Senior Planning Guide

A Massachusetts Guide to Aging with Dignity

With emphasis on

Aging In Place

Dedicated to the Memory of Attorney Robert W. Kelley and Mrs. Barbara Kelley

A Guide for Aging in Place
By Robert E. Kelley, Esquire

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TABLE OF CONTENTS

PAGE

Introduction **7**

I. **Overview of Eldercare Service Networks and Government Funding Sources for Eldercare**: 8

A. Eldercare in a Nutshell 8

B. The Older Americans Act and the Administration on Aging Form the cornerstone of our nation's eldercare system. 9

1. The Older Americans Act through state and local Services Agencies funds the delivery of non-medical support services such as assistance with activities of daily living to qualified elders. 11

2. The Older Americans Act does not fund skilled Nursing Services to frail elders although it will coordinate your Skilled nursing and non-skilled care needs. 12

C. Overview of Medicare and Medicaid: 14

1. Medicare Part A does cover skilled nursing but only Upon discharge from a hospital after at least a three day stay and only for short-term care. 14

2. Medicare does not cover long-term care. 16

3. Medicare stops paying as soon as long-term care Begins. 16

4. Seniors who understand Medicare coverage rules Can save money as co-pays and deductibles are Embedded throughout Medicare Plans. 18

a. Medigap is supplemental insurance designed To cover co-pays and deductibles of Medicare Insured's. 18

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b. Managed Care is private insurance which Replaces Medicare through their lower co-pay May be offset by restrictions where an insured Can receive care. 19

c. Careful Medicare Planning for those without Supplements can reduce the high costs of co-pays. 20

d. State Medicaid Programs are required by Federal Law to cover portions of the cost sharing of Medicare beneficiaries whose incomes are below or just above the Federal Poverty Level. 22

5. Medicaid is the principal government agency to Finance Long-term care for frail elders. 23

6. Medicaid does cover long-term care services but only to those persons who are at or below the Federal Poverty Level and subject to other limitations. 23

7. Medicaid through Mass Health offers a home and Community based waiver program which combines Nursing and personal care services in a single Delivery System to homebound elderly. 24

8. Massachusetts offers several all inclusive medical programs for frail elders in imminent risk of nursing home placement such as PACE and Senior Care Options. 25

D. Wartime Veterans' and their spouses are eligible for aid And attendance benefits for home care. 26

E. Changes to Elder Service Networks and Funding Sources by Government and private sector alike. 27

II. Financing Long-Term Care Through Medicaid

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– Mass Health: 29

A. Non-Countable Assets 32
B. Inaccessible Assets 32
C. Countable Assets 33
D. Income Limitations 33
E. Community Spouse Resource Allowance 35
F. Community Spouse Minimum Monthly Maintenance Needs Allowance 35
G. Annuities 37
H. Deficit Reduction Act of 2005 and its impact on seniors 38
I. Transfer Rules Tighten 38

III. Financing Long-Term Care with Reverse Mortgages and Long-Term Care Insurance: 39

A. Overview of Reverse Mortgage Attributes 39
B. Financing Eldercare using a Reverse Mortgage 42
C. Financing Long-Term Care with Long-Term Care Insurance 45

IV. Overview of the Continuum of Care and Housing Choices for Aging Elders 48

A. Aging-In-Place 48
B. Housing choices for Seniors 49
C. Informal to Formal Eldercare 51
D. Aging-In-Place versus Nursing Home Placement 54

V. Estate and Long-Term Care Planning for Older Clients: 57

A. Life Estates 58
B. Trusts 59
C. Powers of Attorney 60
D. Health Care Proxies 61
E. Wills 61

Conclusion: 61

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ATTORNEY PROFILE

Robert E. Kelley is an attorney focusing in elder and health law. His passion for elder advocacy began as a prosecutor in the Cape and Islands District Attorney's office in the late 1980's where he prosecuted criminal cases including elder abuse. In 1997, having worked in private practice for five years with his dad, Robert W. Kelley, who himself practiced elder law, Attorney Kelley began representing Unity Mortgage, a little known lender of reverse Mortgages which was eventually acquired by Financial Freedom.

Attorney Kelley's experience closing senior loans for hundreds of what Tom Brokaw called aptly the greatest generation has given him special insight into senior interests, challenges, and concerns.

The stories of these seniors are fascinating. A reverse mortgage client revealed how he invented the double hull LNG tanker; another was on the design team for the atom bomb; several clients have described being on the beaches of Normandy during the war. Yet many are afflicted with very serious ailments which cause great suffering and many have been widowed

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after very lengthy marriages or have lost all their siblings and many close friends.

Charlton Heston the actor was emblematic to how some senior's must cope with suffering when upon learning he had Alzheimer's declared to the public "I must reconcile courage and surrender in equal measure". "Please, do not have sympathy for me."

Attorney Kelley has listened to many elderly clients express views about the uncertainty of growing older and he wrote this guide in gratitude for the lessons he has received from those elder clients.

Attorney Kelley attempts to provide with this guide insight into the complex issues and solutions which are available to seniors as they age and he provides a blueprint for eldercare planning and estate planning.

The law office, R Kelley-law, P.C. handles all aspects of eldercare and health law, from planning long-term care strategies, creating estate plans, litigating coverage claims, probate, guardianships, Medicaid planning, and reverse mortgage closings.

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INTRODUCTION

Seniors face unique challenges which come with aging**.** Medical, financial, legal, and housing issues increase in significance and overlap as seniors age. Also, the growth in the elderly population will surely stress an already under-budgeted eldercare system in the near future. Understanding the eldercare delivery system and the government's role in funding these services is key to successfully managing the aging process and is essential to intelligent estate planning.

The manner in which eldercare is delivered is being altered drastically and this trend is expected to continue. Long-term care, the chronic medical and non-medical part of what is eldercare, is moving away from nursing home placements in favor of in-home and community based care.

The trend away from placement of frail elders into nursing homes to live is characterized as "aging in place". This movement is directed at surrounding seniors with resources to remain home during the final aging process. The guide discusses the burdens and benefits of the aging in place movement and it identifies new financial devises to help with the decision to age in place like the purchase of long-term care insurance or a reverse mortgage.

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This guide also outlines public financing sources like Medicare, and Medicaid, or the Veteran's Administration, and their rules for eligibility, particularly the latest Medicaid rules for eligibility. Lastly, Housing and personal care options are presented and an overview of elder law issues, including estate and Medicaid planning is provided.

I. OVERVIEW OF ELDERCARE SERVICE NETWORKS AND GOVERNMENT FUNDING SOURCES FOR ELDERCARE

A. Eldercare in a nutshell.

Eldercare is a term used to describe the networks of services available to aging seniors for those unique and special needs which confront older Americans. This includes medical care, informal supports from a spouse, adult child, or friend: and formal supports such as skilled nursing facilities, home health agencies or assisted living residences.

Thus eldercare supports the medical, social, financial, and housing needs of frail elders. Government funded eldercare comes about through three main agencies, Medicare, Medicaid, and state and local elder services agencies. (The fourth is the Veteran's administration and for wartime veterans and spouses in need of personal care the Aid and Attendance program may be of help.) The guide discusses the three at length as well as

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the veteran's benefit, and private financing mechanisms like long-term care insurance or reverse mortgages.

What will become apparent to seniors is that public financing of eldercare is very disjointed as to what services for example Medicare or Medicaid will or will not cover. This leads to much confusion for seniors.

The lack of continuity is in part due to the agencies' differing missions and constituencies.

For example, Medicare was designed by congress to insure retirees for sickness, not long-term care. Medicaid was created to insure all poor people, not just the elderly.

Area agencies on aging were created to establish networks from which to monitor the lives of seniors across the country, not so much pay for their long-term care. Yet all three strain their budgets to support long-term care even if in limited fashion.

B. The Older Americans Act and the Administration on Aging form the cornerstone of our nation's eldercare system.

While most seniors are familiar with Medicare and Medicaid, many are less familiar with the significant impact for which **The Older Americans Act**; the "Act" has had on their lives. In 1965, congress with the passage of the Act created a federal agency on aging, **The Administration**

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on Aging within the **U.S. Department of Health and Human Services**, and it mandated to have each state create a state unit on aging in order to promote the independence and well-being of elders especially those in need of medical and support services.

A 1973 amendment to the Act led to the creation the **Area Agencies on Aging** which further localized the Act's mission to ensure the dignity and independence of older Americans and to ensure that federal funds reach seniors at the local level to provide for supportive services, preventive health, meals, caregiver supports, abuse prevention services, and nutrition.

