

# PLANNING FOR LONG TERM CARE 2010



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## 1. INTRODUCTION

Do you know someone currently in a nursing home? Have you ever thought about going into a nursing home yourself? Most people answer the first question ‘yes’, and the second question ‘no’. It is one of those situations where we feel *"It could never happen to me."* But studies show that approximately two (2) out of every five (5) people reaching age 65 will need some type of long-term health care. You are likely one of the many people who would prefer to stay at home no matter what the cost, but without the proper planning, the lack of available services and the staggering price-tag may leave you with few alternatives.

The average cost of nursing home care in New York State is **over \$94,000.00** in the upstate area, and **over \$160,000.00** in the New York metropolitan area, and it is climbing each year! If you choose to stay at home, where most of us would prefer to be, and hire home health aides, the cost of your care could be even more. In some cases, people pay over \$200,000.00 per year for 24 hour-a-day home care. What many people fail to realize is that their **health insurance and Medicare will not cover the cost of long-term care, whether at home, in assisted living or in a nursing facility.**

The causes of our long-term care crisis are many: increasing costs, growing population of seniors, poor government management, medical technology resulting in greater longevity, whether in good health or bad, and the inability of families to care for our elderly at home. The result of the crisis is that we must all "rethink" the way we plan for the future, and take into consideration the very real possibility that long-term care may become a part of our lives.

This outline is designed to give our clients a better understanding of the components involved in long-term care planning: **Medicare, Private Insurance, Medicaid, and Estate Planning**, and to explain how recent changes in the law, and future trends, will affect tomorrow's long-term care consumer.

## II. THE COST OF LONG-TERM CARE IN 2009

On Long Island, the cost of nursing home care ranges from approximately **\$115,600.00** to over **\$152,300.00** per year. That is approximately **\$312.00** to **\$612.00**, *per day*. Home health care costs vary widely, but agencies charge anywhere from \$18.00 to \$30.00 per hour for home health aides. Other areas of New York State and the country may differ slightly, but paying for long-term care has become a primary concern across our state and the nation.

## III. MEDICARE

Contrary to the belief of many seniors, **one cannot rely on Medicare for payment of long-term care costs**. Although Medicare is available to most individuals age 65 or older, coverage is limited to: qualified medical expenses (80% of an approved amount for doctors, surgical services, etc.); hospitalization for 90 days per benefit period with a deductible of \$1,100.00 (total) for the first 60 days and a co-payment of \$275.00 *per day* for the remaining 30 days, and an additional one-time, lifetime benefit of 60 days, with a co-payment of \$550.00 per day (for a maximum of 150 days); and post-hospital *skilled* nursing home care with payment in full for 20 days and a co-payment of \$137.50 *per day* for 80 days (maximum of 100 days). Medicare **only** pays for nursing home care if the care provided is considered "skilled care", which is care provided under the supervision of a doctor requiring skilled professionals, as opposed to "custodial care", which provides basic personal care and other maintenance level services. Home health care may be available in limited amounts, but only if "medically necessary", which is a very rigorous standard. For all Medicare benefits there are deductibles and co-payments, which can be substantial. There are excellent insurance policies available to fill these "gaps" in Medicare coverage, appropriately called "Medigap" insurance, which must be purchased privately.

Medicare **does not cover** hospital costs beyond 150 days, skilled nursing home costs beyond 100 days and, more importantly, **Medicare does not cover any custodial nursing home care or non-skilled home health care**. It is difficult for a Medicare recipient to qualify even for the limited “skilled care benefits,” and all others are considered “custodial” patients.

#### **IV. PAYING YOUR OWN WAY**

"Self-insuring," or paying your own way, may be an option. However, you can expect to pay approximately **\$115,600.00** to **\$152,300.00** per year, with the average cost being \$134,000.00 for nursing home care, and more for better facilities. In the New York Metropolitan area the cost of care has risen dramatically, and is projected to increase at 8% per year. If a person has sufficient fixed income and assets, which together produce total income of \$130,000 or more, this may be the way to go. But even then, what about the future well-being of the spouse, children, and families of those who need long-term care?

#### **V. PRIVATE LONG-TERM CARE INSURANCE**

Long-term care (LTC) insurance has been around since 1974, but in 1997 it gained widespread notoriety through federal legislation. New policies are very flexible, providing coverage for all levels of care, and should be considered part of a sound financial plan. New York State regulates LTC insurance, and in January 1992 strict regulations were put in place which set minimum standards for these policies, protecting consumers in New York.

