

Chapter 10: Elder Issues

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Corrections were made to this workbook through January of 2007. No subsequent modifications were made.

LOOMING CRISIS

In recent years, there has been much public debate and discussion about the “looming crisis” in elder care that is facing the country as the baby-boom generation reaches retirement age. The American media paints a grim future by focusing on staggering statistics detailing the needs generated by a disproportionately large segment of the population and the general lack of government and private resources to meet the increased burdens.

According to United States Census Bureau projections, by 2030 nearly 20% of the population will be over age 65.¹ Coupled with ever-increasing life expectancies, the nation will likely face a critical lack of care providers and facilities, and an insufficient tax base to provide care for this large population segment.² The federal government expects that by 2060 the number of nursing home residents will nearly triple compared to the number in 1999.³ Individual long-term care costs are also expected to rise steeply. According to some reports, they are expected to rise at almost three times the inflation rate.⁴

The tax professional is often the first person the elder client asks for advice. Therefore, it is important that he understands the issues. It is also important that he not overstep his expertise in providing this advice.

This chapter highlights some of the issues associated with the elderly population that require advance planning. It also provides a broad overview of ways to help people plan for the retirement years in order to avoid many of the problems predicted in the looming elder-care crisis.

This chapter also discusses available options for long-term care, including alternative solutions to nursing home care. In addition, it covers some of the tools available to help defray the costs of long-term care and sheds light on the various available government benefits. Throughout the chapter, income tax issues are examined. Finally, this chapter provides a listing of various legal instruments, such as wills and powers of attorney that are essential in preparing for the retirement years.

¹ He, Wan, Sengupta, Velkoff, DeBarros, United States Census Bureau, Current Population Reports, P23-209, *65+ in the United States: 2005*, U.S. Government Printing Office, Washington, D.C. 2005

² Atkins, Dallas, “Ready Yourself Now for Crisis in Elder Care,” 93016, *The Faculty and Staff Newspaper of the University of California*, Santa Barbara, Vol. 12, No. 13, April 1, 2002

³ Ibid

⁴ Ibid

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Note. This chapter is meant to be a basic discussion of elder law. Some information is given in a general format and programs may vary from state to state. Also, an estate plan and plan for long-term care are included at the end of Chapter 11, Estate and Trust.

GENERAL TYPES OF LONG-TERM CARE

There is a wide range of housing options and varying levels of care available to suit various lifestyles. The following overview provides a brief description of the major types of long-term care and living options available to seniors today.

CONTINUING CARE RETIREMENT COMMUNITIES

Continuing care retirement communities (CCRCs) give active seniors the opportunity to enjoy an independent lifestyle in a private-home setting with the flexibility to adjust for future medical needs. These communities offer several types of facilities all in one location, such as independent-living residences, assisted-living facilities, and nursing homes. Contracts with these facilities may require buy-in or an up-front annuity purchase followed by monthly payments to cover services, amenities, and needed medical. The buy-in may be fully, partially, or nonrefundable.

Note. Please refer to Chapter 14, “New Legislation,” for information on the TIPRA changes to imputed interest for CCRCs.

ASSISTED-LIVING FACILITIES

Assisted-living facilities are generally for people who require help with **activities of daily living (ADL)** but who desire to live as independently as possible. ADL refers to a variety of routine activities. The inability to perform these activities identifies the need for various nursing-care services. ADL includes:

- Bathing
- Dressing
- Transferring (getting up from a bed to a chair)
- Toileting
- Eating
- Continence

Assisted-living facilities are especially suited to individuals who are not fully able to live by themselves, but who do not require constant and higher skilled nursing care as provided in a nursing home. Many assisted-living facilities also have centers for medical care, but generally, the care offered is not as intensive as the type of care offered at a nursing home. Assisted-living facilities provide an intermediate level of long-term care appropriate for many seniors.

BOARD AND CARE HOMES

There are various types of residential arrangements that provide similar services to those offered at an assisted-living facility, but they are generally smaller and resemble a home-like setting. For example, in Pennsylvania, there are options for assisted-living care in residences known as **Personal Care Homes** and **Domiciliary Care Homes**.

NURSING HOMES

Nursing homes provide 24-hour care to people who can no longer live independently and cannot be cared for at home or in the community. Medical professionals and staff provide a wide range of personal care and health services. For residents with severe illnesses or injuries, specialized medical care is provided on-site. Trained staff members assist with activities of daily living like dressing, bathing, using the bathroom, laundry, and housekeeping.

Many nursing homes specialize in acute nursing care, intermediate care, or long-term nursing care. It is important to note that Medicare does **not** pay for most nursing home care—a common misconception that could prove costly in planning for retirement. Medicare only pays for non-hospital skilled nursing care for a limited period of time and only under certain conditions. A more detailed discussion of Medicare benefits is provided later in the chapter.

IN-HOME SERVICES

Depending on the needs of the individual, seniors may receive assistance with various activities within their own homes. Family members and friends often help with lower-level needs such as laundry, bathing, or cleaning. Volunteer agencies may also provide similar assistance.

Home health agencies often provide skilled nursing care and other health care services. Home health agencies are typically licensed and regulated by a state's health department or similar agency.

Less skilled care may also be given in the home by regulated providers such as **home health aides** or attendant caregivers. Agencies providing this type of care are usually regulated by the state's welfare or social services department.

INCOME TAXATION DEDUCTION OF LONG-TERM CARE

Planning Suggestion. If a taxpayer has high medical deductions which generate negative taxable income and has assets in tax deferred accounts (i.e. annuities, IRAs, 401ks, and other pension plans), then she should consider withdrawing funds from these accounts rather than after-tax accounts (i.e. savings and checking).

She will want to withdraw enough to fully utilize her personal exemption and itemized deductions, so that these benefits are not lost. This also reduces the amount of taxable funds that will be passed on to her heirs after death.