In Massachusetts, the state unit on aging is the Executive Office of Elder Affairs. In 1971, Elder affairs became one of the nation's first cabinet level agencies responsible for addressing the needs of its senior citizens. Elder Affairs divides the commonwealth into distinct planning and service areas.

The community programs such as **Home Care** are delivered to senior applicants through contracts which Elder Affairs has with 27 non-profit organizations called **Area Service Access Points,** 23 of which are also the area agencies on aging.

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1. The Older Americans Act through state and local elder services agencies funds the delivery of non-medical support services such as assistance with activities of daily living to qualified elders.

Seniors with modest incomes in need of non-medical services can apply to an Area Services Access point agency or ASAP, for the following programs and services:

- Personal care including companions, and home health aides
- Homemaking, grocery shopping and chores
- Home-delivered meals
- Adult day-care/health including dementia daycare
- Case management
- Assisted transportation
- Congregate meals
- Nutrition counseling and education
- Transportation
- Legal assistance
- Information and assistance
- Outreach services, emergency response, or wanderer locator.

Seniors who demonstrate deficits in performing activities of daily living such as bathing, eating or walking while living at home, and have low enough incomes will qualify for a limited service plan from an area ASAP.

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A sliding scale is used for income ranges so that co-pays are apportioned with income levels.

2. The Older Americans Act does not fund skilled nursing services to frail elders although it will coordinate your skilled and non-skilled care needs.

The Older Americans Act funds far less in total dollars to support its mission than does Medicaid so there are limitations as to the level of care the ASAP will allow. Its mission is to fund supports to homebound elders at the lower end of the income scale.

For example currently some ASAPS allocate a total of five hours of home care and this is up from three hours just a few months ago and depending on legislative appropriation the three hour limit could return. For a frail elder, the level of support provided by the state home care program and funding uncertainties may prove insufficient for their level of needs.

Enhanced community options programs are available for frail elders clinically qualified to enter a nursing home. This program increases the availability of home care without skilled nursing for nursing home eligible seniors to a degree where daily personal care attendants are available. Unfortunately, however, due to high demand, many ASAP's

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have a waiting list for such services. (These same seniors can apply for a Mass Health home and community based waiver.)

Seniors in need of support services can apply to an ASAP for state home care services such as those listed above. A case manager will evaluate the senior and will qualify them by age, as they must be 60 or older or suffer with dementia, show a deficit in at least three areas of activities of daily living such as bathing or dressing, and have income within limits set by the program.(Financial eligibility is discussed later in the guide.)

The income thresholds are less onerous than with Medicaid and the agency will use a sliding scale from zero to 100% depending on the senior's income. Moreover, the agency is not mandated to place a lien on the elder's home like for Medicaid recipients. The co-pay is technically a voluntary payment.

A plan for services will be prepared in accordance with the impairment levels, the existence of family supports and of course the resource limitations of the program. Those seniors in need of skilled nursing must either qualify for Mass Health or would pay for this care privately.

Recent legislation has brought more emphasis and funding to assist the family caregivers. Seniors who qualify for assistance from an ASAP can

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usually get the allotted hours of care in whatever form which makes sense to the senior and the family caregiver if there is one.

C. Overview of Medicare and Medicaid.

The Social Security Act of 1965 created Medicare under Title 18 and Medicaid under Title 19. Medicare provides medical insurance to persons over 65 among others while Medicaid covers persons who are demonstrably poor, having incomes below the federal poverty level.

Medicare is a social insurance program administered through the **Centers for Medicare and Medicaid.** The insurance program is partially funded by payroll taxes (FICA), and the self-employment taxes. Seniors and their employers contributed almost three percent of their pay to the system. Those eligible for social security or a railroad pension can enroll into Medicare. Those with not enough months at work can enroll and pay a higher premium.

1. Medicare Part A does cover skilled nursing but only upon discharge from a hospital after at least a three day stay and only for short-term care.

Medicare is segmented into Parts A through D. Part A of Medicare charges no premium and covers hospital stays. Medicare Part A pays for skilled nursing at a facility but only after an insured is discharged from a

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hospital admission of at least three days. The patient must enter the nursing home within thirty days of discharge.

The nursing home admission must be medically necessary and related to the hospitalization, and the care required must be skilled nursing or rehabilitative therapy by a licensed therapist; Medicare does not cover non-skilled, personal care services or assistance with activities of daily living unrelated to a skilled nursing event.

Medicare will cover a nursing home visit in full for 20 days, and will extend coverage when the treating physician determines that the care is medically necessary and can lead to an improvement in the patient's condition subject to a co-pay of over 100 dollars per day. Coverage is terminated after 100 days or when the patient is not showing improvement.

Moreover, Medicare will cover home care under similar rules as discussed for skilled nursing care except that home care may also follow a non-hospital treatment as well and is 100% covered with no time limitations.

Medicare part B is medical insurance for out-patient physicians visits, lab tests, durable medical equipment and a long list of other medical items including wheelchairs, canes, and walkers. Part B would also cover a skilled nursing on a part time basis which could include personal care depending on the circumstances. This would be for a short-term duration.

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Part B is optional coverage for seniors still working and there are premiums for this coverage and co-pays for most treatments. Part C is a managed care plan for seniors enrolled in Medicare. The managed care companies are Medicare approved private insurers. The premiums and co-pays for managed care may be lower than standard Medicare but the plan will limit choice like any HMO or PPO. Those who enroll in part C can no longer have Medigap.

Medicare Part D is the prescription drug benefit created to spread the costs of prescription drugs over a broader population, thus reducing its costs per senior. It is a stand- alone coverage unless the senior enrolls in a managed care plan in which case the drug benefit is included.

2. Medicare does not cover long-term care.

Many seniors mistakenly believe that Medicare will pay for long-term care as most do not adequately understand the distinction between medical and long-term care. In fact, a survey by the National Council on Aging found that one-third of baby-boomers incorrectly assumed that Medicare is the primary source for long-term care funding.

3. Medicare stops paying as soon as long-term care begins.

What is Medicare covered Medical and what is long-term care is not easy to determine but it has drastic consequences on coverage by Medicare.

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In fact denial of coverage for this distinction is often times an issue for appeal.

A Senior may enter a nursing home due to a fall and subsequent broken bone having spent many days in the hospital. This medical event begins a benefit period for which Medicare pays. The benefit period lasts until the patient is no longer being helped back to the previous state of health or sixty days after release from the nursing home.

However, the nature of the fall may have been chronic weakness from frailty which would lead to a concern about the patient returning to their home without more extensive therapy or it may be determined that the elder cannot safely return home without supports.

Medicare would cover the first twenty days of rehabilitation at the nursing home or an unlimited amount of days at home and it may cover some of the next 80 days of nursing home care subject to a significant co-pay by the patient.

Long-term care begins when the treatment from the fall is no longer necessary irrespective of whether other care is needed to support the chronic condition of the elder. At this point, the senior would have to pay for the long-term care relating to the chronic weakness either privately, through Medicaid or the VA where applicable.

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4. Seniors who understand Medicare coverage rules can save money as co-pays and deductibles are imbedded throughout Medicare plans.

Medicare is built around the principal of shared costs with its insured and this trend is likely to grow with the aging baby boomers signing up in great numbers over the next few years. There are deductibles, co-insurance and co-pays contained in parts A and B which can result in very high co-pays to seniors.

When one examines the average costs for health care under Medicare, the senior ends up being responsible for about one-half of the total bills. Medigap insurance and Managed-care plans are available to reduce the risk of high cost co-pays.

a. Medigap is supplemental health insurance designed to cover co-pays and deductibles of Medicare insured's.

Medigap supplements are offered in various plans so careful review of covered and un-covered services is necessary in order to understand coverage. The plans in varying degrees pick up the deductibles or co-pays of Part A and Part B coverage.

For example, hospital stays charge a deductible of this year of well over 1,000 dollars per benefit period and after day 61, will charge a co-

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insurance of over 200 dollars per day. There is another increase in co-pays at day 91.Medigap would pay the deductible and co-insurance amount. Medigap would also pay the co-pay after day 20 in a skilled nursing facility.

Part B coverage usually has a small yearly deductible and a co-pay for services of 20% plus excess charges in for example an out patient surgery. Medigap will cover most if not all of those co-pays. Medigap policies also cover some preventive care. However, Medigap does not cover long-term care in the same way that Medicare does not.

