DON'T LET YOUR HEALTH DESTROY YOU FAMILY'S WEALTH

By Victor J. Medina

It's all about family! You want to protect those who are closest and dearest to you. You want assurance that those who cared and sacrificed for you are protected during their time of need. You also want to protect yourself and plan for your own future care. This two-part series will help explain how to pre-plan for future long-term care needs of you and your loved ones and how to plan in a crisis for immediate needs. Be sure to pick up the book that applies to your current situation. We want to help you help your family!

✔THINKING ABOUT PRE-PLANNING... ⇨THIS BOOK!

This book is for those interested in pre-planning for long-term care needs. Provided here is a brief look at different options to plan for long-term care with an emphasis on Medicaid planning. This basic overview of options available is designed to dispel much of the confusion regarding long-term care planning and offer planning techniques to ensure your family can protect as much of your hard-earned assets as the law allows and enable you to receive the care you need without losing everything!

✔HELP ME NOW!

Our book on crisis planning is for you or a loved one who is facing drastic life changes and will be requiring nursing care soon. Geared toward readers who are already familiar with the long-term care options available, our crisis planning book suggests strategic planning techniques to protect as much of your hard-earned assets as possible and help to get you qualified for Medicaid benefits as soon as possible.

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Victor is the founder of Medina Law Group, concentrating on estate planning, and the president of Private Client Capital Group, a registered investment advisory firm. He brings a family-centered approach with a focus on practical solutions for families and high-net worth individuals.

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"After age 65, an American has more than a 70 percent chance of needing long-term care in his or her lifetime."

If you are reading this book, chances are you are reaching your golden years or you have an aging loved one and are considering what impact future potential healthcare costs could have on your family. Because there is a good chance you or your family member might need long-term care services at some point during your lifetime, it is important to explore the options available so you can plan ahead. Waiting until long-term care is actually needed may limit the options available to you.

This guide focuses primarily on pre-planning for long-term care. You may be just "checking things out." Like a routine visit to your doctor's office, everything is fine right now, but you want a current evaluation so you can be proactive and ward off any surprises in the future. With pre-planning, there are more options. There is less stress involved and planning costs are usually lower.

Crisis-planning is much different. Crisis-planning is like emergency room planning. You have a heart attack and you need help now. This type of planning is usually very fast paced, with fewer options, and usually much higher cost. The stress is higher because the family is almost always ill-prepared and confused, not knowing what to expect.

Planning can be done in either situation; but, pre-planning is usually easier and cheaper on the family.

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SHOULD I BE CONCERNED ABOUT LONG-TERM CARE?

Long-term care is generally required when you can no longer take care of yourself and you need help with performing everyday activities, such as bathing, dressing, eating, transferring from bed or chair, or remembering to take medication.

This is more ongoing care than you might receive in the hospital to recover from a sickness or injury. This care could be needed because of a chronic illness, disability, Alzheimer's disease, or age.

By the year 2020, 12 million older Americans are expected to require long-term care services.[1]

Consider these indicators:

- **Age:** as people get older, their likelihood of needing help with performing daily tasks increases
- **Living Alone:** those that live alone are more likely to need assistance with daily living than those living with a spouse, partner, or other family member
- **Gender:** women will more likely require long-term care than men because women usually live longer
- **Lifestyle:** poor diet and little exercise can increase your risk of needing long-term care
- **Genetics:** looking at your family's medical history can indicate if you have a greater likelihood of needing long-term care

As our population continues to age, it is important to realize that most of us will require long-term care.

Ask yourself these questions:

- Who would I turn to for help with my care?
- Are my family members close by and available? Are they physically and financially capable of helping me?
- What if I become the caregiver for someone else?
- The need for long-term care affects the whole family. Seriously evaluate your options. If staying with family is not feasible for you, pre-planning becomes critical.

[1] For more information on Senior Care Statistics visit the SeniorCareMarketer.com

HOW CAN I PAY FOR LONG-TERM CARE?