In general, a taxpayer is allowed to deduct the amount of medical expense which exceeds 7.5% of adjusted gross income (AGI). The deduction also applies to the spouse and any dependent of the taxpayer. In addition, the taxpayer may also deduct medical expenses for a person who **would have qualified as a dependent except** that her gross income equaled or exceeded the amount for the exemption or she failed the joint return test.

Medical Expenses

Medical expenses include payments for the diagnosis, cure, relief, treatment, or prevention of disease. Nursing home expenses in their entirety are **deductible** as medical expenses when the **primary purpose** for being in the nursing home is to receive **medical care**, including meals and lodging expense. If the individual is in the nursing home mainly for **personal reasons**, then only the cost of the **actual medical care is deductible** as a medical expense, and the cost of the meals and lodging is not deductible.

Qualified Long-Term Care Services. Expenses for other qualified long-term care services are also deductible medical expenses. These include any expenditures for medical or personal services that are:

1. Required by a chronically ill individual, and
2. Provided under a plan of care prescribed by a licensed health care practitioner.

To be deductible, **maintenance or personal care services** must have the primary purpose of providing a chronically ill individual with assistance needed because of the disabilities (including protection from threats to health and safety due to severe cognitive impairment).

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An individual is chronically ill if he:

1. Requires substantial supervision to protect his health and safety due to cognitive impairment, **or**
2. Is unable to perform, for a period of at least 90 days, two or more of the following activities without substantial assistance:
 - Eating
 - Toileting
 - Dressing
 - Bathing
 - Continence
 - Transferring

In order to deduct long-term care expenses, the patient must be certified as chronically ill within the last 12 months by a licensed health care practitioner.

Other long-term care living arrangements may also yield allowable deductible expenses. For example, a portion of monthly fees paid by an individual to a CCRC was determined by a federal tax court to be a deductible medical expense. In one case, the Tax Court approved the use of a percentage method for determining what portion of monthly fees paid to the retirement community was deductible.⁵ The case confirmed that a CCRC resident can treat a significant percentage of the one-time entry fees and recurring monthly charges as medical expenses, regardless of the level of health care services actually received by the resident during the year in question. The percentage depends only on the CCRC's aggregate medical expenditures in relation to overall expenses or overall revenue from fees paid by the residents.

Note. See pp. 534–535 in the *2004 University of Illinois Federal Tax Workbook* for a detailed discussion of this case.

Nursing Services. Medical expenses may also include wages and other amounts paid for nursing services. The services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided at home or another care facility.

Generally, only the amount spent for nursing services is considered a medical expense. If the attendant also provides personal and household services, amounts paid to the attendant must be divided between the time spent performing household and personal services and the time spent on nursing services. However, if necessary because of the disability, personal care services provided as part of qualified long-term care can be included in medical expenses, as discussed earlier.

Note. Certain expenses for household services or for the care of a qualifying individual that are incurred to allow the taxpayer to work may qualify for the child and dependent care credit. See IRS Pub. 503, *Child and Dependent Care Expenses* for more information.

⁵ *Baker v. Commr.*, 122 TC 143; February 19, 2004

Attendant's Meals. Medical expenses may also include part of the amount paid for that attendant's meals. Food expense for household members must be separated from the food expense for the attendant in order to determine the cost of the attendant's food. The food expense is multiplied by the time percentage computed above. If the taxpayer had to pay additional amounts for household upkeep because of the attendant, these extra amounts can be added to medical expenses. This can include extra rent or utilities paid because the taxpayer moved to a larger apartment to provide space for the attendant.

Employment Taxes. Employment taxes can also be included in medical expenses. Social security tax, FUTA, Medicare tax, and state employment taxes paid for a nurse, attendant, or other person who provides medical care qualify as medical expenses. If the attendant also provides nondeductible personal and household services, only the amount of employment tax attributable to medical services can be counted.

Note. For information on employment tax responsibilities of household employers, see IRS Pub. 926, *Household Employer's Tax Guide*.

LONG-TERM CARE INSURANCE

The following is a discussion of some factors to consider when evaluating long-term care insurance.

TYPES OF LONG-TERM CARE POLICIES

There are several types of policies to consider when purchasing long-term care insurance.

Most long-term insurance policies are either **indemnity** policies or **expense-incurred** policies. Indemnity policies (a.k.a. **per diem** policies) offer a fixed benefit **regardless of expenses incurred**. Under these policies, the insured is paid a fixed amount for each day he receives long-term care. Under the expense-incurred type of policy, the insured is reimbursed for **actual long-term care expenses** up to a fixed dollar amount.

Long-term care policies usually limit benefits to a maximum dollar figure or a maximum number of days.⁶ Such policies can also have separate benefit limits for the various types of care provided. For instance, a policy may offer \$100 per day for up to five years of coverage for nursing home care while offering only up to \$80 per day up to five years of assisted living and home health coverage.

Consideration should be given to both the amount of daily or monthly benefit, and the overall length of coverage. Insurance companies offer policies that provide benefits for a duration of increments of anywhere from one to six years, or for lifetime.⁷ Naturally, a longer period coverage period carries a higher premium in comparison to a policy with shorter coverage.

LENGTH OF ELIMINATION PERIOD

The elimination or waiting period is the number of days that the beneficiary must receive long-term care before benefits are paid under the policy. During this time, the beneficiary must pay for his care at his own cost. These elimination periods typically range from approximately 20 to 100 days. Generally, longer elimination periods translate into lower premiums, but higher out-of-pocket costs when long-term care is needed.

AGE AT PURCHASE

The cost of insurance for long-term care rises steeply with age. A person in his 50s can expect to pay an annual premium between \$500 and \$2,000. An individual in her 60s might pay a premium between \$1,500 and \$3,000, and

⁶ *Guide to Long-term Care Insurance*, American Health Insurance Plans, p. 10, available at www.ahip.org

⁷ Feldman, Stephen A., *Part Two: Long-Term Care Insurance*, 7th Annual Elder Law Institute, Pennsylvania Bar Institute No. 2004-3528, p. 13

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one his 70s may pay between \$2,500 and \$8,000.⁸ Buying when the individual is too young, while apparently advantageous in light of the lower premiums, can needlessly tie up financial resources for many years and only yielding modest savings on premiums in the long run. On the other hand, waiting too long can result in uninsurability or exorbitant premiums due to advanced age and/or poor health.

