By Bernard A. Krooks & Michael Gilfix

Long-term Care Is Critical

In the national debate over health care reform, more attention should be given to how families pay the devastatingly costly expense of nursing care for the elderly and disabled

Perhaps the greatest development in the world of elder care and special needs law during 2009 was the lack of any real development. With the national debate raging over health insurance and health care reform, we're disappointed that only minimal attention has been given to an issue of enormous importance to older and disabled Americans: the cost of long-term care.

As this article was being prepared, House and Senate health care bills had emerged from committee. Both versions created a modest plan to address long-term care. They provided that premiums would be deducted automatically from paychecks from individuals employed by companies that choose to participate. Coverage—in the form of cash payments to individuals who become disabled—would be limited to those who'd paid premiums for a minimum of five years. Importantly, employees would be able to opt out. Critics point out that the solvency of the program was threatened by the probability that healthy, younger employees would opt out, while those with greater perceived needs would participate.

Once an individual qualifies for this program by establishing a need for long-term care services, he would receive a minimum of $50 per day. The federal program would establish the precise premiums, again with the elusive goal of solvency. The Congressional Budget Office (CBO) concluded that the program would be solvent for many years, but that it would begin adding to the federal deficit after 2029. The CBO assumed average monthly premiums of $123 and benefits averaging $75 per day in making these projections.

The president has reportedly endorsed this approach. It also got the blessing of AARP. But the fate of this proposal was uncertain. And even if it passed, its impact would not be significant. That's because nursing care can cost a minimum of $60,000 to more than $200,000 annually.

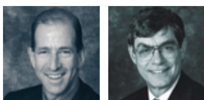
We hope that any revamping of our health care system will more adequately address this critical and costly issue.

Historically, the federal-state Medicaid program has emerged as the source of last resort for Americans facing the relentless, expensive, bankruptcy-provoking cost of nursing home care.

Given the high cost of nursing care, protective planning to preserve assets and rely on Medicaid is inevitable, even for well-to-do families.

But, as we know, Medicaid is intended for the truly needy, so each state's program has strict asset and income requirements that must be met before a person is approved for benefits. Moreover, the Deficit Reduction Act of 2005 severely curtailed the ability of seniors and the disabled from preserving their assets to supplement their cost of long-term care.

Medicare does not pay the ongoing cost of nursing home care—even though as many as 50 percent of older Americans believe that it does. Indeed, under this mistaken belief, few buy long-term care insurance, so



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they face the utter exhaustion of personal assets or look to Medicaid. But even wealthy families can be seriously drained by the combination of long life expectancy, costly nursing care and inadequate long-term care insurance. These burdens are exacerbated by today's depressed home values and the enormous losses many families' investment portfolios experienced in the last 14 months.

Obviously, having Medicaid underwrite all of the nation's elder and disabled care is profoundly problematic. Medicaid is largely funded by states with state resources. It consumes an inordinate share of state budgets across the United States. Governors are consistently up in arms over any effort to expand Medicaid. They argue cogently that the cost of long-term care should be addressed comprehensively at the national level. To make matters worse, many states are going through the worst financial crises in our lifetimes.

We have no illusions. We do not expect a solution to emerge even during this national debate over health care reform. This means that America's elders and disabled will have no choice but to rely on Medicaid, a needs-based program, or to drain their families' coffers to pay the unforgiving cost of long-term care.

Other Developments

This year's news also includes:

- **Medicaid spousal impoverishment standards for 2010—**For the first time in recent memory, the Medicaid spousal impoverishment standards did not increase from the prior year. These figures provide protections to married individuals living in the community whose spouse resides in a nursing home. Although the community spouse's assets and income are taken into account in determining the institutionalized spouse's eligibility for institutional Medicaid benefits, the community spouse is entitled to maintain between $21,912 and $109,560 in resources, depending on the laws of the particular state. In addition, the community spouse is entitled to between $1,821.25 and $2,739 in monthly income, depending on the state. Through proper advocacy, these amounts can be increased at a fair hearing or in court. These amounts are the same as 2009, because increases in these amounts are based on the consumer price index, which actually fell 1.3 percent last year. Additionally, there will be no increase in Social Security or Supplemental Security Income (SSI) benefits in 2010. SSI is a federal program designed to assist individuals who are blind, elderly or disabled by providing cash to meet basic needs for food, clothing and shelter.