Those interested in enrolling in Medigap should do so within three months before or after they turn sixty five or when they enroll into Part B as many working seniors remain on a private plan even after the age of sixty-five. This is called open enrollment, guarantee issue. No medical underwriting is permitted. There could be a waiting period from a pre-existing condition but no denial of coverage for health reasons. Seniors with Medigap continue to pay their part B premium.

b. Managed care is private insurance which replaces Medicare thus their lower co-pays may be offset by restrictions in where an insured can receive care.

Managed care defines its benefit plans and the premiums thereto. The premiums and scope of coverage are defined without regard to Medicare

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rates as the enrollee is no longer in a Medicare plan. The benefits of Managed care are its low premiums and low co-pays but this can be offset by the restrictions imposed within the plan on hospitals and perhaps more importantly specialists a senior can see.

Typically the more choice built into the plan the higher the rate. Pay close attention to the specifics of the managed care plan if it is under consideration and do a side by side comparison with Medicare plus supplements. Managed care plans can include a drug benefit or it may not. If it does not then a senior can enroll into a separate plan.

c**. Careful Medicare planning for those without supplements can reduce the high costs of co-pays.**

Those who choose not to purchase supplemental insurance can save money by understanding coverage issues. Firstly, it is important for seniors without supplements to understand that home care is covered 100% as there are no co-pays, and there are no time or benefit period limits as to coverage other than a showing by the treating physician that the care is medically necessary.

Seniors must be homebound. Hospital discharge planners can recommend home care but the condition of the home and whether family members will be present can impact the decision.

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The durable medical equipment has co-pays of 20% and ambulances do as well but all the hands on care and therapy is covered in full. Most seniors would prefer to treat at home and should push the provider of care for this option when appropriate.

A senior who seeks a routine exam should be aware that Medicare does not cover these. Yet, as long as you give the doctor some complaint of some ailment like sleeplessness or headaches then the exam is covered. Most insured's who seek a routine exam are in some measure of discomfort so the request for a routine exam should not be made as long as a complaint exists. This is especially important when the exam is for eye sight or hearing.

Medicare does not pay for medications unless they are administered at the hospital yet Part D will not allow a senior to purchase generics. Examine the medication needs thoroughly and the availability of generics before deciding on a Part D plan.

Furthermore, the benefit period after a hospitalization will not end until the senior has been out of the hospital and skilled nursing facility for at least sixty days. If home care is appropriate, it will end the benefit period sooner and thus any admission to the hospital thereafter even if for a similar event, a new benefit period will start. Hospice care is also covered almost 100%.

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d. State Medicaid programs are required by federal law to cover portions of the cost sharing of Medicare beneficiaries whose incomes are below or just over the federal poverty level.

Under federal law certain seniors whose incomes fall below or just above the federal poverty levels are entitled to buy-in to a dual enrollment of Medicare and Medicaid with Medicaid picking up co-pays and deductibles or at least part B premiums.

Qualified Medicare Beneficiaries (QMB) are those whose incomes are below the federal poverty level with assets below 2,000 dollars. Medicaid through Mass health would continue Medicare and would pay all co-pays and deductibles and Part B premiums. Special low income Medicare beneficiaries (SLMB) are those making slightly higher than the federal poverty level and for these seniors Medicaid will pay their Medicare part B premiums.

A low income subsidy (LIS) is available to QMB recipients and SLMB recipients and this is a payment by Medicaid for the annual deductibles and monthly premiums for the prescription drug plans.

Seniors who may qualify for a senior buy-in program must apply at a Mass health area office and fill out the senior benefits application. **SHINE,** also known as **Serving the Health Information Needs of Elders** is a non-

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profit organization of volunteers who provide insurance counseling for seniors. The Office of Elder Affairs manages SHINE. Seniors who are interested in any coverage issue can contact shine for assistance.

5) **Medicaid is the principal government agency to finance long-term care for frail elders.**

Medicaid was created as a source of health insurance for individuals with very low incomes. Like Medicare it is managed by centers for Medicare and Medicaid, but unlike Medicare it is not administered at the federal level. Medicaid funds states to insure its poor. Since it is a means testing program, anyone seeking coverage has the burden in showing that their income and asset level is low enough to meet the qualifying thresholds.

Medicaid is available for persons whose income and assets exceed the thresholds provided that the applicant first spends down the excess funds on medical bills. (Financial eligibility is discussed later in the guide.)

6) Medicaid does cover long-term care services but only to those persons who are at or below the federal poverty level and subject to other limitations.

Medicaid is managed in Massachusetts by Mass Health. Mass Health combines the federal allocation of funds which is granted to the state based

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on the percentage of its citizens at or below the federal poverty level and the state will match those federal funds.

Those Medicare recipients who are accepted under Mass Health will become dual eligible with Mass Health managing the Medicare payments and Medicaid payments. The dual eligible seniors will no longer be responsible for premiums and co-pays or will become partially responsible depending on their income levels. Medicaid services as paid for by Mass Health include:

- Clinic, hospital, and nursing services
- Nursing facility and home health care services
- physical therapy
- items of dental such as dentures, prosthetic devices, eyeglasses, and medical equipment
- case management, personal care, and hospice services

7) Medicaid through Mass Health offers a home and community based waiver program which combines nursing and personal care services in a single delivery system to homebound elderly.

Today, the states are authorized to waive the nursing home requirement without first seeking it from Medicaid so long as the person is clinically eligible for a nursing home, can remain safely in the community, and qualifies by income-asset test.

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Home and community based waivers are facilitated through the local ASAP. The waivers are very important to elders seeking to remain in the community because the income threshold is moved up from the federal poverty level to 300% of the monthly supplemental social security amount which this year would be approximately 1900 per month.

Moreover, once qualified to Mass Health under the waiver, the elder can receive almost an unlimited amount of both nursing and supportive services such as daily assistance with activities of daily living, meals, home health aids, etc.(The concept is to provide an equivalent level of care available in a nursing home at the elders home.)

The drawback to Medicaid is its strict income and asset tests. For those elders who are not clinically eligible for nursing home admission, they would have to spend down assets and income to the federal poverty level or slightly higher than this level subject to a senior buy-in, before the state would begin paying long-term care bills.

8) Massachusetts offers several all inclusive medical programs for frail elders in imminent risk of nursing home placement such as PACE and Senior Care Options.

A Program For All-inclusive Care For The Elderly (PACE) was created by the Omnibus Appropriations Act of 1998, to authorize states to

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use a fully capitated Medicare and Medicaid program that serves frail elders who meet clinical criteria for nursing home placement but remain in the community , receiving all their medical and personal care needs from a PACE program. There are six PACE organizations across the state of Massachusetts. The frail elder will receive all geriatric care, including personal care or medication management as well as all medical care from the organization.

Similar program called Senior Care Options also accepts elders clinically qualified for nursing home placement but who remain in the community. Qualified senior care organizations have been selected to contract with Mass Health to deliver all acute, long-term care, and mental health services to those elders in their network. There are three such providers in Massachusetts, Commonwealth Care Alliance, Evercare SCO, and Senior Whole Health.

D. Wartime veterans and their spouses are eligible for aid and attendance benefits for home care.

Aid and Attendance benefits are available to wartime veterans and surviving spouses of deceased wartime veterans who need in-home care, or assisted living care. Many elderly veterans and surviving spouses whose incomes are above the congressionally mandated legal limit for a VA

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pension may still be eligible for the special monthly aid and attendance benefit if they have large medical expenses, including nursing home expenses, for which they do not receive reimbursement.

To qualify, the applicant must have served in active duty for at least 90 days, served at least one day during a time of war having been other than dishonorably discharged, and the applicant must be incapable of self-support to the point of needing assistance almost daily. The veteran's affairs officer for each town in the commonwealth is a good place to go for information about this important benefit.

E. Changes to Elder Service Networks and Funding Sources by government and private sector alike.

The Centers for Medicare and Medicaid are experiencing a dramatic increase in spending as the baby-boomers enter retirement years. As average life expectancies continue to increase, the senior population will continue to require more long-term care services as they age. Medicaid has already received relief from congress with the Deficit Reduction Act of 2005 with the tightening of the rules on gifting assets to loved ones and with the counting of principal residence equity of over 500,000, 750,000 dollars in Massachusetts, among other changes. (The DRA is discussed in detail later in the guide.)

