenue, Ste. 1100, New York, NY 10016 or mbpetroff@aol.com. The complimentary subscription is available to professionals in the fields of geriatrics and health care, caregivers and consumers.

Aid & Attendance is a benefit for veterans and surviving spouses who require the regular attendance of another person to assist in eating, bathing, dressing and undressing or toileting. It also includes individuals who are blind or in a nursing home because of mental or physical incapacity. Assisted care in an assisted-living facility also qualifies. An application will require a copy of DD-214 or separation papers, medical evaluation from a physician, current medical issues, net worth and net income limits, along with out-of-pocket medical expenses. Contact the Veterans Administration at (800) 827-1000 or a Veterans Service Office.

Independence Care System (ICS), a non-profit managed long-term care plan committed to assisting people with disabilities to live independently in the community, has opened its first regional office at 25 Elm Place in downtown Brooklyn. In focusing on the special needs of its Medicaid-eligible consumers who are over 18 and living in the Bronx, Brooklyn and Manhattan, ICS has its own wheelchair ordering and repair department with a physical and occupational therapists on staff. Referrals can be made directly to the ICS intake department at (212) 584-2500.

All private and public hospitals in New York State are required to provide financial assistance to patients who use hospital services. The new law, effective January 1, 2007, is intended to improve access to health care and protect consumers from unfair hospital billing and collection practices. If an individual has limited income and does not have health insurance, or is not able to afford co-payments or deductibles, he has the right to apply for financial assistance to reduce the bill. People who live in New York are eligible for hospital assistance, regardless of immigration status. Receiving such assistance does not affect immigration status. For further information contact the Urban Justice Center, (646) 602-5600. ■

Using the Durable Power of Attorney

The "durable power of attorney" is one of the most powerful planning tools that an attorney can recommend to a client, not only for estate planning, but also for Medicaid and other public benefit planning.

When a person (the principal) signs a power of attorney, he gives another person (the agent) the power to act in his place and on his behalf in managing his assets and affairs. The agent's powers may be broad and sweeping so as to include almost any act which the principal might have performed. It should be noted, however, that, in general, acts which are inherently testamentary in nature, such as the authority to make or revoke a will, may not be performed by an agent.

A power of attorney can be either a "general" power of attorney, where the agent may perform almost any act the principal might have performed himself regarding the financial management of his affairs, or a "limited" power of attorney where the agent has one or more specific powers, such as the power to sell a particular property to a particular purchaser at a particular time.

A single principal may name one or more agents who can be authorized to act either "jointly" or "severally" (alone without the signature of the other agent or agents).

The "durable" power of attorney is unlike the ordinary power of attorney in that it does not become inoperative upon the incapacity of the principal. The durable power of attorney, provides that those powers granted to the agent shall not be affected by the subsequent disability or incapacity of the principal or by the lapse of time.

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Change Service Requested

Durable Power of Attorney *continued from page 1*

In drafting powers of attorney, care should be given to confer powers with as much specificity as possible in order to avoid the possibility of a court construing a specific omission as an intent to fail to grant that specific power. Such an adverse finding could be a serious detriment to the principal's assets. The power of attorney for asset management in the case of a seriously ill or disabled person is especially useful in situations where the person's assets may be modest and, accordingly, do not warrant the expense associated with other planning techniques such as trusts or guardianships.

The great advantage of the durable power of attorney is that it remains in effect after the principal's incapacity. The agent, therefore, can act immediately upon the principal's incapacity to manage his assets or to take various measures without initiating costly and time consuming guardianship proceedings to obtain the court's authorization for such transactions.

In a few states, the principal is allowed to delegate to the agent in the durable power of attorney various health care powers in addition to control over financial matters. In New York State, however, a health care proxy must be a separate document from a power of attorney.

Under New York law an individual may appoint someone she trusts – for example, a family member or close friend – to decide about treatment if she loses the ability to decide for herself. She can do this by using a health-care proxy in which she appoints her health-care agent to make sure that health-care providers follow her wishes. Her agent can also decide how her wishes apply as her medical condition changes. Hospitals, nursing homes, doctors and other health-care professionals must follow the agent's decisions as if they were the patient's. The individual can give her health-care agent as little or as much authority as she wants. She can allow the agent to decide about all health care or only certain treatments. ■

Medicare 2009 in a Nutshell *continued from page 2*

100% of the cost of the drugs until he pays a total of \$4,350 out-of-pocket. At that point, he pays 5% of his drug costs or a small co-payment (\$2.40 or \$6.00) for the rest of the calendar year and the monthly premium.

If the individual's annual income is less than \$16,000 (\$21,000 for couples) he may qualify for Extra Help, a program that reduces the Medicare Part D out-of-pocket costs. If the individual qualifies for Extra Help, the drug-plan premium could be free and the co-payments as low as \$2.40 for each prescription. Persons who qualify for Extra Help do not have the coverage gap (the donut hole).

With so many plans to choose from and the list of covered medications different from one plan to another, help is needed. The NYC Department for the Aging through its HIICAP unit has trained counselors at 2 Lafayette Street in Manhattan and at numerous sites across the City to provide assistance. Staff members are prepared to assist beneficiaries with their specific needs and choices, including Extra Help for low-income beneficiaries. Please call 311 for locations. ■

Supplemental Needs Trusts Defined

Supplemental-needs trusts have become widely used planning tools for persons with disabilities. Such trusts, also referred to as special-needs trusts, are intended to enhance the lives of disabled individuals without jeopardizing their eligibility for Medicaid and Supplemental Security Income (SSI).

Supplemental-needs trusts pay for the personal needs of beneficiaries, including luxuries and necessities. The trust assets may include cash, stocks and bonds, and a home, a condominium or cooperative residence. The following examples illustrate situations in which a supplemental-needs trust may be used:

- A supplemental-needs trust may be established for the benefit of a disabled person under the age of sixty-five using that person's own funds – without incurring a penalty period for Medicaid and SSI eligibility. Note that upon the death of the disabled beneficiary, the State has a right to recover against the remaining funds in the trust for whatever Medicaid charges were incurred by the individual. The law provides, however, that there are no limits on the amount of trust income or principal that may be spent on behalf of the disabled person during his lifetime.
- A parent, family member or friend may establish a supplemental-needs trust for a disabled person without risking that person's eligibility for public benefits. In such a case, Medicaid has no right to recover against assets remaining in the trust upon the death of the beneficiary. Such assets may be distributed according to instructions included in the trust agreement by the individual who funded the trust.
- A disabled person of any age may transfer his assets to a supplemental-needs trust for another disabled person under the age of sixty-five without disqualifying himself for Medicaid home care or nursing-home care. ■

ABOUT THE EDITOR: The law practice of Martin Petroff & Associates provides a broad range of services concentrating on the rights of the elderly and disabled. Martin Petroff, formerly staff attorney for health affairs at the New York City Department for the Aging, is a member of the New York State Elder Law Section. He is a member of the Long-Term Care Community Coalition where he serves as a director; and he is a member of the advisory councils of the Henry Street Settlement House Senior Companion Program and CIDNY-Independent Living Services.

The *Elder Law Report* is published to provide an informative summary of current legal issues affecting the elderly and disabled persons of any age. Those individuals concerned about legal issues discussed in this publication are advised to secure counsel from an elder-law attorney. ATTORNEY ADVERTISING pursuant to NY DR2-101(f). Copyright © Summer 2009 Martin Petroff & Associates. All rights reserved. ■