> In Mississippi, legal fees associated with filing a Medicaid application are capped at $2,000; with regard to trusts, they're capped at $1,500.

- **Medicare premiums to rise in 2010—**The Centers for Medicare and Medicaid Services has announced its 2010 premium and coinsurance rates. Although Medicare premiums will go up, the increase won't affect most Medicare beneficiaries. This is because Social Security benefits are not going up so only the high-earner Medicare beneficiaries will experience an increase in premiums.

- **Mississippi imposes a cap on attorneys' fees—**Is this the wave of the future? This Mississippi maneuver is sure to be challenged in court:

  The executive director of the Mississippi Division of Medicaid has issued a policy memorandum addressing the payment of legal fees by a Medicaid applicant. Legal fees associated with filing a Medicaid application are capped at $2,000. According to the memo, the fee cap is intended to take into account the amount of time the attorney spends to complete the application, to appear in front of the Medicaid agency for the in-person interview, and to assist the Medicaid applicant in connection with securing all the documentation necessary to complete the application. It also includes any attorney involvement in the appeals process if one is necessary.

  Of course, the Medicaid applicant is permitted to

spend more than $2,000 on attorneys' fees, but only $2,000 will be allowed as part of the Medicaid spend-down. Amounts paid in excess of this amount will be treated as an uncompensated transfer of assets subject to the Medicaid look-back and penalty period provisions.

There are further restrictions on the payment of legal fees associated with personal services contracts and preparing trusts.

With regard to trusts, the legal fees are capped at $1,500 provided that Medicaid determines that the trust benefits the Medicaid applicant or recipient from a Medicaid perspective. The attorney is required to explain to Medicaid how the trust benefits the applicant and then Medicaid will make a decision on whether the legal fee is allowable.

Do any of our readers want to open an office in Mississippi? After all, the memo makes clear that retaining an attorney to assist a family with the Medicaid application process is anyone's right. You just have to find one who is willing to work for these rates. What's next? Caps on accounting fees? Realtor commissions?

• **SSDI income must be used to offset Medicaid nursing home costs despite a special needs trust**—Another disturbing potential trend reared its ugly head in New York:

Affirming a district court ruling, the U.S. Court of Appeals for the Second Circuit held that Social Security disability payments (SSDI) placed into a Medicaid recipient's special needs trust (SNT) count as income for purposes of calculating the amount he must contribute towards the cost of his nursing home care.[1]

The case was an appeal from an award of summary judgment in favor of the government. The result of this case effectively prevents nursing home residents from using SNTs to shelter their monthly SSDI income from certain Medicaid eligibility determinations.

The case involved a Medicaid applicant, Sai Kwan Wong, who was under age 65 and resided in a nursing home in New York City due to permanent disabilities. Medicaid had been paying for the cost of his care since 2005. In November of 2006, Wong began transferring his monthly SSDI payment of $1,401 into his SNT, which was established pursuant to 42 U.S. Code 1396p(d)(4)(a). During the relevant time period, this was his sole source of income.

The parties did not dispute the fact that Wong was eligible for Medicaid and continued to be eligible for Medicaid after he commenced the transfer of his SSDI payments to his SNT. The issue on appeal was whether Medicaid was allowed to count as Wong's income the SSDI payments he transferred to his SNT. By continuing to count his SSDI payments as income, Wong was effectively in the same position as he was prior to transferring those payments to the SNT. Namely, the SSDI payments had to be spent down on the cost of his care. Under New York law, a nursing home resident on Medicaid is permitted to maintain no more than $50 per month in income. The remainder of his income (subject to certain deductions) must be turned over to the nursing home to help defray the cost of his care. Wong's position was that Medicaid should not have been allowed to count as his income the SSDI payments that were transferred into the SNT.