Generally you have at least three options to pay for long-term care:

- **You can pay**
- **Insurance can pay**
- **Government can pay**

Let's look at these options more closely.

1. You Pay: Private Pay:

You or your family can privately pay out of pocket from your own funds. Unfortunately, many people underestimate the expense of long term care. If you think you can pay long-term for you or your family's care, consider the cost.

The average cost for nursing home care in New Jersey is about $6,000 a month or about $72,000 per year.

Writing the nursing home a check for $6,000 each and every month could quickly wipe out your hard-earned savings and be devastating to you and your family. To create $72,000 a year in income would generally require at least $3 million dollars in income-producing assets. With the average length of stay in a nursing home being about three years, private pay is not a good option for many middle-class Americans.

2. Insurance Pays:

Insurance: Long-Term Care Insurance can pay some if not all of your long-term care costs. If this insurance is available for you, it should be considered. An annual premium for a married couple is often less expensive than one month of stay in a nursing home.

When incorporated with proper planning, insurance may enable you to stay home with assistance if you become ill. The cost of the premium will depend upon your age when you apply for the insurance, the type of care you need and what type of medical professional provides the care. Individual policies differ from company to company so it is advisable to seek the aid of an insurance professional.

3. Government Pays: Medicaid:

Medicaid is a federal program, administered by the states, that provides health care coverage for people with limited assets and incomes. It covers the cost of nursing home care for those who meet the program's financial and medical eligibility requirements.

***Note on Medicare:** Don't count on it! Medicare is a federal insurance program for people 65 years of age or older and for certain individuals with disabilities. It does not cover long-term care costs.[2] Medicare only covers "acute" care for people who are likely to recover from their medical conditions. It does not cover custodial care for people who need help performing everyday activities. Medicare will pay 100% of all costs up to 20 days in an approved "skilled nursing facility" or nursing home. After 20 days, Medicare can pay a co-pay amount for an additional 80 days.

However, after 100 days have passed, the patient is completely responsible for the cost of care. These options are not independent of one another and often include combining all three. Knowing about the options available will help you make better decisions in choosing the best strategy. Since the government has offered to pay if qualifications are met, let's briefly explain how the government's Medicaid plan, works.

[2] 2014 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, published by the U.S. Dep't of Health & Human Services, available on-line at http://www.medicare.gov/publications/pubs/pdf/02110.pdf.

MEDICAID MYTHS

Many people rely on their family, friends, or neighbors for advice about Medicaid. They hear talk at the local coffee shop or beauty shop and believe it as the truth. Uneducated free advice can be very costly!