The collective wisdom points to between the ages of 45 and 60 as a good time to purchase a long-term care policy. During this period in the insured's life, her premiums would be moderate and the likelihood of good overall health is higher compared to later in life. Moreover, the insured may no longer need life insurance policies and might be ready to terminate her policies and apply the savings in premiums or the cash value of the policies to the cost of long-term care insurance.

TAX ISSUES

Income Tax Deductibility of Premiums

A long-term care plan that is federally **qualified** may offer some income tax deductions.⁹ Premiums paid for such plans may be counted as medical expenses for income tax purposes. This deduction is available for individuals who itemize their deductions and for self-employed individuals as part of their self-employed health insurance deduction.

Not all long-term insurance qualifies as deductible. The premium is deductible if the policy meets the following criteria:

1. Coverage is limited to **qualified** long-term care **services**, as defined under deductible long-term care services.
2. The policy does not reimburse expenses covered under Medicare, except when Medicare is a secondary payer, or the contract makes **per diem** or other periodic payments without regard to expenses.
3. It is guaranteed renewable.
4. **It does not have a cash surrender value** or provide for a value that can be pledged as collateral or borrowed. This does not apply to refunds upon death of the insured or complete cancellation of the contract. Such refunds are taxable to the extent the premiums were previously deducted.
5. It provides for any refunds of premiums or dividends to be applied to future premiums or an increase in benefits
6. It meets certain consumer protection provisions.¹⁰

Caution. Many long-term care policies are not deductible since they do **not** meet the requirements. Practitioners should ask clients to verify the tax status of the plan with the insurance provider.

There are additional limits, based on a policyholder's age, for the total amount of long-term care premiums that can be deducted. The taxpayer can include premiums paid on a qualified long-term care insurance contract for himself, his spouse, and/or his dependents. But, for each person covered, only the smaller of the following amounts can be included in 2006:

Person's Age at End of Year	Lesser of Amount Paid, or...
40 or younger	\$ 280
41 to 50	530
51 to 60	1,060
61 to 70	2,830
71 or older	3,530

⁸ Landro, Natalie S., *Part One: Everything You Wanted to Know about Long Term Care Insurance, but Were Afraid to Ask*, 7th Annual Elder Law Institute, Pennsylvania Bar Institute No. 2004-3528, p. M-3

⁹ IRC §213(d)(1)

¹⁰ IRC §7702B

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Income Tax Treatment of Benefits Received

The receipt of benefits under **qualified plans is nontaxable up to a maximum daily benefit of \$250 for 2006.**¹¹ This amount is adjusted each year for inflation. Any amount of benefit that exceeds this limit is counted as gross income to the extent it is in excess of the actual cost incurred.¹² The receipt of benefits under nonqualified plans is taxable.

Note. If the benefits are nontaxable, only the net out-of-pocket expenses should be reported on Schedule A. If the benefits are taxable, 100% of the long-term care expenses are included in medicare expenses on Schedule A.

The policyholder receives Form 1099-LTC from the insurance agency showing the total amount received for the year. The taxpayer is required to report this amount on Page 2 of **Form 8853, Archer MSAs and Long-Term Care Insurance Contracts**, to show how much, if any, of the benefits are taxable. Failure to do so results in the taxpayer receiving an IRS notice proposing to tax the entire amount of the benefits received.

Caution. Many taxpayers do not recognize Form 1099-LTC as a tax form that should be given to their tax preparer. When practitioners are aware that a client is receiving long-term care **services**, they should ask if the client is also receiving long-term care **insurance benefits**. If so, they should insist on seeing the Form 1099-LTC from the insurance company before finalizing the return.

Example 1. During all of 2006, Roscoe Smith was a resident of a nursing home, which charged \$320 per day. He paid the nursing home a total of \$116,800 in 2006. He received \$300 a day per diem benefits from his long-term care insurance, for a total of \$109,500. Although he is physically unable to take care of himself, he is not considered terminally ill.

The following shows the Form 1099-LTC he received and the Form 8853 he attached to his 2006 return. Note that Page 1 of Form 8853 relates to Archer MSAs and is not included with his return.

CORRECTED (if checked)

PAYER'S name, street address, city, state, ZIP code, and telephone no. LTC Insurance Inc 3500 Safety Net Safehaven, CT 06074		1 Gross long-term care benefits paid \$ 109500	OMB No. 1545-1519 2006	Long-Term Care and Accelerated Death Benefits
PAYER'S federal identification number 37-2222222		2 Accelerated death benefits paid \$	Form 1099-LTC	
PAYER'S identification number 37-2222222	POLICYHOLDER'S identification number 555-55-5555	3 Per diem <input checked="" type="checkbox"/> Reimbursed amount <input type="checkbox"/>	INSURED'S social security no. 555-55-5555	Copy B For Policyholder This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this item is required to be reported and the IRS determines that it has not been reported.
POLICYHOLDER'S name Roscoe Smith Street address (including apt. no.) 65 Hospital Avenue City, state, and ZIP code Urbana, IL 61801		INSURED'S name Roscoe Smith Street address (including apt. no.) 65 Hospital Avenue City, state, and ZIP code Urbana, IL 61801		
Account number (see instructions) Itc5555-999	4 Qualified contract <input checked="" type="checkbox"/> (optional)	5 (optional) <input checked="" type="checkbox"/> Chronically ill <input type="checkbox"/> Terminally ill	Date certified 06/30/2006	
Form 1099-LTC		(keep for your records)		Department of the Treasury - Internal Revenue Service

10

¹¹ Rev. Proc. 2005-70, November 21, 2005

¹² IRC § 7702B(d)(1)

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For Example 1

Form 8853 (2006)

Attachment Sequence No. **39** Page **2**

Name of policyholder (as shown on Form 1040)

Roscoe C. Smith

Social security number of policyholder ▶

555 ; 55 ; 5555

Section C. Long-Term Care (LTC) Insurance Contracts. See **Filing Requirements for Section C** on page 6 of the instructions before completing this section.