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There is a movement nationally and within the Elder Affairs mission to rebalance the government and provider establishment bias toward nursing home care, which has been the historic process to deal with frail elders, in favor of home and community based care.

Home care is less costly because the elder is financing their own housing and food costs, items factored into the nursing home bills. The policy is strongly favored by the elderly as they almost universally loathe the thought of entering a nursing home environment as a place of residence as nursing homes are licensed institutions which treat very ill people.

However, seniors must be prepared to shoulder a greater financial burden for their long-term care as they age because while Medicaid will save money with the waiver system, the "rebalancing" of financial responsibility onto the elder will certainly bring financial distress to many seniors particularly those who own a home as the costs of care and home carrying costs even with Medicaid contributing will remain very high.

Seniors need to plan for the aging challenge and a discussion later in the guide on the use of reverse mortgages and long-term care insurance are but a few suggested financial tools to ease the burden for seniors who wish to age at home but with more costs.

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II. Financing long-term care through Medicaid – Mass Health.

Seniors who can no longer afford to pay for ongoing medical bills must look to Medicaid-Mass health for coverage. However, the application process can be difficult and time consuming and this guide attempts to make the process understandable.

Medicaid is insurance for all the poor so the financial determination for eligibility to receive coverage under Mass Health is based on family incomes. This becomes complicated when one spouse is being placed in a nursing home while the other must maintain a standard of living while living in the community.

Thankfully, there are rules which address the financial needs of the community spouse. The applicant must initially list all the income and assets of themselves and their spouse at the time of application. Then depending on the income and assets of the couple combined and upon the financial needs of the spouse at home, a determination is made as to how much of the family portfolio remains with the spouse at home. The rules provide for an asset allowance and an income allowance to spouses living in the community.

The asset allowance is referred to as the **Community Spouse Resource Allowance (CSRA)** and under federal law community spouses are

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allowed a percentage of the couple's assets up to a limit.(the limits are discussed later in this section.) The income allowance is referred to as the **Community Spouse Minimum Monthly Maintenance Allowance (MMMA).**

An applicant for Mass health for nursing home care must pay all their income but 60 dollars per month and have no assets other than 2,000 dollars. The community spouse's income is not counted at the time of admission of her husband and if the income of that spouse is insufficient to support the community spouse then she can use the institutionalized spouses' income up to the limits set forth in the rules. The resources are split in accordance with what the rules say as to how much the community spouse can use while living at home.

The determination of eligibility for Mass Health will hinge on the senior establishing that of the countable assets and income and after the community spouse receives her portion of the portfolio for her living needs, the applicant holds no more than what the rules say is allowed before Mass Health will begin paying medical bills. But what is countable as an asset and what is not is made clear in the rules and careful observance of these rules is what in essence is Medicaid planning.

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The details of what is and is not countable income or assets and when transfers were made out of the estate are of critical importance as there exists many legitimate ways to allocate a countable resource into a non-countable one.

The following is a break down of countable assets and income:

ASSETS	**INCOME**
Anything of value such as:	All money an applicant receives such as;
Cash	Social Security
Invested funds like a Mutual fund	Dividends
Real estate	Interest income
Personal property	Pensions

Asset and income limitations are strict and the burden of proof is on the applicant to prove that the senior's income and assets does not exceed the thresholds. Mass Health divides assets into three categories:

1. Non-countable assets;
2. Inaccessible assets; and
3. Countable Assets.

Only countable assets are considered with respect to the asset limit. Non-countable assets are exempted from the determination of asset limits.

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A. Non-Countable Assets

1. A principal residence in Massachusetts subject to the equity caps and other rules discussed hereinafter;
2. Household belongings and furnishings;
3. Personal belongings, such as clothing and jewelry;
4. Burial plots for applicants and members of their families;
5. Pre-paid funeral contracts;
6. A 1500 dollar burial account for funeral expenses
7. Life insurance with a face value of up to 1,500; and
8. One automobile of any value for use by the applicant or his family.
9. Business property
10. A special needs trust in which the applicant is the beneficiary provided that the trust is drafted in accordance with the Mass Health rules
11. Necessary home improvements and maintenance

B. Inaccessible assets:

Like non-countable assets, inaccessible assets are also not included in the calculation of an applicant's assets. Inaccessible assets are assets to which the applicant has no legal access, such as expected inheritances before probate is completed or a divorce asset prior to a final decree.

C. Countable Assets:

Countable assets include all assets which are not excluded as non-countable or inaccessible. In some cases joint assets and assets in an irrevocable trust will be considered countable assets. The rule of thumb is that if the trustee has the discretion to distribute principal to the beneficiary who is the applicant for Mass Health, then it is an asset.

Assets in a life estate or a revocable trust are countable assets. Medicaid will presume that all funds held in a joint account belong to the applicant. The presumption can be overcome only when the non-applicant can demonstrate that he or she contributed to the account and for how much.

D. Income Limitations:

In addition to the asset limits, Medicaid places a limit on the monthly income an applicant can receive and still qualify for Medicaid. Medicaid has a different income limitation for individuals living in the community from those living in a nursing home. For example in 2008, an individual over 65 living in the community can have incomes of 867 dollars per month or 1167 dollars per couple. Most of these seniors would receive Mass Health as a dual coverage for Medicare under the buy-in as discussed earlier.

Medicaid considers earned income (wages) and non-earned income (social security, pensions, etc), less any medical benefit premiums paid, when calculating an applicant's total income. When income exceeds the limit, the applicant is approved for Mass Health subject to a spend-down

procedure. The spend-down periods are for six months. The spend-down impacts excess income and assets.

Spend-down is a term used by Medicaid-Mass Health Each person's medical expenses must be spent down from private sources of funds which Mass Health determines at application. Once the spend-down is complete, the bills begin to be paid by Mass Health.

For example, a widow living in the community receives 900 per month in social security and has begun to incur medical bills for long-term care. Each month her income receives a shelter of 522 dollars which leaves her with a bill of 378 dollars which she must contribute toward her long-term care. Over six months her share of the bills is 2,268 dollars.

The above example would be different if the same woman received a waiver because the income limits increase. However if the widow is placed in a nursing home, she would pay them the 900 less 60 dollars for an allowance and less any medical insurance premiums.

E. Community Spouse Resource Allowances(CSRA)

As stated, under the rules, a couple's assets are added together for the purpose of determining eligibility. When a married applicant enters a nursing home, Medicaid calculates the couple's countable assets. The assets of both spouses are pooled without regard to who owns the assets. The

spouse living in the community is allowed to keep a portion of the couple's assets, what is called the "community spouse resource allowance".

Today, the community spouse may keep one-half of the couple's assets up to 101,640. In appropriate circumstances, where for example the community spouse needs more income, he or she can appeal for additional assets or convert some assets to be income producing. This adjustment should be done only with assistance of qualified counsel.

F. Community Spouse Minimum Monthly Maintenance needs allowance.

The spouse of an individual in a nursing home is entitled to a portion of the institutionalized spouse's income under certain circumstances. This sharing of income is allowed when the community spouse has income below a minimum amount as set by Medicaid. This minimum monthly income level is called the "minimum monthly maintenance needs allowance (MMMNA).The MMMNA is currently 1,711.25 plus an excess shelter allowance up to a maximum of 2,541 dollars. The shelter allowance is the community spouse's actual monthly housing costs, including mortgage payments, rent, property taxes, homeowner's insurance, less 30% of the minimum amount. The income of the institutional spouse is accessible to the community spouse when the community spouse's income is inadequate subject to the limits discussed above.

However, if the combined income of the spouses is inadequate to meet the allowable MMMNA of the community spouse, then the community spouse is allowed to have an enhanced Community Spouse Resource Allowance. A hearing is required to determine the appropriate amount of allowance to go to the community spouse. There is a three step process, at the hearing:

First, the hearings officer will determine the gross income available to the community spouse including the income that would be generated if the asset allowance were invested in an account generating income equal to the current bank rate monitor index for a five- year Certificate of Deposit, which is established monthly.

Secondly, if the gross income available to the community spouse is less than the allowable MMMNA, then the hearing officer shall allow an amount of income from the institutionalized spouse (after allowable deductions) to be given to the community spouse that would increase the community spouses income to an amount equal to, but not exceeding, the MMMNA.

Thirdly, if after application, of the first two steps the gross income available is less than the MMMNA, then the hearing officer shall increase the community spouse's asset allowance (CSRA) by the amount of additional assets that would produce enough investment income to raise the income to the allowable MMMNA.