Benefits to look for in a LTC insurance policy of include: nursing home and home care coverage; sufficient daily payouts (\$300.00/day is a good start); elimination periods (the number of days you must be in the Nursing Home before benefits begin, typically 0 to 100 days); duration of benefits (2 years, 3 years, a lifetime); renew ability (make sure it is **guaranteed** renewable); waiver of premiums (allows you to stop paying premiums during the

time you are receiving benefits); inflation protection; etc. As with life insurance, the older an applicant is, the harder it is to obtain a policy and the more expensive LTC coverage becomes.

New York State has also adopted a program which integrates long-term care insurance with Medicaid. A project funded by the Robert Wood Johnson Foundation studied long-term care insurance and its potential uses in New York State. The result was a proposal which was adopted by New York State in 1993 creating a public/private partnership between the State Department of Health and the Insurance Industry.

Insurance companies offer policies which bear the logo of the **New York State Partnership for Long-Term Care**, provided they meet certain minimum policy requirements. The State has launched [www.planaheadny.org](http://www.planaheadny.org) to help educate consumers on the specifics and advantages of these types of policies. The 2010 basic components of the policies are: a three-year benefit period for nursing home care (six years for home care); minimum daily benefits of \$229.00/day for nursing homes and \$115.00/day for home care (annually adjusted for inflation); a 5% compound annual increase in benefits; and other mandatory features. The inflation protection is optional for persons 80 years of age or older. If an individual purchases a policy of "Partnership Insurance," he or she will use the insurance proceeds, supplemented by the individual's income and assets, to pay for the first three (or six) years of care, which could be anywhere in the country. **At the expiration of the applicable term, the individual will become automatically qualified for Medicaid, but only by New York State.** All of the assets owned by that person will be **exempt** for Medicaid purposes, and the individual will be allowed to keep an unlimited amount of resources and still qualify for Medicaid. **Income, however, continues to be available,** and must be "spent-down" to pay for the individual's care. The Medicaid rules are complex, and should be fully understood prior to buying a partnership policy.

Counseling clients on the use of Long-Term Care Insurance has become a sub-specialty of Elder Law, and an integral part of comprehensive estate planning. Choosing a solid company, the right policy (partnership or traditional), daily benefit amounts, etc. calls for independent advice from a qualified professional or attorney, a service which we are pleased to provide. Please contact us for our brochure "Questions and Answers on Long-Term Care Insurance," or to schedule an appointment for a consultation.

## **VI. MEDICAID & THE DEFICIT REDUCTION ACT OF 2005**

Medicaid is a government program which pays medical costs and long-term care costs. Unlike Medicare, however, Medicaid is designed as a *payor of last resort*, however, and to qualify you must meet strict financial and other eligibility requirements. The rules governing Medicaid are complex and require great care when planning and applying for benefits. On February 8, 2006, the **Deficit Reduction Act of 2005 (DRA)** became law. New York State officially implemented its provisions as of August 1, 2006 with many of the provisions being retroactive to the February 8, 2006 date. The following is a summary of the changes now in effect in New York State:

**1. Extend the Look-Back Period:** under the old law (which existed prior to February 8, 2006), transfers and gifts outside of a trust were subject to a 36 month look-back period, and transfers to or from trusts were subject to a 60 month look-back period. Under the new law, the look back period for all transfers will be 60 months, and now applicants for Medicaid will need to submit five full years of financial records and documentation. Starting on February 1, 2009, all New York residents must provide documentation in excess of 36 months. The increase to 60 months for all non-trust related transfers will gradually increase month by month until February 1, 2011.

**2. Delaying the Start of the Penalty Period:** under the old law, applicants for Medicaid were assessed a “penalty” for the gifting of assets during the look back period, which is actually a time period of ineligibility before acceptance into the program. The penalty period started the month after the transfer was made and the application would have been submitted after the penalty period ends. Under the new law, the penalty period will now only start in the future when you need the nursing care and have already applied for Medicaid.

**3. Counting Home Equity:** under the old law your home was generally treated as an exempt asset. Under the new law, if your house is worth more than \$750,000, you may not be eligible for Medicaid because of your home equity. The home equity cap does not apply if the Medicaid applicant’s spouse or child lives in the home. A reverse mortgage could be used to lessen the equity in your home, but the proceeds from that mortgage would probably have to be used first.