If more than one Section C is attached, check here

16a Name of insured ▶ **Roscoe C. Smith** **b** Social security number of insured ▶

17 In 2006, did anyone other than you receive payments on a per diem or other periodic basis under a qualified LTC insurance contract covering the insured or receive accelerated death benefits under a life insurance policy covering the insured? Yes No

18 Was the insured a terminally ill individual? Yes No
Note: If "Yes" and the **only** payments you received in 2006 were accelerated death benefits that were paid to you because the insured was terminally ill, skip lines 19 through 27 and enter -0- on line 28.

19 Gross LTC payments received on a per diem or other periodic basis. Enter the total of the amounts from box 1 of all Forms 1099-LTC you received with respect to the insured on which the "Per diem" box in box 3 is checked

19	109,500
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Caution: Do not use lines 20 through 28 to figure the taxable amount of benefits paid under an LTC insurance contract that is not a **qualified LTC insurance contract. Instead, if the benefits are not excludable from your income (for example, if the benefits are not paid for personal injuries or sickness through accident or health insurance), report the amount not excludable as income on Form 1040, line 21.**

20 Enter the part of the amount on line 19 that is from **qualified** LTC insurance contracts

20	109,500
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21 Accelerated death benefits received on a per diem or other periodic basis. Do not include any amounts you received because the insured was terminally ill (see page 7 of the instructions)

21	
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22 Add lines 20 and 21

22	109,500
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Note: If you checked "Yes" on line 17 above, see **Multiple Payees** on page 7 of the instructions before completing lines 23 through 27.

23 Multiply \$250 by the number of days in the LTC period

23	91,250
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24 Costs incurred for qualified LTC services provided for the insured during the LTC period (see page 7 of the instructions)

24	116,800
-----------	----------------

25 Enter the **larger** of line 23 or line 24

25	116,800
-----------	----------------

26 Reimbursements for qualified LTC services provided for the insured during the LTC period

26	
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Caution: If you received any reimbursements from LTC contracts issued before August 1, 1996, see page 7 of the instructions.

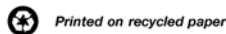
27 Per diem limitation. Subtract line 26 from line 25

27	116,800
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28 Taxable payments. Subtract line 27 from line 22. If zero or less, enter -0-. Also include this amount in the total on Form 1040, line 21. On the dotted line next to line 21, enter "LTC" and the amount

28	0
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Form **8853** (2006)



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Observations for Form 8853:

1. Since Roscoe's long-term care insurance policy pays on the **per diem** basis, the total amount in Box 1 of Form 1099-LTC is reported on **Line 19** and \$0 is reported on Line 26.
2. If the policy paid on a **reimbursement** basis, the total amount in Box 1 of Form 1099-LTC would be reported on **Line 26** and \$0 would be reported on Line 19.
3. Even though Roscoe received more (Line 19) than the maximum excludable amount (Line 23), none of the benefits are taxable because he spent more (Line 24) than he received.

MEDICARE¹³

Medicare is a federal health insurance program that provides health coverage to individuals age 65 or older. The program also provides health insurance to some disabled individuals under 65. The **Centers for Medicare and Medicaid Services (CMS)** is the component of the United States Department of Health and Human Services that is charged with administering the program. The Social Security Administration (SSA) is responsible for administering the application and eligibility processes.

DEDUCTIBILITY

Medicare premiums qualify as tax deductible medical insurance premiums. Since the premiums are usually withheld from SSA benefits, many taxpayers forget to include them in the amount of health insurance premiums they paid for the year.

BASICS OF ELIGIBILITY

Generally, individuals qualify for Medicare if they are 65 years old **and** meet the following requirements:

- They, their spouse, or their former spouse have paid social security taxes for at least 40 calendar quarters **or**
- They are eligible for Railroad Retirement benefits.

Younger individuals who have a disability and have received social security disability (SSD) cash benefits may also qualify. Finally, those who do not have the requisite 40 quarters of employment may pay premiums and buy into Medicare Part A and B.

PARTS OF THE PROGRAM

Medicare Part A. This is the portion of the Medicare program that covers in-patient hospital care. It also covers skilled nursing facilities, home health care, and hospice care. There is generally no monthly premium for beneficiaries of Part A. Part A covers:¹⁴

- Inpatient hospital services for acute care or rehabilitation
- Skilled nursing facility services for up to 100 days (per spell of illness) following a hospital stay of three or more days. This does not include custodial or long-term care.
- Home health care for up to 100 days (per spell of illness) following a hospital stay of three or more days. It also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
- Hospice care that includes nursing care, physical/occupational therapy, counseling, and so on
- Psychiatric hospital treatment for up to 190 days in a beneficiary's lifetime

¹³ For more information, see the United States Dept. of Health & Human Services, Centers for Medicare and Medicaid Services publication *Medicare & You, 2006*, CMS Pub. No. 10050, January 2006, and/or www.medicare.gov.

¹⁴ For more detailed information, see the AARP website at www.aarp.org.

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Medicare Part B. This is the portion of the Medicare program that pays for various services provided in various outpatient medical facilities, including doctors' offices and in the home of the beneficiary. This coverage is optional and is partially funded through premiums paid by participants. Part B covers:

- Physicians' services (e.g., osteopaths, MDs, chiropractors, optometrists, etc.) including office visits
- Medical equipment and supplies, such as wheelchairs, or oxygen apparatuses known as **durable equipment**
- Limited home health services
- Outpatient hospital services
- Outpatient mental health services
- Laboratory services
- X-rays
- Mammography
- Ambulance transportation
- Certain prescription drugs (e.g., for cancer treatments)

Medicare Part C. Also referred to as **Medicare Advantage** (formerly known as **Medicare+Choice**), Medicare Part C is a plan offered by a private company that contracts with Medicare to provide an alternative managed care method through which a beneficiary may receive all of her Medicare Part A and Part B benefits. Different types of organizations may participate in this program, such as Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), or Provider Sponsored Organizations. Medicare pays the private health organizations a fixed amount each month for each beneficiary.