G. Annuities

There is the Medicaid Qualifying Immediate Annuity or Single Premium Immediate Annuity. The applicant or spouse pays over to the insurer a lump sum and the funds are returned in a sinking fund payback over a period fixed by the plan; this must be consistent with life expectancy tables under the HCFA life expectancy tables.

This is a popular technique used to transform excess assets into a non-countable income stream as the community spouse's income is not used to determine eligibility of the institutional spouse. This annuity can also be used to fund periods of ineligibility from gifting, although this technique is often challenged by the division of medical assistance. Also, the state must be named a contingent remainder beneficiary in either first or second position.

H. Deficit Reduction Act of 2005 and its impact on seniors :

In 2005, Congress passed legislation intended to curb abuses of Seniors who deliberately impoverished themselves in order to receive state subsidies to finance long-term care. This technique is not favored today. Instead, seniors should plan their estates with the risks of needing long-term care built into the plan. They should make gifts while they are healthy but only when it does not place them in financial distress.

I. Transfer Rules Tighten

Congress changed the transfer of asset rules by increasing the look-back period from 36 months to 60 months or five years. The look back period is the period in which Medicaid reviews all of your financial records and where evidence exists that a senior transferred an asset for less than fair market value, then the value of the gift(s) is added up and the applicant will be deemed ineligible for the total amount of the gifts over the five years divided into 256, the average cost of a nursing home.

The new rule also shifted the period of ineligibility to the date the applicant enters the nursing home. Previously, the penalty began when the transfer was made.

Another significant change in the rules was the imposition of a cap on home equity. In Massachusetts, if a senior enters a nursing home having lived alone, her home equity cannot exceed 750,000 dollars or the excess equity would have to be spent down to the limit in order that the senior would qualify for Mass Health. The annuity rules were also changed, adding the requirement that the state be named as a beneficiary on the annuity.

Mass Health can play a role in funding care for frail elders but as this guide shows, the over-reliance on this program will cause more not less financial distress. Seniors wishing to age in place and use in-home care to delay nursing home placement must concede that with the income and asset

tests of Mass Health set so low, their savings are going to have to be used to pay for long-term care.

This is why the use of a reverse mortgage is becoming so essential as homeowners can access their home-equity to help with their maintenance bills without it affecting Mass Health eligibility. And the senior receives a life estate with lien priority over Mass Health.

III. Financing Long-Term Care with Reverse Mortgages and Long-Term Care Insurance

A. Overview of Reverse Mortgage Attributes

A reverse mortgage is a loan against the equity in the principal residence of a person over the age of 62 where interest charges accumulate but are deferred until the death of the last spouse, sale of the home or when the home is no longer the principal residence for over a period of twelve months.

The mortgage is a lien against the property. The title remains with the borrower and it can be passed onto loved ones subject to the loan being repaid. The loan can release the accumulated equity in the home in which the senior lives while interest charges will be added to the lien until the loan is paid off. Seniors are not qualified for these loans on their credit scores or income levels because the lender looks solely to the appraised value of the property for repayment.

The most popular reverse mortgage product is called the Home Equity Conversion Mortgage (HECM), which is a home equity loan with the deferred payment procedure as outlined above. (Although for higher priced homes there exists a loan program which is not insured by HUD.)

The FHA Reverse Mortgage allows Seniors to access the cash only when needed. There are several ways to receive funds; a line of credit, a tenure payment which is similar to a fixed annuity, a term tenure, or a combination of the tenure and line of credit.

The Housing and Community Development Act of 1987 reestablished a Federal Mortgage Program to be provided by the Federal Housing Administration (FHA), a division of the US Department of Housing and Urban Development (HUD). HUD's mandate as set forth by congress is to offer insurance to Home Equity Conversion Mortgages – Reverse Mortgages to Seniors over the age of 62.

This Mortgage insurance premium, or MIP, provides an incentive for lenders to grant these loans and gives Seniors comfort in knowing that if a lender becomes in-solvent, the government will fulfill the loan commitments as stated in the loan. HUD's involvement also ensures transparency in the origination of the loans, especially for the imposition of fees and costs.

Because Reverse Mortgages are insured, lenders can and do offer Senior Loans as non-recourse, meaning that the loan balance can only be re-couped from the equity in the home but never from the Senior or their heirs.

Non-recourse consumer loans are almost never granted on the forward mortgage side.

Recent legislation will require all senior loan brokers to be licensed in the state to which the Reverse Mortgages Loans are originated. Moreover, the loan origination process is replete with consumer protections so that Seniors are well informed of the loan characteristics, fees, payment procedures, etc. Some of the protections include:

Seniors must enroll in a counseling session with an approved counselor and be certified to have understood the program's basic features. There is a three day right of rescission for each borrower meaning that either can cancel the loan for three days after closing. There is a document which discloses the annual cost of the loan with closing costs taken into consideration, and no pre-payment penalty for early re-payment.

B. Financing Elder care using a reverse mortgage:

A reverse mortgage may be an appropriate retirement tool under many scenarios whether to reduce debt, make home improvements, or to supplement retirement income. However, in the context of funding long-term care the reverse mortgage can be an important tool for seniors whose eldercare costs are eroding savings too quickly.

The cornerstone of using a reverse mortgage to help fund eldercare is for seniors who desire to age in the principal residence as reverse mortgages only be made to homeowners. Moreover, the primary reason a senior

chooses a reverse mortgage to assist in paying medical bills is due to the unexpectedness of these expenses. It is difficult to set aside money for long-term care when the costs are not easy to determine in advance. Yet, it is comforting to know that home equity can be used to fund these unexpected bills as they arise.

The potential unforeseen costs of health care include co-pays and deductibles of Medicare, the costs of long-term care which is not covered by insurance and the costs of remaining in the community if a senior does qualify for Mass Health.

Reverse Mortgages offer a great solution to seniors either about to apply for Mass Health or are expected to do so at some point in the future as the proceeds from the loan are not counted as income or as an asset for purposes of Mass Health eligibility. (Please note that the funds received from the lender must be spent in the month received or the remaining funds could be counted as an asset.) This feature assists many seniors known as house rich and cash poor to receive needed government assistance and an income supplement as well.

There are many other positive attributes for obtaining a reverse mortgage for a senior receiving Mass Health. Principal among them is the lien priority which the reverse mortgage enjoys over the Medicaid lien as such liens are rarely filed while the senior remains in the home. The individual living at home who must be placed in a nursing home may only

be a candidate for a reverse mortgage if the prospects of returning home are excellent.

The reverse mortgage gives a senior on Mass Health access to equity which could be eventually taken by Medicaid for reimbursement of medical expenses. For example, A senior with Alzheimer's who is placed in a nursing home could have all the equity taken by the state to reimburse it for all those years of paying the nursing home. Therefore having access to the home equity while it is at risk of loss can be quite important for many seniors.

Moreover, the equity can be used for some other important reasons where at least one spouse is on Mass Health. Home equity could be used to fund a period of ineligibility if for example a senior gifted assets to a child during the look-back period or in some cases be used to fund long-term care insurance. The proceeds can be used to assist a community spouse when her allowance is inadequate to maintain the home; or it can be converted to a non-countable asset such as the purchase of a new car or home improvements.

Seniors who wish to consider tapping home equity to assist them in funding eldercare must be careful in how the loan proceeds are used. In applying for Mass health, it is not advisable to use reverse mortgage proceeds to pay health insurance premiums, co-pays or long-term care bills as these will be subtracted from countable assets and income when eligibility

is determined. The loan proceeds are best reserved for maintenance expenses, taxes or food as these costs are not factored into Medicaid eligibility.

C. **<u>Financing Long-term care with insurance.</u>**

Long term care insurance (LTCI) is an important planning tool for seniors concerned with financing long-term care costs and who have assets to protect against depletion from the need to pay for long-term care. In short, persons should consider L.T.C.I. when they have significant assets or income to protect, or some assets to protect together with the desire to pay for long-term care without government assistance.

L.T.C.I. if properly funded will shield a senior from having their homes secured by the state by lien to reimburse it for paying long-term care bills. In Massachusetts for example, if a senior has coverage for at least 730 days of the current daily amount, now $125.00 then the state cannot place or enforce a lien on the applicant's home to recoup it for long-term care services paid on their behalf even in instances where the senior disclaims any intent to return home.