**4. Annuities:** under certain circumstances, annuities would have to name the State as a remainder beneficiary.

While these changes have dramatically changed how an individual can be eligible for these benefits, some of the Program’s requirements have not changed. For example, an individual applying for Medicaid **in a nursing home** can still have only \$13,800.00 in total assets, plus an *irrevocable* burial fund of any reasonable amount and certain exempt assets (a car, clothing, jewelry, etc.). If the Medicaid applicant is married, and enters a nursing home while the other spouse remains in the community, the "community spouse" may keep \$74,820.00 (or one-half of a couple's resources up to a maximum of \$109,560.00) in assets, in addition to the home. Income must also be contributed toward the cost of care, and an individual in a nursing home is entitled to keep only a \$50.00 per month allowance. A "community spouse" is allowed a minimum income of \$2,739.00 per month, with adjustments

for certain items. Without proper planning, all assets and income above these levels must be spent on care or on exempt items before Medicaid can be applied for.

Individuals seeking to obtain Long-Term Care services outside of a nursing home must utilize a different set of eligibility for rules, depending upon the type of services required. One of the primary goals expressed by our clients is to remain in their own homes or at least in the most independent setting possible. Navigating the maze of community care requires an in-depth knowledge of the services available in the home, and of adult homes and assisted living facilities, and an ability to manage income and resources to maximize their value, while utilizing Medicaid services wherever available to supplement the care provided by the individual and their family.

Community-based Medicaid services are available through several programs, including The Personal Care Aid program, the Consumer Directed Assistance program and traditional home care. Generally, however, Medicaid does not pay for adult home or assisted living care (with limited exceptions), which under existing rules must be paid for privately.

In order to access community-based care, an individual is allowed to keep \$13,800 in total assets, but they may also retain the home in which they live along with the other exempt assets listed above. Recipients of Medicaid home care are allotted an income allowance of \$767.00 per month, although income over the \$767.00 limit may be contributed to a “Pooled Trust”, which can then be used to pay other expenses necessary to live in the community. A married couple is subject to extremely harsh rules in order to obtain community-based Medicaid, with a total combined asset allowance of \$20,100 in combined assets, along with the home and other exempt property, and an income allowance of \$1,117.00 per month combined. Detailed information on the various home care programs, and the planning available to access community-based Medicaid, is available upon request.

What if an individual gives assets away in order to qualify? As you might expect, there are old and new rules governing such transfers. When one gives money or property away, that individual and their spouse will be **ineligible for “institutional” Medicaid for a certain number of months**. Exceptions are made for any transfer to a spouse or a disabled child, and for certain transfers of the home to siblings or caretaker children. The transfer of asset rules does **not apply** to Community Based Medicaid, (leaving the possibility of transferring assets and qualifying for Medicaid immediately.) While, the penalty period for nonexempt transfers is still calculated the same way, the Deficit Reduction Act of 2005 has changed *when* the penalty period starts to run. The penalty is determined by dividing the total value of all property transferred by the average monthly cost of nursing home care in your area. The State determines this "average" each year for different regions across New York State. For example, if a Long Island resident transferred \$108,520.00, he or she would have been **ineligible for Medicaid for 10 months** as \$10,852.00 is the average 2010 cost of nursing home care for Long Island. (Average costs in other regions are \$9,838 in the New York City; \$9,439 in the Northern Metropolitan area; \$7,418 in the Western area; \$7,766 in the Northeastern New York region; \$8,720 in the Rochester area and \$6,938 in the Central New York area.)

Depending upon the fair market value of the assets transferred, the penalty period could extend well beyond five years. In that case, the "look-back" period will become relevant. When applying for Medicaid, the County Department of Social Services or the New York City Human Resources Administration will ask for financial records, bank statements, tax returns, etc. since February 2006 or a full 60 months depending on when the application is filed and when any transfers were made (either pre-DRA enactment or post-DRA enactment). A thorough analysis of all transactions within the look-back period and the resulting penalty period should be undertaken **prior** to filing for Medicaid. Our firm provides services that include advice on Medicaid eligibility, preparation and filing of the Medicaid application, and advocacy and litigation services for Medicaid denials, spousal claims and estate recoveries.