Medicare Part D. This is the **Medicare Prescription Drug Plan**. Under it, private insurance companies provide expanded prescription drug coverage to supplement Parts A and B. This new program became effective on January 1, 2006. It provides coverage for both brand name and generic prescription drugs for everyone eligible for Medicare, regardless of income or financial status. However, participation is voluntary. Under the program, participants:

- Choose a drug plan,
- Pay a monthly premium, which varies with each plan,
- Pay copayments or coinsurance, which also vary by plan, and
- Pay an annual deductible of no more than \$250.

For individuals with lower incomes and fewer resources, the premiums and deductible may be waived under a program the SSA refers to as **Extra Help**.¹⁵ To qualify, a single individual's **assets**, including savings, investments, and real estate (other than her main home), must be **\$11,500 or less**. In addition, an individual's annual **income** must be under **\$14,700**. If they live together, a married couple's combined **assets** must be **\$23,000 or less** and their combined **income** must be under **\$19,800**. For more information on income that is included and excluded in determining annual income, see SSA Pub. No. 05-10115, *Getting Help with Medicare Prescription Drug Plan Costs*. People who think they qualify may apply for extra help by completing Form SSA-1020 which is available at the local SSA office or by completing the on-line enrollment at www.ssa.gov.

¹⁵ *Getting Help with Medicare Prescription Drug Plan Costs; Income and Resource Limits 2006*, SSA Publication No. 05-10115, March 2006, ICN 468740

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Note. According to the SSA, assets do **not** include property needed for self-support, such as **rental property** or land used to grow produce for home consumption.¹⁶

Additional information concerning benefits and deductibles can be obtained from the National Committee to Preserve Social Security and Medicare web site at www.ncpssm.org.

MEANS-TESTING OF THE MEDICARE PART B PREMIUM¹⁷

In 2006 and prior, the base premium for participants in the Medicare Part B program was set at approximately 25% of the program's total costs. In 2006, the base premium is \$88.50. However, **beginning in January 2007, premiums will vary according to the income of the participants.**

In accordance with the Medicare Modernization Act of 2003, **single participants with income above \$80,000 and married participants with income above \$160,000** will be charged higher rates than other participants. The rates will vary across income brackets. Individuals with income over \$200,000 (\$400,000 if married) will pay the highest premiums. Increases in the premium will be phased in over the next three years. Ultimately, participants with income in the highest bracket will pay premiums based on 80% of the program's costs. The thresholds will be adjusted each year for inflation.

The SSA will calculate the participants' income from income tax records filed with the IRS. In most cases, the tax returns from two years prior will be used (i.e., for 2007 premiums, the SSA will examine 2005 returns). If a participant has not filed returns for both two and three years prior, the SSA will assume that the participant is not required to file and that the participant's income is below the minimum threshold.

SSA will calculate the income starting with AGI plus the following tax-exempt income:

- Tax-exempt interest
- Interest from U.S. savings bonds used to pay higher education tuition and fees
- Foreign earned income
- Income derived from sources within Guam, American Samoa, or the Northern Mariana Islands, and
- Income from sources within Puerto Rico

In the fall of 2006, participants will receive a notice from the SSA informing them of their 2007 premium rate. This notice also explains the procedures to appeal the SSA determination. Appeals may be made if:

- Information provided by the IRS was incorrect,
- An amended tax return was filed that changed the income used by the SSA,
- The SSA used information from three years prior, and the participant wants to provide information from two years prior, or
- The participant experienced a major life-changing event that resulted in a significant reduction in income compared to the year used by SSA.

¹⁶ Ibid

¹⁷ SSA, 20 CFR Part 418, RIN 0960-AG11, *Medicare Part B Income-Related Monthly Adjustment Amount ACTION: Notice of Proposed Rulemaking (NPRM)* as published in the Federal Register: March 3, 2006 (Volume 71, Number 42)

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Major life-changing events are defined **exclusively** as the following:

1. A spouse dies
2. The participant marries
3. The participant divorces
4. The participant or spouse stops working, or works significantly less
5. A reduction in income caused by a loss of income-producing property
6. The participant or spouse loses certain forms of pension benefits

Events that affect expenses, but not income, are not considered life-changing for these purposes. For example, changes in health that result in burgeoning medical bills are not considered life-changing for purposes of appeal, unless this change also affects the participant's income.

Caution. The above rules and procedures are taken from the SSA's **proposed** rules as of March 2006.

Supplemental Insurance

Medicare supplemental insurance policies, known as Medigap policies, are available to fill **gaps** in the Medicare Plans. Medigap policies are sold by private insurance companies to pay for services not covered by Medicare Parts A and B. There are 12 standard Medigap policies, each offering a different set of benefits.

PHARMACY ASSISTANCE PROGRAMS

Approximately **30 states sponsor programs to provide increased access to prescription drugs for the elderly and the disabled.** Many programs were designed to fill gaps in coverage by the Medicare drug benefit. Coordinating state pharmacy benefits with Medicare has proven to be a boon for many states as combining benefits has freed up funds to expand other services for seniors. Most states offer **direct coverage for pharmacy benefits**, with primary consideration for those with limited income and resources. Other states offer **drug discount programs** for all seniors or provide **tax credits** for drug expenses.

Illinois has a pharmacy assistance program designed to **wrap around** the Medicare drug benefit. Under the **Illinois Cares Rx Program**, the state helps pay the costs of the Medicare Prescription Drug Plan for qualified participants. If the participant enrolls in one of the plans which coordinate benefits with the state, Illinois will also pay the monthly premium and yearly deductible. Illinois also offers several other programs to help defray the high costs of prescription medications. Qualifications vary depending on the age, income, and disability status of the participant. For more information see www.illinoiscaresrx.com.

