



Financial and Legal Issues

Preparing for your Future

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Financial and Legal Issues: Planning Your Future
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I. Estate Planning for Disability

A. INTRODUCTION

Everyone should have a plan for the orderly management of financial and medical decision-making in the event of disability or death. This includes both those in their retirement years and those younger working individuals. What follows are some of the tools available to assist you in providing for the proper management of your affairs should you become disabled.

The following are several myths about estate planning that will help you in determining what estate planning documents you need:

1) **Estate Planning is for rich people:** Everyone needs a Will. A Will allows you to designate who will receive your property when you die. If you die without a Will, your assets will be distributed pursuant to the terms of New Jersey laws of “intestate succession.” That means that your money and property could end up with family members you haven’t seen in years rather than a close friend or charity you want to support. A Will doesn’t have to be expensive, and dying without a Will almost guarantees that your estate will be more costly to settle. Additionally, if Congress fails to act, starting in January of 2013, you don’t have to be very “rich” to benefit from some estate planning to avoid the federal estate tax, which will revert to the pre-2001 tax of 55% on all estates over \$1,000,000. Even without the federal estate tax, New Jersey residents are subject to a New Jersey estate tax on assets passing at death in excess of \$675,000. While the rate of New Jersey estate tax is less than 10%, you can avoid or reduce this tax liability by simple estate tax planning within your wills or trusts.

2) **If I die without a will everything will go to my spouse.** This is not necessarily true here in New Jersey and many other states. In NJ if you die without a Will your spouse will receive a portion of your estate but a portion could go directly to your children or even your parents. This can create all sorts of problems.

3) **If I have a Will my estate won’t go through probate.** All wills are subject to probate. In probate the court determines whether the document is valid and ensures that the relatives and creditors are notified of the probate. Here in NJ this is a fairly simple process and while complete settlement of the estate can take six months or more, the actual probate of the will is inexpensive and quick.

4) **After I create my Will or a Living Trust, I am all set.** This is a common misconception and leads to problems later on. You need to review your

estate planning documents at least every 5 years and certainly whenever you have a major life event such as a marriage, death, birth, or other family changes.

5) I could be held responsible for a deceased parent's debts.

In general, children are not responsible for a deceased parent's debts. Even a spouse's obligation to pay the debts may be limited, depending upon the state laws. Surviving spouses should consult with an attorney before paying debts incurred by their deceased spouse. Only the estate is responsible for paying the decedent's debts. If there aren't sufficient assets in the estate to cover the amount owed, the debts usually go unpaid.

B. Last Will and Testament:

Nearly 60% of Americans don't have a basic Will. There are all kinds of reasons for this oversight. Some people just haven't gotten around to creating a Will or Trust. Others think they don't need an estate plan because they don't have much of an estate. Some people fear that as soon as they write a Will, they'll die! In reality, there is no evidence to suggest that creating an estate plan will hasten your demise. This much is certain, though: You are not going to live forever. If you die without an estate plan, you could leave a legacy of bad feelings and avoidable fees and taxes.

C. Trust Agreements:

Trusts are sometimes used in estate planning. There are several kinds of trusts.

1) A Revocable Living Trust is referred to as "revocable" because, as the name implies, it can be revoked in whole or in part during the creator's ("Grantor's") life. Of course, the beneficiaries can be changed during the Grantor's life, although few Grantors make such changes. The term "living" means the Trust was created during the life of the Grantor, as opposed to "at death," as happens with Trust provisions in a Will, which is called a Testamentary Trust. While the Trust does become irrevocable (unchangeable) at the death of the Grantor, there are usually broad grants of power given to the Successor Trustees (the ones who take over after the Grantor's death) to make discretionary distributions to family members for a variety of purposes. If all of your assets have been retitled into the name of the Trust, your estate will not have to go through "probate" although it will still have to be "settled" and taxes will have to be paid as if you owned the assets yourself.

2) An Irrevocable Living Trust cannot be revoked, changed or altered. This means that once an asset is placed in an irrevocable living trust it should stay there and be distributed according to the terms of the trust. Irrevocable Living Trusts, unlike Revocable Living Trusts, can provide estate tax savings for larger estates.

3) Special Needs Trusts are used by families who wish to protect a beneficiary who receives benefits based on their disability as well as their income and resource status. They can be "living" or "testamentary." A Testamentary Trust is one

which does not exist until your will has been probated, and the terms of the trust are set forth in the will. A living trust exists during your lifetime, possibly with limited assets, and then is funded more fully by life insurance or a distribution from your estate.