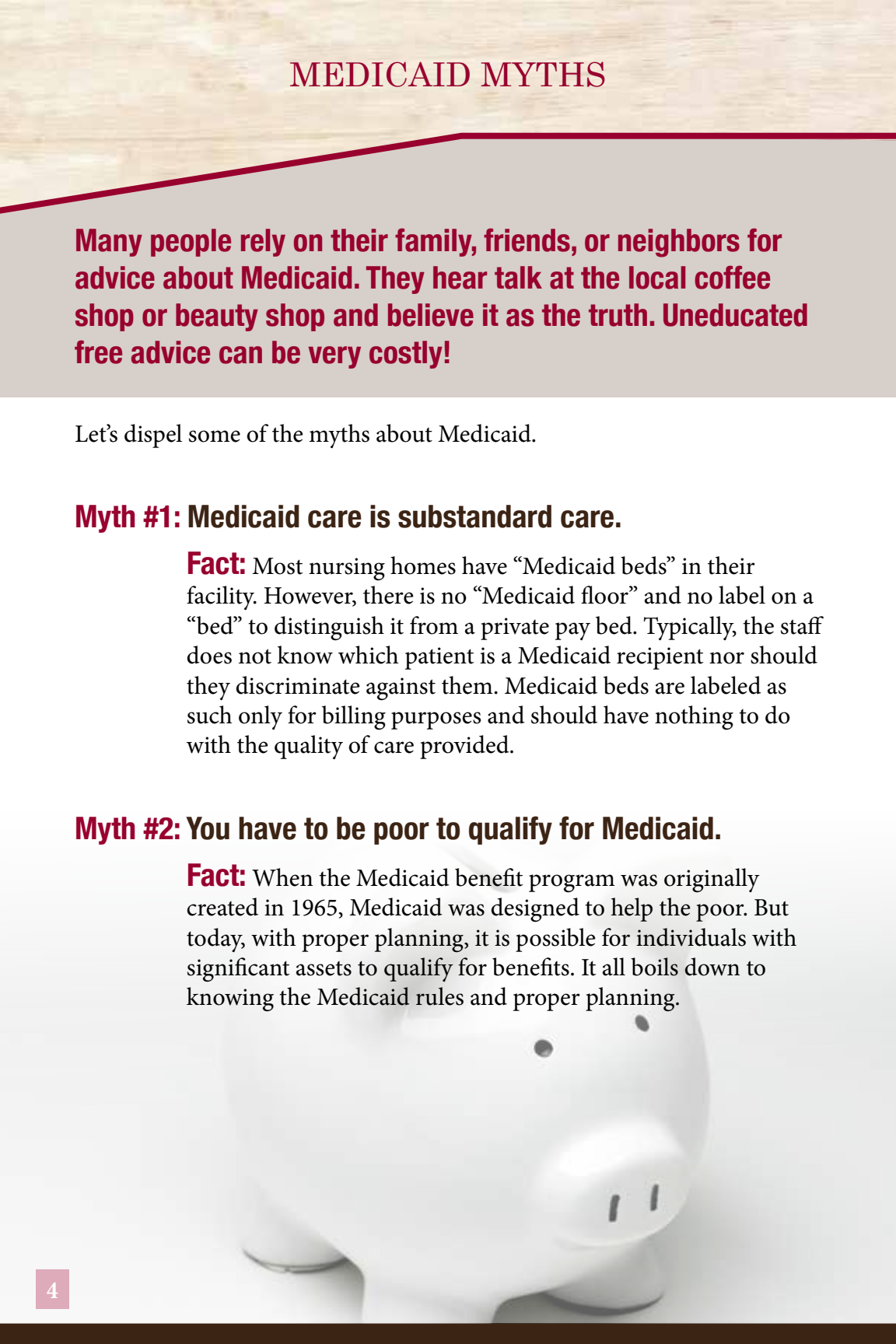
Let's dispel some of the myths about Medicaid.

Myth #1: Medicaid care is substandard care.

Fact: Most nursing homes have "Medicaid beds" in their facility. However, there is no "Medicaid floor" and no label on a "bed" to distinguish it from a private pay bed. Typically, the staff does not know which patient is a Medicaid recipient nor should they discriminate against them. Medicaid beds are labeled as such only for billing purposes and should have nothing to do with the quality of care provided.

Myth #2: You have to be poor to qualify for Medicaid.

Fact: When the Medicaid benefit program was originally created in 1965, Medicaid was designed to help the poor. But today, with proper planning, it is possible for individuals with significant assets to qualify for benefits. It all boils down to knowing the Medicaid rules and proper planning.



Myth #3: If you need nursing home care, Medicaid will take away your home if you apply for benefits.

Fact: If you are married, Medicaid will not take your home while you are living or after you die. If you are single, the New Jersey Medicaid Estate Recovery Program allows the state of New Jersey to make a claim against the estate of a deceased Medicaid recipient to seek reimbursement for Medicaid benefits paid. However, there are several exceptions to this rule. First, it must be cost-effective for Medicaid to go after the estate for unreimbursed medical expenses. Second, the Medicaid Estate Recovery Program only applies to individuals who are 55 and older. Third, your home is exempt from estate recovery if the following conditions are met:

After death of an unmarried Medicaid recipient,

- there is a surviving child or children under 21 years of age;
- there is a surviving child or children of any age who is blind, has a visual impairment or who has low vision and is totally disabled under Social Security requirements; or
- there is an unmarried adult child residing continuously in the Medicaid recipient's homestead for at least one year before the time of the Medicaid recipient's death.
- a hardship exists.