LTCI is costly because insurance companies charge premiums based on the aggregate costs of the types of care the insurance pays for and most policies cover most forms of in- home and community based care as well as assisted living and nursing care. Plus most policies offer inflation protections and all have elimination periods; this is like a deductible.

There are tax-qualified policies and non-tax qualified policies as well as individual and group policies. The tax qualified policies are important to seniors still in the work force as the employer has an incentive to offer it to the older employees. Most companies offer substantial discounts where spouses seek simultaneous coverage.

Tax-qualified policies are fully tax deductible by employers and partially tax deductible to insured's who make use of itemized deductions. There are group and individual policies. The policy cannot be cancelled but it can lapse due to non-payment.

Tax- qualified-policies will not activate until an insured needs help with at least 3 activities of daily living. For non-tax qualified policies the threshold is usually two activities. Employers can discriminate in offering LTCI as a fringe benefit so older employees should not hesitate to negotiate it as a compensation package and children can receive LTCI on behalf of a parent as a fringe benefit as well.

LTCI is appropriate for seniors with significant assets who are currently healthy, and who can afford the premiums. Older persons risk being denied coverage as policies are medically underwritten such that any evidence of a chronic condition such as diabetes will result in a denial of coverage.

The use of Reverse Mortgages to finance long-term care insurance may be appropriate but in very limited circumstances. The one product

which is available and which could be appropriately funded with a Reverse Mortgage is called by most insurers the asset-preserver long-term care insurance. This product is a hybrid between a tax-deferred annuity and LTCI. The asset preserver grows guaranteed at between 4% and up to 8% tax deferred.

The funds invested into the asset preserver remain tax deferred if used to finance long-term care. If long-term care is never needed, the asset can be passed onto loved ones. The product may be appropriate to fund with the reverse mortgage as the growth rate of the invested cash will closely match the interest expense of the loan, while the policy is customized to finance long term care if needed at a tax free rate. If long term care is never used, then the appreciated asset can be passed onto loved ones.

IV. OVERVIEW OF THE CONTINUUM OF CARE AND HOUSING CHOICES FOR AGING ELDERS

A. Aging-In-Place

"Aging in place" is a philosophy on aging which places high importance on remaining in the home of choice while frailty reduces independence. Studies have shown that over 80% of senior homeowners do not want to move. Aging in place is a counter-movement to the longstanding tradition of placing frail elders into nursing homes when ever they could no

longer live safely at home. As previously discussed, there is a national movement at government levels to re-allocate funds from nursing homes to home care.

Aging-in-place includes the management of nursing and personal care as in-home as opposed to nursing home care. This is for many the home but aging in place also includes the placement of seniors in continuum care retirement communities or assisted living facilities. Most persons who think of long- term care think of a nursing home. Yet, long-term care today includes an ever evolving array of services directed toward persons needing assistance compensating for limitations in their ability to live independently.

B. Housing options for seniors

The Home: Studies show that seniors prefer to remain at their homes as they age. (Approximately 80% of seniors own a home.) However there are two main obstacles to remaining home as frailty occurs; the first is a safety concern as to the design and condition of the home such as stairs not to code or inadequate lighting just to name a few; the second concern is excessive isolation.

One professional organization, Certified aging in place specialists (CAPS) are certified to adapt senior homes to accommodate their disabilities such as installing ramps, special showers, extra hand rails or first floor bed and baths for easier living. Seniors can also access a network of agencies to

combat social isolation, including transportation, senior centers, Councils on aging and adult day care centers.

Independent Living: In addition to the home many developments include housing for the elderly. Most communities have low-income housing for the elderly. These apartments have income constraints but are typically subsidized through tax credits or from HUD. The senior only pays a percentage of their income usually approximately thirty percent while the government subsidizes the remaining rental obligation. These apartments will include utilities.

For seniors who do not qualify for low-income housing there are many developments which offer independent housing which adjoins an assisted living facility or it may be a condominium complex which will offer meals and recreation as part of their management fee. Independent living is a part of the developments calling themselves continuum care retirement communities. This model offers independent, assisted, and nursing home care all on one campus.

Assisted Living: These apartment style developments are constructed with frailty in mind. In Massachusetts, assisted living facilities must be certified by the Executive Office of Elder Affairs and as such have to be designed for disabled or handicaps in mind, provide 24 hour care, from a trained staff under the supervision of Elder Affairs. These facilities provide personal care services to the residents, as well as meals and recreation. A

new trend in assisted living is specialized Alzheimer's care. These units are separated from the other residents, provide twenty-four hour supervision, additional security, and activities designed to delay memory losses.

Nursing Homes: Skilled nursing facilities provide housing to elders who need regular nursing and have significant deficiencies with activities of daily living. These facilities are licensed by the department of public health as long-term care and rehabilitation facilities. Moreover, skilled nursing facilities treat persons with serious medical conditions rehabilitate for those injuries. As such, these facilities are not optimal housing choices for most frail elders without the need for regular nursing.

Continuum care retirement communities: These master developed communities combine independent, assisted, and nursing onto a single campus which allows the senior to progress with age by making seamless transitions into the various levels of care. The models typically use a buy-in method, which is a large deposit of approximately 300,000. The deposit counts as an asset for purposes of Medicaid eligibility but the bond is used to fund the higher levels of care and can be depleted as quickly as other programs.

C. Informal to formal Eldercare

Long-Term Care integrates the medical, social, financial, and housing needs of frail elders not just the medical issues. It usually begins with informal supports where a spouse, adult-children or a trusted friend begins to

help the senior manage their daily activities when some disability begins to gradually erode their independence. Daughters are still the predominant caregivers to frail elders.

Gradually, this informal process may become unmanageable to the family caregiver and the senior will then turn to formal supports; this is long-term care by licensed or certified providers, some certified to handle care on behalf of Mass Health or the Executive Office of Elder Affairs while others are strictly private pay contractors providing nursing or personal care needs. Families must assess their abilities relative to a loved one's condition as sometimes the need for skilled professionals outweighs the love and desire to care for a parent.

When formal supports become necessary, the senior must be assessed by either a private or a public organization as to their level of impairment, their housing and financial situation, and a care plan will be devised. Most often, the referral to a long-term care provider will follow a hospitalization or come from the recommendation of an internist or other geriatric physician. As previously discussed, there is a public eldercare network available for seniors who qualify by income and for others there exists a geriatric care community which manages many frail elders who pay privately. This is a critical juncture for families as often times they are ill-prepared for the costs and choices which are presented to them. Professional advice at this stage is recommended.

Long-term care service assessments are usually supervised by the ordering physician but conducted by a geriatric case manager or geriatric nurse attached to a certified home health agency or an ASAP. (This could be the hospital's home care agency or the VNA) However, a good place to begin when the decision is made to bring in professional services is to contact the local counsel on aging.

There are 348 Councils on Aging in Massachusetts. These are municipal agencies of volunteers who attempt to link elder needs and resources by developing and/or coordinating services, community education, and advocacy. The COA should be a helpful source for seniors and families as they look to transition onto formal care.

Private geriatric care managers can be retained by families to facilitate the transition into the formal support networks. These professionals are cross-trained in Geriatrics, gerontology, social work, nursing and counseling. As such, these professionals are skilled in providing an un-biased assessment as to the appropriate level of care and they assist families in devising a sound financial plan to pay for the care.

Geriatrics is a specialty as common afflictions such as immobility; instability, incontinence, and impaired intellect/memory create very complex care cases. Care plans must address present and future care needs and for example with Alzheimer's there will occur a progression to the disease which must be well understood by the professional advising on living

arrangements, security issues, and medication management issues just to name a few.

Because eldercare issues are complex, a senior should seek a second opinion or contract for a geriatric professional of their own when a recommendation is made on a care plan. The care plan recommended may have undesirable consequences such as a recommendation to a nursing home when a child may be willing to build an in-law apartment or the home could be made more senior friendly. Inputs from family members are essential to appropriate care planning.

Organizations such as the National Guardianship Association, the National Association of professional Geriatric Care Managers, and the American Association of Critical Care Nurses are good sources to contact when looking for a referral to an area professional who can assist a senior in choosing various care options. Elder lawyers can also be a forceful advocate to the senior and their families.

D. Aging in place versus nursing home placement.

Most Seniors with any level of debilitation have ongoing anxiety over the thought of entering a nursing home as their place of residence. Thankfully, with the expansion of home care, elders can get services even daily nursing right at home. Aging in place represents a significant shift in philosophy by the geriatric community and government alike by placing a

higher value than in the past on keeping seniors at their home of choice or to a residential facility as they age.