Below are a few of the terms and concepts with which you should be familiar when considering the benefits of accessing the Medicaid system to help finance long-term care:

- **Look-Back Period.** The "look-back" period (i.e., the period of time prior to the Medicaid application for which you will have to provide financial information) is currently to February, 2006 and will be increased to 60 months under the DRA. Currently, a look-back period of 60 months applies for transfers to or from a trust regardless of the DRA. All transactions within the applicable look-back period will be examined for nursing home care, but not for community care.
- **Penalty Period.** There is no cap on the length of a penalty period imposed because of an uncompensated transfer of assets within the applicable look-back period, which is calculated by dividing the value of the transfer by the "regional rate". As such, an informed Medicaid applicant will wait up to 60 months from the date when he or she made pre-DRA transfers or a full 60 months from the date after larger post-DRA transfers were made before filing his or her Medicaid application, at which point the transfers need not be disclosed and therefore will not be taken into consideration for eligibility purposes. Regardless, it may be prudent to retain sufficient resources to pay privately during the penalty period or obtain Long Term Care insurance for this period to avoid using private assets to pay for nursing home care during this 60 month term. Again, there is no penalty for Community-Based Medicaid.
- **Jointly Held Assets.** If assets are held in an account by a Medicaid applicant and another individual as "joint" owners, and funds are withdrawn by either individual, it will count as a **transfer against the Medicaid applicant**. For example, withdrawal of funds from a "joint" bank account by the child of a Medicaid applicant will be treated as though the Medicaid applicant parent had transferred the funds to the child. In addition, funds held in a joint account in a bank or similar financial institution will be ***presumed to be owned entirely by the applicant***. If both signatures are required to withdraw funds (i.e., some brokerage accounts

require all named owners to sign), only ½ of the value will be counted as belonging to the applicant. Each asset should be evaluated to determine ownership and ownership rights.

- **Home Care Benefits.** Under current law, **transfers do not count** against an applicant who is seeking only Medicaid benefits under New York's home care program. It is uncertain, however, how long the state will continue to exempt transfers for applicants applying for home care.
- **Trusts.** If assets are held in a **revocable** trust, they are all available for Medicaid purposes. An individual who establishes an **irrevocable**, income-only trust (otherwise known as a "Medicaid" Trust), will protect the assets held by the trust after the expiration of the applicable penalty period imposed as a result of the transfer of property into the trust. Income generated by assets held in the trust will be considered available to pay for the cost of long-term care. If assets are held by a community spouse, the state may have the right to recover all Medicaid paid on behalf of the applicant spouse. These rules are evolving, and must be analyzed in each case.
- **Estate Recovery.** States are **required** to seek recovery of benefits paid to a Medicaid recipient from his or her estate. It has been left to each individual state to determine what assets will be included in the "Medicaid estate," which could conceivably include assets held in trust, and other partial transfers, such as deeds with retained life estates. The New York State Legislature, however, currently defines "estate" as the "probate" estate only, or those assets **passing by will or by intestacy**. Any non-probate assets, such as trusts (Medicaid trusts or other types of trusts), joint accounts, life-estate deeds and annuities, currently escape recovery.
- **Hardship.** New York State is required to establish procedures to determine whether the denial of Medicaid eligibility would work an undue hardship on an applicant. If an individual makes transfers "innocently," which disqualify him or her from receiving Medicaid, the state

may waive the eligibility requirements. As a practical matter, these "hardship exceptions" are difficult to prove and are not often granted.

## **VII. PLANNING FOR LONG-TERM CARE**

What can be done to plan for long-term care, ensure that a health crisis or chronic illness will not erode an individual's security and dignity, and provide for family and loved ones? As you may have already gathered, the answer is not simple. **A careful analysis of each individual's personal and financial situation must be done to formulate the proper plan.** Factors such as income from social security, pensions and investments; the nature and value of assets; age and health; family situation; and other considerations must be evaluated in order to make the right choices. **(A comprehensive questionnaire which we have prepared to assist our clients in gathering the information needed is available upon request.)**

Based upon the current condition of the Long-Term Care marketplace and Medicaid, if an individual is *insurable* and the long-term care insurance premiums are *affordable*, such policies should be integrated into an estate plan to provide protection without the need for transferring assets. If an individual falls in the "target range" for a New York State Partnership policy, the asset protection feature provided by automatic Medicaid qualification would be a valuable benefit. When income levels are high (we consider \$50,000.00 for individuals and \$75,000.00 for married couples to be "high" for the purpose of this analysis), or asset protection is not the only planning goal, traditional policies of long-term care insurance, using an indemnity benefit and increased home care coverage, may be preferred. Again, it is important to analyze each individual's situation to determine the proper fit for a long-term care policy.