In addition to these exceptions, there are several planning strategies that your qualified elder law attorney can use to protect assets from estate recovery. It is important to discuss these strategies with your advisor in advance to maximize the options available to you.

Myth # 4: You have to give your assets away to protect them.

Fact: Gifting can be a great tool to help you qualify for Medicaid. But, giving away your property can create unintended tax consequences and often can do more harm than good! Should you choose gifting as a planning strategy, consult with a qualified Elder Law attorney to ensure proper timing.

Myth #5: If you transfer assets, you have to wait 60 months before you can qualify for Medicaid benefits.

Fact: The 60 month time period is only a window of time that Medicaid uses to determine if transfers were made. When you apply for Medicaid, the Medicaid office requires that you provide them with every financial transaction you have made within the last 60 months. The Medicaid office is looking for any uncompensated transfers (transfers made for less than actual value) made within that time period. Uncompensated transfers within this window of time may delay the qualification for benefits.

Myth #6: My assets are already protected because they are in a Living Trust.

Fact: A revocable living trust does not shelter your assets when applying for Medicaid. Typically, when assets are held in a living trust, they are available to the Medicaid applicant and will be considered for Medicaid eligibility.

HOW DO I QUALIFY FOR BENEFITS?

In order to qualify for Medicaid benefits, an individual must pass three tests:

✓ **Health Test** ✓ **Income Test** ✓ **Asset Test**

Health Test

An individual must meet the "medical necessity" requirement. Usually, this means the individual needs chronic or ongoing care and cannot perform at least three activities of daily living (bathing, dressing, transferring from bed or chair, walking, eating, and toilet use).

The person must also meet national and New Jersey residency requirements, be age 65 or older, or be disabled or blind.

Once a person becomes physically qualified, then he or she must become financially qualified.

Income Test

In New Jersey, the income cap (the maximum gross income a person can earn) for individuals applying for Medicaid is $2,199 per month.

If the individual applying for Medicaid is married, the healthy spouse ("community spouse") can have unlimited income (but at least $2,980.50 per month) without affecting the Medicaid applicant's eligibility.

Asset Test

In New Jersey, a Medicaid applicant can have up to $2,000 in countable resources and qualify for Medicaid. If the Medicaid applicant is married, the community spouse is allowed to protect a minimum of $23,844 and a maximum of $119,220 of the couple's joint countable assets. Under certain situations, this amount can be even more!

HOW DO I QUALIFY FOR BENEFITS?