Community and home-care options as previously discussed include home health care, home personal care, adult day care, respite care, hospice and residential care at an assisted living facility or continuum care retirement community. These are the providers who collectively promote the aging in place concept. These options as previously discussed are funded either privately or through an ASAP, Medicare or Medicaid.

Keeping elders home as they age is the goal of elders and case managers alike. However, when the senior can no longer remain home without significant risk of injury or death, or when excessive isolation exists, the recommendation may be to move into a home and care environment which could be an assisted living or nursing home environment depending on the health of the senior.

Historically, the development of nursing homes had been driven primarily by the medical concerns of the elderly. Frail elders whose primary issue was impairment in doing activities of daily living were lumped together with medically needy persons even though the care given the elder was typically personal care. Moreover, Medicaid would only pay for nursing home care which explains why so many elders impoverished themselves in order to receive state funded care.

Today, assisted living facilities focus on their residents' social needs and subjective well-being while giving them assistance with activities of daily living. The assisted living community has displaced the non-medical care regimens of the nursing home but in a residential setting. The concept has grown because of the availability of in-home care at the facility allows assisted living facilities offer comparative services to a nursing home while remaining residential.

Assisted Living Facilities are usually very skilled at dispensing personal care services as the facility operators undergo a rigorous certification process in Massachusetts through the Executive Office of Elder Affairs which includes approval of the layout of the facility, the service plan to be implemented, and the existence of a bill of rights for the occupants.

These facilities are especially skilled in managing memory impairments such as dementia as many newer facilities have dedicated memory care units which are designed with additional security, 24 hour supervision within the unit and memory restoration activities intended to delay the effects of the disease.

Nursing homes in contrast, focus on improving the lives of the patients with the assistance of skilled nursing. It is the "residential" character of an assisted living facility and its focus on the subjective well-being of its residents which is distinguishable to a nursing home's "institutional" character and its focus on treating serious medical conditions.

Those elders who need daily nursing may not be appropriate for an assisted living facility but it is not uncommon for assisted living residents to be placed in nursing homes for shot periods of time.

V. ESTATE AND LONG-TERM CARE PLANNING FOR OLDER CLIENTS

While it is never too early to begin the process of estate planning, for older clients with accumulated assets planning becomes of paramount importance. Estate planning becomes more of a challenge when the client is about to enter or is in long-term care because some tools such as gifting or long-term care insurance may no longer be viable options. Early planning is advised.

There are many levels of estate planning and the complexity of one depends upon the size of the estate as larger estates have greater tax consequences to deal with. This guide will emphasize basic estate planning. This section is intended as an overview of the various legal documents used to protect assets, dispose of assets after death and address health issues.

For seniors who have sizable estates, it is advised that you retain competent advice on protection strategies as the area of law is very fluid and in constant flux. For senior homeowners, you already fall into the category of needing an estate plan as the home as an asset is of value and there are

many strategies you can employ to preserve this asset and pass it onto loved ones inexpensively.

Older seniors should seek legal ways to guard against sudden illness, chronic illness and sudden death. The will, health care proxy, and durable power of attorney are important documents to create in an estate plan.

Seniors who wish to establish ground rules on how their assets should be handled while alive and after they pass should consider using a living trust. The following is an over view of the basic estate planning documents available to seniors wishing to protect assets and manage frailty:

A. Life Estates:

A life estate is a form of home ownership where the life tenant simply deeds out the future interest in the property to a person of their choosing, usually children or a sibling. The life tenant retains all the rights of an owner, including the right to use, occupy, and enjoy the property.

The transfer is known as a gift that is not completed until the death of the life tenant. The life tenant pays all the bills but receives any rental income as well. The life tenant can never be evicted from the home after creating the life estate. Upon death, the holder of the future interest records a death certificate and title has passed free of probate. There is a step up in basis for life estates, meaning that the children may sell the asset free of any capital gain tax. Moreover, the estate is subject to the five year look-back rules of Medicaid.

B. Trusts:

Trusts are effective instruments for seniors to have who wish to control their assets during their lives and after they pass away as the trust survives the death of the donor. Revocable trusts allow its grantor to make conditional gifts which can be taken back or amended at any time. This form of trust avoids probate, receives a step up in basis at the death of the grantor, and is included as an asset for purposes of Medicaid eligibility.

Irrevocable trusts are outright gifts to the beneficiary although the income and principal of these trusts can be reserved for use by the grantor. The gifted interest held by the beneficiary will take the basis of the grantor, meaning that if the grantor paid 40,000 for a home in 1970, and the beneficiary sells the property after the death of the grantor, the beneficiary pays a capital gain based on the difference between the price sold and the 40,000 dollars.

The irrevocable trust is subject to the five year look-back rules of Medicaid so long as the senior has any beneficial interest even if they are incurring no income from the property. Irrevocable trusts if formed properly will not count as an asset to them after the five years. Both revocable and irrevocable trusts are commonly used in estate tax planning especially when an estate is large enough where without proper titling, the decedent would incur an estate tax.

C. Powers of Attorney:

A power of attorney is a document which authorizes the attorney in fact to handle all of or a part of the senior's legal matters like managing bank accounts or executing important legal documents. There is a durable power of attorney which is valid whether or not the elder is incapacitated: there is a springing power of attorney which is validated when a doctor declares the elder incapacitated: and there are limited powers of attorney which are limited in accordance with the senior's wishes.

D. <u>Health Care Proxies:</u>

The health care proxy is an important document to have because seniors understand the uncertainty of their good health once the aging process begins to erode independence. Seniors are allowed by law to direct health care providers to treat them during an end of life issue in the manner of the proxy's choosing.

E. <u>Wills:</u>

A will is an important document to execute if the senior wishes to direct how her property is to be divided upon her death. A will can establish guardians and trusts so that the senior in effect can control how their assets are spent even after they pass. Wills should be prepared even for those who

wish to title their assets to avoid probate as many times property comes into an estate after the estate plan is put in place.

Conclusion

Hopefully, this guide has educated its readers to be vigilant in managing their aging process. The aging in place movement is simply a mindset whereupon if our elders wish to choose their living environment to age, then the health care and personal care agencies as well as our government must accommodate them in this yearning.

However, the benefits of this free choice will come at a cost. Seniors will be expected to contribute financially to the aging in place choice especially if they age at a home they own. A reverse mortgage will become an important consideration for those who choose to age at home for the reasons stated herein and for those seniors with sufficient assets, long-term care insurance may be an appropriate asset protection strategy. .

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Glossary of Terms

Activities of Daily Living (ADLs) – Basic tasks essential for day-to-day functioning, such as bathing, dressing, grooming, eating, and getting in and out of a bed or chair. The inability to perform one or more ADLs usually indicates the need for some type of long term care or supportive housing services.

Adult Day Health Program- Program providing structured supervision, recreation, and health care services during the day to older people.

Alternative Care Provision- Feature required in individual long-term care insurance policies that may cover unspecified treatments or services if agreed to by the insured, the insurer, and the insured' health care practitioner.

Alzheimer's Care- Indicates that the residence has a separate unit that provides specialized care to individuals with Alzheimer's disease or other dementia.

Assisted Living Residence – A housing option for older adults who need some assistance with activities of daily living but do not require 24-hour nursing care.

Benefit Triggers- Term used by insurance companies to describe when the policy will begin to pay benefits.

Care management Services- A service in which a professional, typically a nurse or a social worker, may arrange, monitor, or coordinate long- term care services.

Chore Care – Non-medical services that are provided in the insured's home and are designed to maintain the insured's home so that it remains habitable, including at a minimum, vacuuming, washing floors defrosting freezers, cleaning ovens, cleaning attics and basements, yard work, snow removal and any other activity to keep the elder in a well kept environment.

Cognitive impairment- A deficiency in a person's short or long-term memory, orientation as to person place and time, deductive or abstract reasoning or judgment as it relates to safety awareness.

Community Based Services- Services designed to help older people stay independent and in their homes.

Continuing Care Retirement Community (CCRC)- A residential community for older adults that combines independent retirement housing, assisted living, and nursing facility care, usually on one campus.

Custodial Care (Personal Care)- Care to help individuals meet personal needs such as bathing, dressing, and eating. Custodial care is not medical care and may be provided by someone without professional training.

Daily benefit- The amount of insurance benefit in dollars per day that a person chooses to buy for covered expenses.