Other states have different plans. For example, **Pennsylvania's PACE program** is a direct-coverage plan. Pennsylvania's Pharmacy Assistance Contract for the Elderly (PACE) is a program that provides direct coverage for prescription drugs to seniors 65 years of age or older who meet certain income limitations and who are not receiving prescription benefits under the state's Medical Assistance program. Single persons whose annual income is \$14,500 or less and married couples with an income of \$17,700 or less are eligible to join the drug plan. PACE members must pay a copay of \$6 for each generic prescription and \$9 for a brand-name drug. Pennsylvania's **PACENET** is a similar program for higher-income seniors which has a monthly deductible and higher copay. The state's new **PACE Plus** program will work in tandem with the new Medicare Part D drug plan by coordinating benefits between the state and federal programs.

I-SaveRx is a program that offers residents of Illinois, Kansas, Missouri, Wisconsin, and Vermont access to prescription drugs from licensed and inspected organizations in Canada, Ireland, and the United Kingdom. People who enroll in the program may save from 25–50% on brand name prescriptions. Covered drugs for chronic illnesses and oral contraceptives are included. There are no enrollment fees, or income or age restrictions.

SUPPLEMENTAL SECURITY INCOME

Supplemental security income (SSI) is a monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter.

Many people confuse **SSDI** (social security **disability** income) and **SSI**. Both programs provide income to disabled people and both programs are administered by the Social Security Administration (SSA). However, **SSI is a welfare program** (a.k.a. “needs-based” or “means-tested”), not an entitlement program like SSDI. Unlike SSDI, income always reduces or eliminates SSI benefits. SSI also imposes strict asset limitations. No asset limitations exist for SSDI.

For 2006, the basic federal SSI benefit is \$603 a month for a single person and \$904 a month for a couple. It is increased each year for cost of living. State supplements vary from a few dollars to a hundred or more over the Federal Benefit Rate. For example, in California, the state supplement for a single disabled person living alone is \$233, for a total SSI benefit of \$836, starting April 1, 2006.

Eligibility criteria for SSI include the following four factors:

- Protected groups,
- Residency or citizenship,
- Income, and
- Assets.

Protected groups include the aged, blind, or disabled. The aged include U.S. citizens over age 65 and legal residents over age 65 who applied for benefits before August 22, 1996. The disabled are persons who suffer from physical or emotional impairment that prevents them from doing any substantial work, whose disability is expected to last at least 12 months or to result in death.

The **residency or citizenship** test requires the applicant to live in the United States or the Northern Mariana Islands and be a U.S. citizen or national. However, in some cases, noncitizen residents can qualify for SSI. For more information, see SSA Pub. No. 05-11051 ICN 480360, *Supplemental Security Income (SSI) For Noncitizens*.

The **income limits** vary depending on where the applicant lives. SSI counts various forms of income against benefits including cash income, gross earned and unearned income, pensions, annuities, gifts, inheritances, social security retirement and disability benefits. **Noncash income** is defined as in-kind support and maintenance (ISM) such as food and shelter. As of March 2005, the SSA changed its rules to delete “clothing” as a form of ISM.

SSI does not count some income against benefits, for example:

- \$20 of any type of income, unless it’s also welfare
- \$65 from earnings, plus half of any earnings each month over \$65
- Some irregular, or infrequently earned and unearned income
- Income tax refunds
- Loans, but **proceeds of a loan become a countable resource** to the extent carried over into the next calendar month
- Outside noncash receipts that are not ISM
- Some other forms of welfare, such as food stamps, and home energy and housing assistance

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All **countable assets** above \$2,000 for a single person, or \$3,000 for a married couple prevent eligibility. Countable assets include cash and other liquid assets, and all real and personal property the applicant or beneficiary owns and could convert into cash for her own support and maintenance. These include joint bank accounts and revocable trusts.

In addition, for irrevocable trusts established on or after January 1, 2000, by the SSI beneficiary or spouse, assets in the trust are treated as available to the extent payments **could conceivably** be made from the trust to the beneficiary, or spouse. Available assets in the trust could include income, exempt assets, such as a residence, and disclaimed property. These rules do not apply to certain **special needs trusts** and **pooled trusts** established under §§1917(d)(4)(A) and (C) of the Social Security Act.

Noncountable assets are those that are classified as either **exempt** or **unavailable**. These include such things as:

- \$2,000 or less in cash or other assets
- Home and land, if used as a residence
- Automobile used for the transportation of the beneficiary or member of the beneficiary's household
- Personal effects and household items
- Wedding and engagement rings
- Property needed for medical care
- Property needed for self-support, including tools of trade or business
- Cash values in life insurance policies with total face value up to \$1,500
- Burial plots, and up to \$1,500 each located in burial funds for the beneficiary and spouse

Giving Away Assets to Meet Eligibility Limits

An SSI applicant may be disqualified from getting benefits if he has given away assets within the last 36 months. Similarly, a current SSI beneficiary apparently disqualifies herself if she gives away newly received assets (e.g., an inheritance, personal injury settlement, or life insurance payment). The number of months of disqualification is approximately the number of months the value of the gifted assets would have lasted if consumed at SSI rates including the state supplements. The disqualification starts with the month of the transfer and runs no longer than 36 months. There are exceptions for gift transfers to a **Medicaid payback trust**, for hardship, and other circumstances.

MEDICAID

Medicaid is a joint federal and state program that helps pay medical costs for some people with limited incomes and resources. Medicaid programs vary from state to state. People with Medicaid may get coverage for services such as nursing home, and home health care that aren't fully covered by Medicare.

DEFICIT REDUCTION ACT OF 2005

According to a study conducted by the University of California, as of 2003, Medicaid paid for 66.2% of all nursing home costs. Because Medicaid is a primary payer of long-term care costs and the costs are rising, the government is looking at ways to reduce the costs. On February 8, 2006, President Bush signed the **Deficit Reduction Act of 2005 (DRA)**. This was a massive 776-page law, which includes significant changes for Medicaid eligibility and nursing home care payments.

The first major change is that the **look-back period for all asset transfers is now five years**. This includes any transfers made on or after February 8, 2006. Under the old rules, the look-back period for most transfers was three years.