4) Discretionary Spendthrift Trusts are used to protect a beneficiary from his or her own inability to manage and conserve their resources. Again, this trust can be “Living” or “Testamentary.”

5) A Pour Over Will is used with a Trust, so that any assets which you neglected to retitle into the name of the Trust will be “poured over” into the trust for distribution after your death.

D. Power of Attorney:

The simplest method of substitute management is the use of a Durable Power of Attorney. The principal designates a person, called the agent or attorney-in-fact, to manage financial affairs. Often financial institutions prefer their own form. Because of recent changes in the law, an attorney should be consulted before giving a General Durable Power of Attorney.

E. Joint Ownership:

Joint ownership allows the joint owner to manage the asset in case of incapacity. However, since joint ownership also creates a right of survivorship in the joint owner and a current ownership interest in the joint owner, it should not be used as a tool for management unless a right of survivorship and a current ownership interest are also intended.

F. Health Care Proxy/Living Will:

Just as an individual can name an agent to make financial decisions, he or she is now permitted to appoint an agent to make medical decisions using a Health Care Proxy. An individual may name only one agent, but an alternate agent may be listed. If an individual wishes the agent to make decisions regarding artificial nutrition and hydration, this must be specifically noted. The Health Care Proxy should be the lead document for the orderly management of medical decision-making in the event of disability. The Health Care Proxy empowers the agent to make all medical decisions, including those encompassed in a Living Will. A Living Will is a document that does not appoint an agent, but describes the kind of health care measures an individual would desire if he or she were seriously ill with no reasonable hope of recovery.

G. Guardianship:

If a provision for substituted management of an estate has not been made or you have no one you can trust to appoint as agent under a power of attorney and/or health

care proxy, then when you can no longer manage your estate it may be necessary to seek court appointment of a Guardian.

II. Payment of Long-term Care Costs

Planning for medical expenses associated with long-term care generally involves four sources of payment: Medicare, private insurance, Medicaid and private payment.

A. Medicare

1. Eligibility

Most individuals who have reached the age of 65 are eligible for Medicare coverage. Individuals who have not yet attained the age of 65 are eligible for Medicare coverage if they have been entitled to (but not necessarily receiving) Social Security disability benefits for the past 24 months, or if they have suffered permanent kidney failure and need maintenance dialysis or kidney transplants. Long-term care costs are covered to a very limited extent. There are several parts to Medicare: Parts A (hospitalization), Part B (major medical), Part C (HMOs) and the new Part D (Pharmaceutical coverage).

2. Nursing Home Coverage

a. Medicare provides very limited coverage for Skilled Nursing Facility Care (SNF). Medicare does not cover custodial care in a Nursing Home, only skilled care. In order to qualify for coverage, the patient must have been hospitalized for medically necessary inpatient hospital care for at least three (3) consecutive calendar days (72 hours) for the same condition that is to be treated in the SNF; the patient must be admitted to the Nursing Home and receive the needed care within thirty (30) calendar days after the date of discharge from the hospital; and the patient must require and receive daily skilled care. Nursing or skilled rehabilitation services are the most common qualifying services. Days 1-20 in the SNF are fully covered if the care is qualified as outlined above. Thereafter, for days 21-100 there is a co-insurance payment of \$144.50 (2012).

b. Many services are denied initially by the Nursing Home or by Medicare, but are often approved upon appeal to an Administrative Law Judge. Vigorous advocacy can often obtain up to 100 days of Nursing Home care coverage under the Medicare program.

3. Home Care Coverage

Additionally, Medicare beneficiaries can receive, in theory, an unlimited number of home health care visits without deductibles or co-

insurance if the following conditions are met: the beneficiary requires and receives intermittent nursing, physical, occupational or speech therapy; the beneficiary is homebound; and a physician certifies the need for home health care. Realistically, benefits are usually limited to three days a week for three hours a day or, possibly, five days a week for four hours per day.

B. Private Insurance

1. Medicare Supplemental Insurance - Medigap

Medicare supplemental policies, often referred to as “Medigap” policies, should be purchased by all Medicare recipients. Federal law requires that all “Medigap” policies be one of nine standard options. This simplifies selection of the appropriate policy. You should shop around for the best policies. HMO’s are now offered for seniors. These HMO’s provide comprehensive care, but require that the participants use doctors, hospitals and nursing homes in the HMO network.