Generally, the determination of whether assets or income placed into a trust is available to pay for the cost of a Medicaid recipient's care depends upon whether the trust is revocable or irrevocable. For revocable trusts, the entire corpus and income of the trust counts in determining an individual's eligibility for Medicaid. Irrevocable trusts are a different story. Although the rules do vary depending on which state you are in, the corpus of an irrevocable trust will not be considered available with respect to an individual's Medicaid eligibility determination so long as there are no circumstances under which the trustee can distribute principal in favor of the settlor. Discretionary distributions will not satisfy this standard. There cannot be any circumstances under which the trustee may distribute principal to the settlor. Of course, any income that can be distributed to the settlor will be considered in determining his Medicaid eligibility.

SNTs described in 42 U.S.C. 1396p(d)(4)(a) are an exception to these trust rules. They are designed to enhance the quality of life of an individual with disabilities. The SNT can pay for things that are not covered by government assistance. The assets

of an SNT do not count when determining the Medicaid eligibility of the beneficiary. Moreover, assets or income transferred into an SNT by a person under age 65 are not subject to the Medicaid transfer of asset penalty provisions.

The Medicaid agency took the position that SNTs are not excluded from post-eligibility determinations such as how much income one must contribute towards the cost of his care. The Second Circuit agreed.

Thus, even though the assets of an SNT do not count in determining a beneficiary's eligibility for Medicaid, the income placed into that trust each month does count for purposes of computing the individual's contribution towards the cost of his nursing home care.

While the *Wong* case is a defeat for the Medicaid applicant in that he must utilize his SSDI income to help pay for the cost of his nursing home care, there are two helpful conclusions that can be drawn from the case:

(1) The transfer of the SSDI income into the trust each month did not disqualify Wong from Medicaid in the month the SSDI was received. While this might seem like a moral victory, at least we know that from an eligibility standpoint this should not present problems for other Medicaid applicants.

(2) To the extent that an individual can assign his income directly into an SNT, that is to say, the beneficiary will not directly receive the income, the income should not be countable by Medicaid. Also, the assignment will not be subject to the Medicaid transfer-of-asset penalty provisions, because transfers to an SNT by someone under 65 are exempt.

Unfortunately, most Medicaid recipients have Social Security and/or pension as their only source of income, neither of which is assignable. There generally is not a significant amount of interest or dividend income since Medicaid recipients are only permitted to have a few thousand dollars in resources.

- ***Martinez* settlement required the SSA to pay $500 million to 80,000 recipients**—In a federal court-approved settlement of *Martinez v. Astrue*,[2] the Social Security Administration (SSA) agreed to repay more than $500 million to income beneficiaries whose benefits were suspended because they were deemed to be "fugitives." These suspensions flowed from a program designed to deny benefits to people who were "fleeing to avoid prosecution." The plaintiffs claimed that the program operated in an overly broad manner, treating anyone with an outstanding warrant as a fugitive.

> The least we can do is understand precisely what benefits are available—so we can fully inform clients about their options.

The case was brought by the National Senior Citizens Law Center (NSCLC), an organization founded in 1972 and devoted to protecting the rights of low income elders and disabled Americans. The NSCLC can be contacted at its national office: 1444 Eye St., NW, Suite 1100, Washington, D.C., 20005.

Arm Yourself

There are no easy solutions to our health care dilemma in general and the problem of long-term care, in particular. But while policymakers address or avoid these issues, estate-planning professionals around the country are on the front lines, forced to deal with clients' very real concerns and immediate needs. The least we all can do is understand precisely what public benefits are available—so we can fully inform clients about their options and devise plans that maximize benefits, while supplementing them with private funds.

Endnotes

1. *Wong. v. Doar*, No. 08-4992-CV (2d. Cir. June 22, 2009).
2. *Martinez v. Astrue*, 2009 WL 807460 (E.D. Cal.).