If long-term care insurance is not an option, and personal income and resources are not sufficient, **one planning technique is to transfer assets into a "Medicaid" Trust**, retaining the

income for the "Grantor", and preserving the principal of the assets (the assets held by the Trustee) for the spouses, children or other beneficiaries of the Grantor. When properly drafted, the trust will provide **asset protection**, with significant **tax benefits** as well, including avoidance of gift taxes, and elimination of capital gains taxes. In addition, trust assets will **avoid probate**. The trust allows the Trustee to **access the principal** of the trust during the Grantor's lifetime **for the benefit of the Grantor's children or other beneficiaries**, although the Trustee cannot give the principal directly to the Grantor. Most Grantors also choose to maintain the right (called a Special Power of Appointment) to change the ultimate beneficiaries of the trust, by "reappointing" the assets to different family members at a later date. This power retains control for the Grantor, and prevents transfers to the trust from being treated as taxable gifts.

A properly drafted "income-only" trust that gives a Trustee no discretion to distribute principal to the Grantor-Beneficiary, or to his or her spouse, is still a viable long-term care planning tool. **Therefore, a senior doing estate planning may keep the income from an irrevocable, "income only" trust for himself or herself, with the remainder distributable to specific beneficiaries, and qualify for Medicaid without the assets in the trust being considered as available by the State and County to pay for the cost of long-term care.**

In addition, should the trust own your primary residence, you will have the exclusive right to occupy and enjoy the property and you should not lose any of the real estate tax exemptions you had prior to the transfer into the trust. A deed transferring the primary residence while retaining a life estate can certainly help the family in several ways. Moreover, you can direct the Trustee to sell the residence and purchase another for you from the proceeds of that prior sale. Please note however, that obtaining mortgage financing (including a reverse mortgage) will not be possible should an irrevocable trust own your primary residence.

Unlike a transfer of an asset to an individual, it is very important to note that due to the legal protections of this type of a trust, if a personal issue should affect you, your trustee or another beneficiary (such as divorce, premature death or court judgment), the trust property should be entirely protected as none of these individuals have any personal ownership rights over the property within the trust.

Please be wary to not confuse a “Revocable Living Trust” with this *irrevocable* trust. While a revocable trust may have several benefits and uses, it is important to note that a Revocable Trust *does not* offer asset protection. A revocable living trust is typically only implemented for asset management and probate-avoidance reasons.

If use of a trust is not desired, it is still possible to make "outright" gifts of property and then wait until the expiration of the new 60-month look-back period and then apply for Medicaid. If the home is the only asset to protect, **a deed to children or others, with a retained life estate for the Grantor**, will protect the property and the right to Medicaid, once the look-back period has expired, along with preserving the STAR exemption and other tax benefits. This life estate deed would give you the right to live in the residence for your lifetime. Since, the period of ineligibility for nursing home services under Medicaid is equal to the uncompensated value of the resource (the value of the residence less the value of the retained life estate) transferred divided by the regional rate for nursing home care, the use of a life estate deed will result in a shorter transfer penalty than if the transfer were outright or to an Irrevocable Trust.

While the life estate appears to have an initial benefit of a shorter penalty period, there are several drawbacks which must be noted. First, if you sell the residence in the future, you would need the consent of your children. Second, the proceeds would be distributed partly to you as the life tenant and partly to the children as “remainderpersons”. Third, the transfer may adversely affect your ability to maximize your capital gains tax exclusion of \$250,000

(\$500,000 for a married couple) on the gain from the sale of the residence as your children (the “remainderpersons”), may not reside in the home with you. If they do not reside with you, their portion of the proceeds will not qualify for the capital gains tax exclusion and therefore their portion will be subject to both Federal and New York State capital gains taxes.

Moreover, if the residence were sold while you were residing in a Nursing Home, then the sale proceeds may adversely affect your Medicaid eligibility as you would be receiving a portion of the net proceeds which would disqualify you from the Medicaid program. An alternative to selling the residence would be to rent the residence to a third party but please note that the net rental income would be part of your Medicaid budget.

Upon your demise, the fair market value of the residence will be included in your estate for Federal and New York State estate tax purposes. Estate tax returns may be required and taxes may be owed. However, the children would own the entire interest in the residence by operation of law and the residence would not be subject to a probate proceeding. Lastly, this transfer would result in your children receiving a “step-up” in basis for income tax purposes upon your demise which will minimize any income taxes on the subsequent sale of the residence subsequent to your demise.