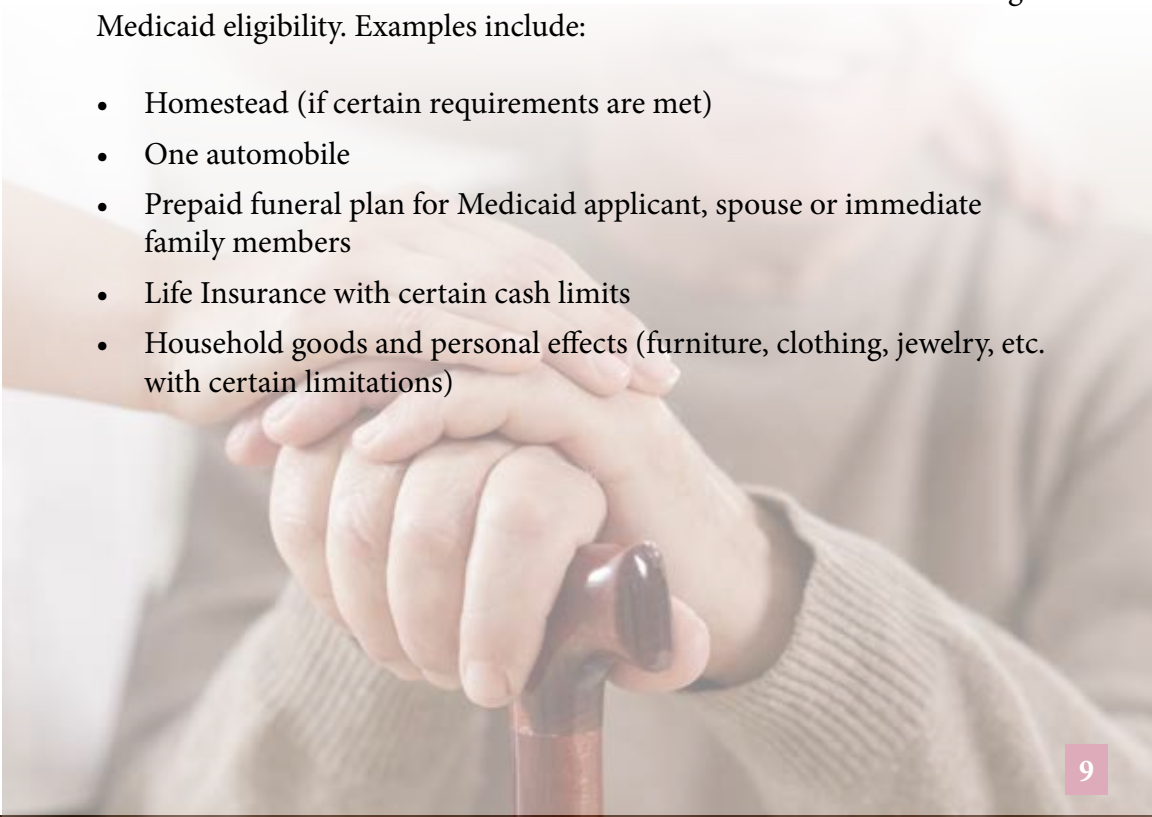
Under the federal Medicaid rules, assets fall into two categories: **Countable Resources and Non-Countable Resources.**

Countable Resources are assets that are considered in determining Medicaid eligibility. They consist of assets that could be readily converted to cash in order to pay for cost of care. Examples include:

- Bank and Investment Accounts
- IRAs, 401k(s)
- Stocks & Bonds
- Life Insurance Policies over a certain amount
- Real estate, excluding the homestead

Non-Countable Resources are assets that are not counted in determining Medicaid eligibility. Examples include:

- Homestead (if certain requirements are met)
- One automobile
- Prepaid funeral plan for Medicaid applicant, spouse or immediate family members
- Life Insurance with certain cash limits
- Household goods and personal effects (furniture, clothing, jewelry, etc. with certain limitations)



Diagram

Here is a diagram to help you understand the Income and Asset Rules:

Monthly Income

Married Couple

Community Spouse
Unlimited but at least $2,980.50

Nursing Home Spouse
$2,199.00

Unmarried Person
$2,199.00

Assets

Married Couple

Community Spouse
At least, $23,844.00 up to $119,220.00 (possibly more)

Nursing Home Spouse
$2,000.00

Unmarried Person
$2,000.00

- **Home**
- **Prepaid Burial Expense**
- **Automobile**
- **$1,500.00 Life Insurance Death Benefit Cash Value**
- **Household Goods & Personal Effects (with limitations)**

- **Home (if requirements are met)**
- **Prepaid Burial Expense**
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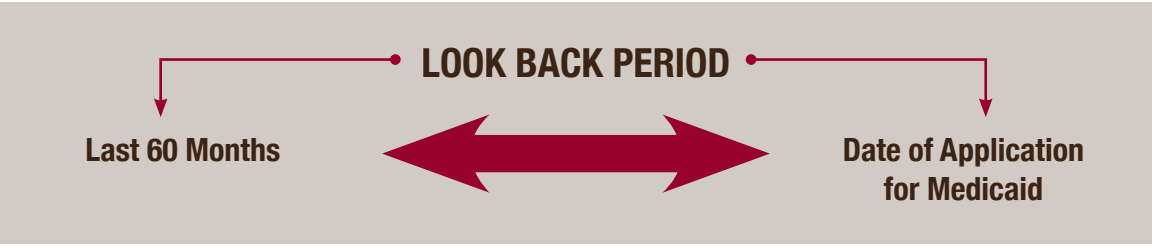
Transferring Assets to Qualify for Medicaid

The Medicaid office puts restrictions on making gifts to prevent people from becoming eligible for Medicaid simply by giving their property away.