Dementia- Deterioration of intellectual faculties due to disorder of the brain.

Elimination Period- A type of deductible. It is the length of time an individual must pay for covered services before the insurance company will begin to pay for the services.

Group Adult Foster Care Provider- Indicates that the residence participates in the Massachusetts Division of Medical Assistance program that pays for some assisted living services for clinically and financially eligible individuals. These individuals often have their room and board expenses covered by SSI-G (See below).

Group Policy- A policy sold through an employment based group, association or special group insurance trust. Individuals receive certificates

of coverage from the group policy. These policies are not subject to most state insurance requirements.

Guaranteed Renewable-Policy feature guaranteeing the insured's right to continue a policy.

Home Health Services- Household services done by someone other than yourself because you're unable to do them; Services include shopping, planning menus, preparing meals, home delivered meals, light house cleaning, vacuuming and other such services.

Home Health Care- Services for occupational, physical, respiratory, speech therapy or nursing care; also included are medical, social worker, and home health aides.

Hospice Care-Services to ease pain of terminally ill individuals provided by an agency or program licensed by the Massachusetts Department Of Public Health or any agency or program meeting the requirements of the state in which hospice services are provided.

Individual policy- A policy sold directly by a company to an individual without requiring the individual to be a member of an employment based group.

Inflation Protection- A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services. Applicants usually have the choice of automatic increases or periodic special offers to increase benefits.

Lapse- Termination of a policy when a renewal premium is not paid.

Medicaid (Mass Health)- a state and federal health insurance providing health care coverage for individuals including the elderly with limited outcomes or have been impoverished by their medical expenses.

Medicare- A federal health insurance program providing health insurance coverage for elders 65 and older and permanently disabled individuals. Medicare Part A provides coverage of inpatient hospital services, skilled nursing facility care, home health services, and hospice care. Medicare part B helps pay for the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.

Medicare Supplement Insurance- A private insurance policy that covers many of the gaps in Medicare coverage.

Nursing Facility- Facility provides 24 hour nursing care, rehabilitative services and assistance and assistance with activities of daily living to chronically ill as well as those who have been hospitalized for an illness or operation and require a short period of rehabilitation before returning home.

Respite Care- Short term care in a furnished apartment usually used to provide relief for family care-givers or enable prospective residents to "try out" an assisted living residence.

SSI-G- A state funded program that pays the room and board expenses of individuals who receive federal Supplemental Social Security Income (SSI) and live in assisted living residences that participate in the State's Group Adult Foster Care Program.

Subsidies- Private funds such as a **trust** fund or endowment or state / federal funding that a residence may have that enables them to rent assisted living apartments at below market rates. Individuals may or may not have to qualify for group adult foster care to be eligible.

The Federally Insured Reverse Mortgage
The home loan that requires no monthly payments

If you own a home and are 62 or older or know someone that is, this may be the answer they have been looking for. It will help improve their quality of life and their financial security and wellbeing and will help provide them with more happiness during their retirement years.

Equity lines of credit and Reverse Mortgages for Seniors

Reverse Mortgages have been helping thousands of senior home owners unleash the power of the equity in their home. It can also, afford them the ability to purchase a smaller home when downsizing, with minimal cash outlay. The program truly provides financial relief and flexibility without the worry of making mortgage payments. Please read further to discover many of the benefits offered to Seniors.

- It allows them to payoff their existing mortgage and forever rid themselves of monthly mortgage debt
- It allow them to supplement their monthly retirement income
- It helps offset rising health care costs and property taxes
- It protect their heirs from Medicaid State Recovery
- It helps them afford home healthcare and assistance
- It provides them with cash to do home repairs and improvements
- It never impacts Social Security income and benefits
- They never owe more than the value of the home
- They never have to give up title or pay taxes on income
- They never have to move or make monthly payments
- It requires no repayment until the house is sold
- NO INCOME and NO CREDIT VERIFICATION is required

I provide mortgage services you can trust and depend on.

I learned a long time ago that there is so much more to the mortgage lending business than crunching numbers and calculating interest rates. It's about helping people realize their dreams… I don't trust my dreams to just anyone, and I wouldn't expect you to either. That's why I'd like an opportunity to demonstrate my knowledge and ability, as well as earn your friendship, trust and referrals…So you can do business with someone who values your dreams as much as you do. Call me today for a free-no obligation consultation.

Jay P. Austin

Licensed Mortgage Professional - Senior Consultant

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The Federally Insured Reverse Mortgage

The home loan that requires no monthly payments.*

Do you know someone 62 or older? Owns a home, and is looking to improve their quality of life?

Reverse Mortgages have been helping thousands of senior home owners unleash the power of the equity in their home. It provides financial relief and flexibility

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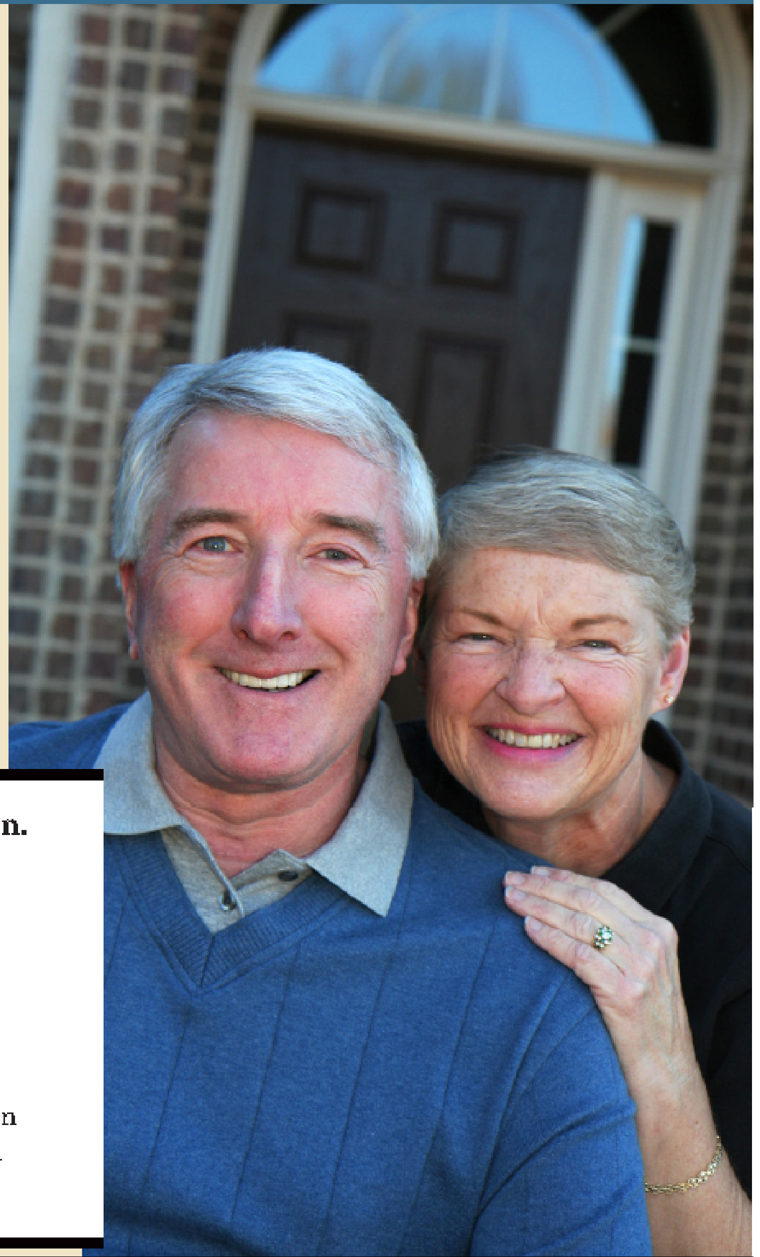
FREE 66 page Senior Planning Guide



Mortgage services you can trust and depend on.

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Introducing Reverse Mortgage...

*The home loan that requires no monthly payments.**

What is a reverse mortgage? A reverse mortgage is a special type of home loan that lets a homeowner convert a portion of the equity in his or her home into cash. The equity built up over years of home mortgage payments can be paid to you. But unlike a traditional home equity loan or second mortgage, no repayment is required until the borrower(s) no longer use(s) the home as their principal residence.

Who qualifies for a reverse mortgage? All owners of the property must be at least 62 years of age and must occupy the home as their principal residence. There are no income, employment or credit qualifying restrictions.

Call now to learn more about reverse mortgages.

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