While it appears that existing planning opportunities have been limited by the enactment of the DRA, opportunities exist nonetheless. Several new strategies have been created due to the DRA and more are evolving as the new laws are being utilized and enforced. For example, utilizing Promissory Notes and Caregiver Agreements are becoming more popular as the possibility of needing care draws closer. Proper *advance* use of the Medicaid transfer rules still allow an individual to provide security for themselves and a legacy to their families, while ensuring that they will receive long-term care.

One very important fact to remember is that if an individual can live at home with the assistance of **home health care**, it is possible to transfer assets and qualify for Medicaid

*immediately* to cover home care costs. Caution must be exercised however, because home health care may be appropriate initially, but if the individual's condition deteriorates to the point where he or she cannot be safely maintained at home, then nursing home placement may be required. If this higher level of care is needed, a new application is required, and the Medicaid transfer rules will be imposed. Thus, when planning for *home care*, the possible need for institutional services must be evaluated before transfers are made.

### **VIII. POTENTIAL MEDICAID RECOVERY ISSUES**

In the current environment of budget deficits and the mandate handed down by the State to the Counties to pursue recoveries from community spouses and the estates of Medicaid recipients and their spouses, litigation by the Department of Social Services over the payment of Medicaid benefits is on the upswing. Once a spousal refusal has been submitted, there are issues which a community spouse should be aware of. The most significant risks to the effectiveness of your long term care planning include the following:

1. **The execution of a spousal refusal by an excess-resourced community spouse.**

A spouse who is deemed to have excess resources may be sued by the Department of Social Services for support on behalf of the institutionalized spouse. Even when this does occur, however, the community spouse almost always still comes out ahead because of the difference between the private pay rate and the Medicaid pay rate, which translates into a significant savings to the community spouse even if full support is required.

2. **Claims against the estate of the community spouse.**

A community spouse who is found to have had excess resources at the time benefits were paid may be found to have an "implied contract" with the State to pay back the benefits paid out on behalf of the institutionalized spouse. This implied contract may ultimately be enforced as a claim against the estate of the community spouse.

3. **The spousal elective share right.**

If the community spouse dies before the Medicaid spouse, the Medicaid spouse will have a statutory right of election against the estate of the community spouse. A Medicaid Trust of the community spouse will be considered to be a testamentary substitute, and therefore included in calculating the net elective estate for elective share purposes. However, even if the Department of Social Services does move to enforce this right, only one-third (1/3) of the net elective estate is required to be paid out to the institutionalized spouse, and given proper planning it may be possible to preserve up to fifty percent (50%) of the elective share amount for family members. If possible, Waivers of the right of election should be signed by both spouses in advance of the Medicaid application.

4. **Transfers After Medicaid Eligibility is Determined.**

Once a spousal refusal Medicaid Application is accepted, under current New York law the community spouse may transfer assets without penalty. The federal Center for Medicare and Medicaid Services (CMS), however, has indicated that a state may treat any transfers or gifts made by the community spouse as a disqualifying transfer for the Medicaid recipient. At this time New York State's regulations do not adopt this policy, but there is a risk that the Department of Social Services may attempt to recover resources that have been gifted by a community spouse based upon New York's Debtor and Creditor Law, by alleging that the transfers are fraudulent. Therefore, any asset transfers done "post-eligibility" must be carefully planned and executed.

Although the risk of estate recovery exists as outlined above, in spite of gifting or utilization of an Irrevocable Medicaid Trust, *these risks can be mitigated through proper planning*. Despite the risks, the Grantor of an Irrevocable Medicaid Trust and his or her family is almost always better off having utilized the Trust or a gifting plan. We are available to work with you to create a well crafted and well implemented long-term care plan.

## **IX. WHAT THE FUTURE HOLDS**

The crisis in health care and long-term care will shape public policy for years to come. It has become clear that long-term care, such as nursing home and home health care, will not be a part of any new universal health insurance program, and that there will be continuing pressure to limit expenditures on existing programs, including Medicare and Medicaid. **It is thus imperative that seniors, those approaching retirement age, and the families of those needing long-term care take advantage of the planning opportunities that exist today.** Everyone's situation is unique, and it is impossible to discuss all of the planning opportunities in this outline. As with any planning, a good way to begin is to seek competent advice from a qualified professional. At the Law Offices of Brian Andrew Tully, PLLC we are dedicated to helping you find solutions to your long-term care concerns. Please call (631) 424-2800 for a consultation.

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