Once an application for Medicaid benefits is made, the Medicaid office will review all financial activity over the last 60 months ("the look back period") to determine if any transfers occurred. Medicaid then evaluates these transfers and categorizes them as either compensated or uncompensated transfers. Uncompensated transfers will result in a delay of Medicaid coverage.



A compensated transfer is a transfer of assets to a person or entity when the giver receives something of equal value in return. For example, you offer to pay a painter to paint your house. You both agree the value of the service is $5,000 and you pay the painter $5,000. No gift has been made because you gave equal value for equal value. This is a compensated transfer.

An uncompensated transfer is a transfer of assets to a person or entity when the giver receives no value, or less than the value transferred in return. For example, you give your son-in-law $15,000 to paint your house when the value of the service is only $5,000. You just made a $10,000 gift to your son-in-law. Gifts within the look-back period are uncompensated transfers and will trigger a penalty for Medicaid eligibility.

**Note that there is a difference between the annual federal gift tax exclusion and gifting for Medicaid. You may have heard that every taxpayer can give up to $14,000 per year to any individual without having to pay gift tax. Many people mistakenly believe they can use this gifting strategy to qualify for Medicaid. Not True! The Medicaid office is not concerned with IRS rules regarding the gift tax exclusion. If any uncompensated transfer is made during the look back period, it is considered a gift under the Medicaid rules and a penalty will be applied.*

HOW DO I QUALIFY FOR BENEFITS?

The penalty period for uncompensated transfers equals the number of months that could have been paid for a nursing home had the amount not been transferred.

The penalty period is calculated by dividing the value of the uncompensated transfer by a "monthly divisor." The monthly divisor is the statewide average cost of one month in a nursing home. In New Jersey, the monthly divisor is $156.34/day, or roughly $4,739 per month.

To illustrate the calculation of the penalty period, let's use an example: You made a gift of $100,000 within the last 60 months and now wish to qualify for Medicaid. This gift was an uncompensated transfer; therefore, a penalty period would apply. To determine the length of the penalty period, here is the calculation:

$100,000 ÷ $156.34 = 639 days (about 21 months) of penalty

Based on this example, if you applied for Medicaid today and were otherwise qualified, you would need to pay your own way for 639 days (about 21 months), and then Medicaid would cover your future nursing home expenses.

WHAT CAN I DO NOW TO QUALIFY LATER?

What if you don't financially qualify for Medicaid? Is there something you can do? **Most likely, yes!**

There are numerous strategies available to qualify for Medicaid benefits. Let's explore a few of the options available.

Problem: You have too much income!

Solution: It may be advisable to transfer the source of the income to the community spouse, who is allowed to have unlimited income. Medicaid adheres to the "name on the check" rule. If the Medicaid applicant's name is not on the asset or income stream, it is presumed to be out of the Medicaid applicant's estate for calculating Medicaid eligibility.

Problem: You have too many assets!

Solution: Certain types of trusts can protect your assets and help you to qualify for Medicaid. The key to using these trusts is timing. The sooner you plan, the more you can save. Here is what a trust can do for you and how it may work:

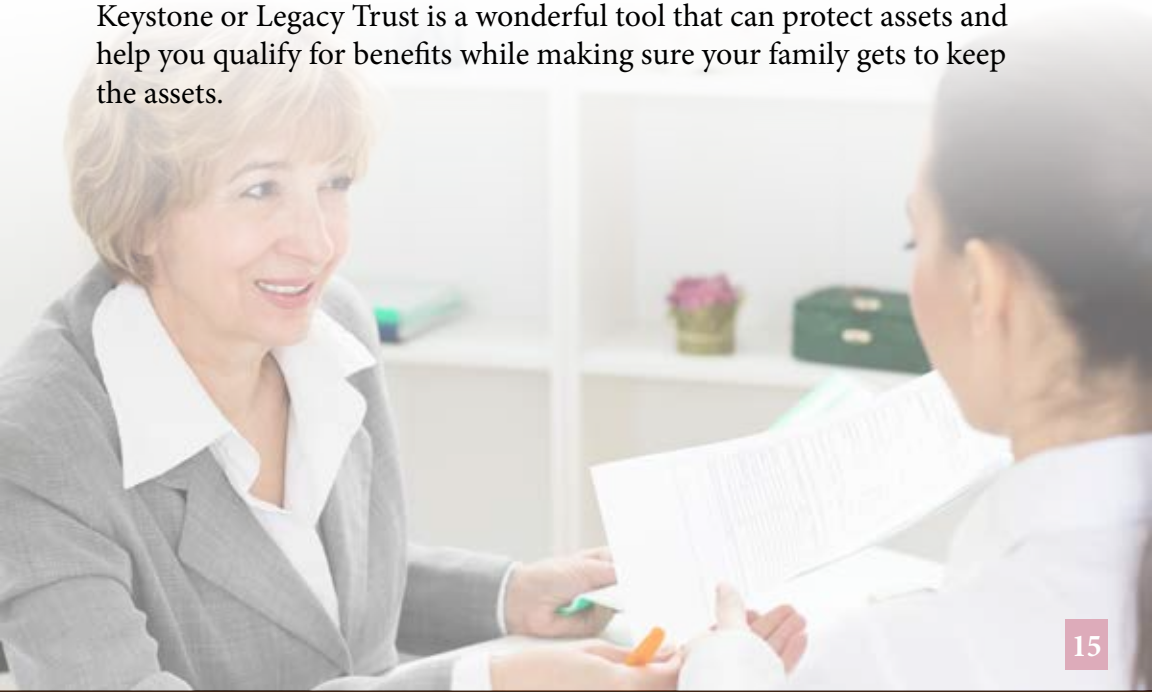
Protect your assets.

When your assets are too high to qualify for Medicaid, you could give your assets away to reach the required limits. But, there are no assurances that the person to whom you gave the gift would be able to keep it. If the recipient had poor spending habits, got divorced, had lawsuits or other creditors, the assets you gave away could be lost. The use of a Keystone or Legacy Protection Trust can not only protect the assets from loss, but can also remove them from your estate.

Qualify for Medicaid Benefits.

Transferring your assets to a Keystone or Legacy Trust can start the penalty clock at the time of the transfer. For example, let's say you have an estate worth $600,000 that you want to protect for your children instead of spending it on nursing home expenses. You can preserve these assets by creating and funding a Keystone or Legacy Trust. If you can avoid the nursing home for the next 60 months, the trust's assets will not be considered when you apply for Medicaid benefits because the transfers will have occurred outside the 60 month look-back window. Medicaid coverage could then begin immediately if the Medicaid applicant was otherwise eligible. The $600,000 estate is protected by the trust.

If a nursing home was needed before 60 months had passed from the date you transferred assets to the trust, you could pay your own way with insurance or private pay and delay the application for Medicaid benefits until 60 months had passed. Then, when you applied for benefits, Medicaid would not see the transfer that had been made over 60 months ago. The Keystone or Legacy Trust is a wonderful tool that can protect assets and help you qualify for benefits while making sure your family gets to keep the assets.



There is no "one size fits all" strategy to position your assets to financially qualify for Medicaid benefits. Each case is different because all families' goals and needs are different. The strategies offered in this book are just a sampling of the tools open to you.

We encourage you to consider the planning options available because the key to protecting assets from long-term care costs is proper planning. The more you know about how to get the help and protection you deserve, the better you will be able to look out for your family's best interests. The sooner you begin planning, the fewer surprises there will be.

GET THE RIGHT HELP.

Contact us today to determine how our family can help yours.

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