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Example 2. John Public transferred his home and most of his assets to his children on January 31, 2006. If he applies for Medicaid before January 31, **2009**, he must disclose this transfer. His sister Mildred Public waited until February 28, 2006 to transfer her assets; her look-back period does not expire until February 28, **2011**.

In addition for transfers on or after February 8, 2006, the start of the penalty period begins when the Medicaid applicant has exhausted her resources and is eligible to apply for Medicaid. Previously the penalty period began on the date of the gift.

Example 3. Use the same facts as **Example 3**. At the time of the transfer, the total value of John's assets was \$90,000. His state's nursing home cost factor is \$3,000 per month, so those assets would have paid for 30 months of nursing home care. He is ineligible for Medicaid nursing home coverage until August 1, 2008, which is 30 months from the first day of the month following his transfer.

Example 4. Use the same facts as **Examples 3 and 4**. At the time of the transfer, Mildred's assets were worth \$21,000, which would buy her seven months of nursing home care. If she applies for Medicaid before February 28, 2011, she will have to wait seven months after the date of her application before she can receive help from Medicaid with her nursing home costs.

DRA also makes any individual with **home equity** of more than \$500,000 (or if the states elect, they can raise this to \$750,000) ineligible for Medicaid. Under the old law the home was an exempt asset. Under the new law the home **may** be an exempt asset, but only so long as the home equity is not greater than \$500,000 or \$750,000 depending on the state.

Under DRA, some **assets that used to be exempt** are now counted as part of the resources available to the Medicaid recipient. These assets include certain annuities, promissory notes, and mortgages. In addition, the law requires the state to be named as the remainder beneficiary on annuities, although it could be secondary after a spouse or a minor/disabled child.

Caution. DRA greatly complicates the Medicaid application process. Individuals may find that inadvertent transfers prevent them from qualifying for Medicaid. The advice of an experienced elder-law attorney is more important than ever under these new rules.

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	Law before Passage of DRA February 8, 2006	Law after Passage of DRA February 8, 2006
Gifts to family or others	For any uncompensated transfer of assets for less than FMV (gifting), the look-back period is 36 months. For transfers to certain revocable and irrevocable trusts and transfers from certain trusts, the look-back period is 60 months.	Look-back period for all transfers made on or after February 8, 2006 is five years (60 months), whether by individuals or trusts. Each state may implement the law change at different dates, but all will have to implement the change within the next few years.
Beginning date for imposition of penalty period	Period of ineligibility (penalty period) commences the first day of the month following the month in which the individual transfers assets for less than FMV.	Penalties commence on the later of one month following the date on which the individual disposes of assets for less than FMV or the date on which the individual is "otherwise eligible" for medical assistance (date of application for Medicaid).
Hardship waivers	Provides limited hardship waiver processes for those cases in which an individual does not meet eligibility criteria but needs care.	Provides added hardship waiver requirements and authorizes long-term care facilities to file undue hardship waiver applications on behalf of residents upon their consent. May become burdensome as nursing homes become the "collector of last resort" for costs of medical assistance.
Disclosure and treatment of annuities	Most states required annuities to be issued only by a commercial entity, be paid back to annuitant with level payouts, and be paid out over a time no longer than the actuarial life of the annuitant. Children and others can be remainder beneficiaries to receive income upon death of annuitant.	Applicant must disclose any interest the individual and spouse have in certain annuities they purchased. Applicant must generally list the state benefits are received as first or second remainder beneficiary under annuity for the amount the state spends for nursing home care. Failure to do so can cause a penalty for a transfer of assets.
Eligibility for assistance due to home equity	Senior's home exempt from Medicaid eligibility calculation, regardless of value. Home not counted as a resource, unless the applicant is a single person, there's no intent of that person to return home, and there's no other exempt person who lives in the home.	Single persons with more than \$500,000 in home equity will not be eligible for Medicaid. States may elect to raise this amount to \$750,000. Can adversely impact families in states with a high cost of housing or farm families.
Treatment of continuing care retirement communities contracts and deposits	Not addressed under federal law.	Authorizes continuing care retirement communities and life care community admission contracts to require residents to spend all resources declared for purposes of admission before applying for medical assistance. Includes amounts paid in a lump sum for admission and held in reserve to return to resident's estate upon death of the resident.

CHALLENGES UNDER DRA

Unfortunately, many seniors could be adversely affected by gifting their resources for legitimate reasons such as college tuition payment for grandchildren, charitable contributions, or payments to caregivers and family members.

When applying for Medical Assistance for nursing home care, the applicant will be required to provide five years of financial information for the period immediately prior to application for Medicaid assistance. This may be difficult for family members who are helping seniors and who do not have access to this information. It will be especially cumbersome in situations where the applicant has dementia and is not able to assist in the process of providing the information. In addition, this requirement may be difficult for Medicaid caseworkers sifting through five years of financial records and aggregating all gift transfers.

The penalty period begins only when the applicant is already receiving either supportive living facility services or nursing home service and the applicant has applied for Medicaid and is otherwise eligible. Therefore, seniors may find they are ineligible for Medicaid assistance, even though they may have spent down substantial assets on private-pay long-term care expenses.

The applicants only recourse will be to argue gifts were not made for the purpose of qualifying for Medicaid. Pattern gifting such as tithing to the church, or giving birthday gifts to children may qualify for this exemption. However, it is difficult to know how effective any arguments will be until regulations are more clearly defined.

Advance planning for seniors is required now more than ever.

ELDER CARE ESTATE PLANNING DOCUMENTS

POWER OF ATTORNEY

A power of attorney (POA) is a written document with which an individual appoints a person to act on his behalf by endowing him with certain powers and duties. A POA can be more important to an individual's welfare than a will because in a crisis situation, a trusted person of the individual's choosing will be the one to handle his affairs. Without a POA, an individual's family must endure the costly and time-consuming court process to appoint a guardian or conservator in the event of sudden incapacitation.

A **general POA** is typically used to designate an **agent** to take care of matters when a person is not able, or is unavailable to do so. A general POA endows the agent with broad powers such as:

- Conducting banking transactions,
- Buying and selling property,
- Entering into contracts,
- Filing tax returns, and
- Making gifts.

The **principal** is the individual creating the POA. The agent has a statutory duty to act in a manner consistent with the best interests of the principal. A **limited POA** is used to appoint an agent to handle a specific task or type of task.

Specific rules governing POAs vary by state. Most states require that an individual be at least 18 years old and not mentally incapacitated to make a POA. The document must be properly executed by the principal. Many states require that the agent sign an acknowledgment accepting the appointment. Some states require that the document be notarized.

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A traditional POA becomes effective when signed and continues until the principal dies or becomes incapacitated. A **durable POA**, contrastingly, is effective for life, unless it is revoked by the principal. Many states require that the document explicitly state that the agent's power remains effective upon the incapacity or incompetence of the principal in order to create this durability feature. A **springing durable POA** is not effective **until** the principal becomes incapacitated, but it remains effective throughout the rest of the principal's life.

Some states have in their law a statutory presumption that all POAs are durable unless specifically provided otherwise. The principal may revoke, terminate, or modify the POA at any time. The document is automatically revoked upon death, or upon incapacity if it is not durable, or upon the filing of a divorce where the spouse is the agent.

A **healthcare POA** is a similar device that focuses exclusively on healthcare issues. It allows an individual to designate someone to make healthcare decisions for her in the event of unconsciousness, mental incompetence, or the inability to make such decisions. Powers generally include:

- Authorizing admission to a medical or nursing facility,
- Executing consent forms for such admission,
- Entering into agreements for care of the principal in a medical facility, and
- Authorizing medical and surgical procedures.

In many states, the healthcare POA may contain the principal's wishes concerning life-sustaining procedures in the event of a coma or terminal illness. Such provisions provide guidance for the agent in making healthcare decisions for the principal. Notwithstanding these provisions, the principal should discuss her preferences concerning healthcare with her agent and her primary physician.

LIVING WILL

Individuals should formally document their specific desires concerning medical treatments to prepare for circumstances in which they cannot communicate their wishes, such as severe illness or unconsciousness. This may be accomplished by including these provisions in a healthcare POA, as mentioned above, or by other means. Such advanced directives are more popularly known as **living wills**. These advanced directives typically contain instructions tailored to the individual, such as which medical treatments should be given or withheld in different circumstances. The directives may forbid certain treatments and/or, in some cases, direct that food and water be withheld.

Some states also provide for a specific document known formally as an **advanced healthcare directive** that combines elements of both the healthcare POA and the living will.

In order to execute a valid advance directive for healthcare, a person must be at least 18 years old in most states. Generally, the advance directive must also be signed and properly witnessed in order to be effective.

DO-NOT-RESUSCITATE (DNR) ORDER

A do-not-resuscitate (DNR) order is an order entered into the patient's medical records by a physician stating that cardiopulmonary resuscitation should not be administered to the patient, in the event the patient suffers cardiac or respiratory arrest. More generally, it refers to a doctor's directive not to apply any techniques for restoring heart and lung functions or, in some cases, other forms of life-prolonging treatment.

DNR orders can supplement other healthcare directives, but they are generally made only for those who are terminally ill and who because of the nature of their illness do not wish to receive CPR or life-sustaining treatment. In the hospital setting, a terminally ill patient can request her attending physician add a DNR order to her medical record.

For situations outside of the hospital setting where medical personnel do not have access to an individual's medical records, a means of notifying emergency responders of the desire not to be resuscitated is required. Many states have procedures by which a person can obtain an **out-of-hospital** or **pre-hospital** DNR order, bracelet, or necklace that instructs emergency medical personnel not to provide CPR in the event of a cardiac or respiratory arrest.

LAST WILL AND TESTAMENT

The will is perhaps the most familiar of all the estate planning documents. A last will and testament controls the distribution of the estate, guardianship of minor children, and who will manage the estate. The person creating the will is called the **testator**. A will should be drafted by an attorney who will ensure the required formalities are present in the document, such as a valid signature by the testator. In addition, each state has different requirements concerning the number of witnesses and manner in which the witnesses attest to the validity of the testator's signature.

Tax Apportionment Clause¹⁸

Generally, a testator should provide in his will the method of allocating the burden of estate and inheritance taxes. Since inheritance taxes can consume more than half of a person's estate, the tax clause can have a greater impact than any other general provision in the will. Accordingly, careful attention should be given to this portion of the will.

Without an effective tax apportionment clause, state law will generally determine how the tax burden will be shared. At one time, most states followed the common law rule which provided that death taxes, like administrative expenses, were to be paid from the residuary estate. However, a majority of states now require that the estate tax be equitably apportioned among the beneficiaries. In such a case, each of a testator's bequests would be equally burdened by any tax owed.

Essentially, this means that each bequest must pay the tax which it creates. If the testator wishes to avoid this, the testator's will should clearly state the method to use to determining who will bear the tax burden. The method chosen depends on an individual's financial situation and family circumstances.

Example 5. In her will, Peg left \$10,000 to her favorite niece and the residuary of her estate to her brother. She did not include a tax apportionment clause in her will. Her estate paid 40% of it's worth in federal and state inheritance taxes. Under her state's laws, the 40% is allocated proportionately among the beneficiaries, so her niece only received \$6,000 of the amount Peg meant to leave to her. If Peg had specified that the estate taxes were to be paid from the residuary estate, her niece would have received the full \$10,000.

Most states also require the apportionment of tax between probate and nonprobate assets, unless explicitly stated otherwise in the will. This is critical because beneficiaries who receive significant nonprobate assets, such as insurance benefits, might need to reimburse the estate for their share of the tax burden.

Note. For information about various types of trusts, please refer to Chapter 11, Estate and Trust.

¹⁸ First, David M., "Wills: Importance of Tax Apportionment Clause," *The CPA Journal Online* (April 1989), NY State Society of CPAs

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