2. Long-Term Care Insurance Overview

a. You should also consider Long-Term Care insurance. Long-Term Care policies usually pay for skilled, intermediate and sometimes custodial care in a Nursing Home and may include home care services and assisted living as well. Quality Long-Term Care insurance is a relatively new phenomenon in New York State. All policies should be reviewed by an independent professional, before being purchased.

b. Criteria to look for in a Long-Term Care Policy include the following: The daily benefit should be high enough to pay all or most of the cost of a Nursing Home and should include an inflation rider (in New York City, a person would need benefits of at least \$350 per day or more); the policy should not require prior hospitalization; the policy should cover custodial care and home care; the policy must be renewable for life; premiums should be level and there should be a waiver of premium provision, and the company should have a corporate rating of A+. Most policies have either a maximum benefit amount or a maximum period of coverage, and deductibles are common.

c. Many applicants will be unable to obtain coverage due to age or health. Furthermore, all policies contain limitations and exclusions, such as preexisting condition limitations, deductibles or waiting periods, exclusions for mental illness, intentionally self-inflicted injuries, substance abuse or chemical dependency, etc.

C. Medicaid

1. **Introduction**

Medicaid, a joint Federal and State funded program was established by Federal Law in 1965. It is a needs-based/means-tested program originally conceived as a way to provide health care for the poor. Over the years it has come to be a major payer of Long-term Care, especially Nursing Home Care, costs for the middle class.

2. **Eligibility**

New Jersey Medicaid has two separate programs that cover long term care. The Medicaid Only Program covers long term care needs in the community, through a variety of programs, and in skilled nursing homes. The Medically Needy Program ***only covers nursing home costs and does not provide any coverage for hospital co-payments, day care, home care or assisted living.*** The income and resource tests for these two programs are slightly different. The Medicaid Only Program is only available to individuals with fixed monthly income that does not exceed \$2,094 (2012 figures) and resources that do not exceed \$2,000. The Medically Needy Program is available to individuals whose income is in excess of \$2,094 (2012) and resources not exceeding \$4,000. With the exception of certain exempt resources, for example, the home and automobile, assets in excess of \$2,000/\$4,000 these amounts have to be spent or otherwise be unavailable at the time of application in order for the individual to be eligible for Medicaid. Once eligible for Medicaid the Medicaid recipient is required to contribute all available income in excess of the Medicaid guidelines toward the cost of their care. ***Until July of 2012, the income set asides are:***

- \$ 35/month for personal needs
- \$551.63/month standard shelter allowance for community spouse
- Up to \$2,841.00 for community spouse support

3. **Protection of Spouse**

a. **Treatment of Resources**

The general rule is when one spouse is institutionalized and applies for Medicaid the total value of the assets held by either spouse is computed. Regardless of which spouse holds title to the assets, Medicaid will require the couple to spend down the assets until the spouse who is remaining in the community has no more than the amount the state says the community spouse is allowed to

retain as the Community Spouse Resource Allowance. **For 2012 the Community Spouse Resource Allowance in New Jersey is one-half of combined assets subject to a cap of \$113,640.00 and a floor of \$22,728.00 *This means that the community spouse cannot be left with less than the floor of \$22,728.00 and will not be able to retain more than \$113,640.00 for applications made in 2012.*** The Community Spouse Resource Allowance can be increased if greater resources are needed to generate income equal to the minimum monthly maintenance needs allowance explained below or by court order.

b. Inter-spousal Transfer of Assets

In addition, the law allows unlimited transfers from the institutionalized spouse to the community spouse.

c. Treatment of Income

The Community Spouse is allocated a minimum monthly maintenance needs allowance of \$1,828.75 (until July 2012) and will be allocated the income of the Institutionalized Spouse necessary to bring the Community Spouse's income to this level. In addition to the minimum monthly maintenance needs allowance above the community spouse may be entitled to the Standard Utility allowance or the heating, non-heating and telephone allowances. The Community Spouse's minimum monthly maintenance needs allowance cannot exceed \$1,828.75 unless so ordered by an order of the Court through a Fair Hearing or a Family Court proceeding for support. This amount is adjusted each year for inflation. In addition, there is a family allowance, which can be deducted from the Institutionalized Spouse's monthly income for each dependent family member. If a Community Spouse's income exceeds the allowance of \$2,841.00 he or she is entitled to retain all of his or her income but will not receive any from their institutionalized spouse.

4. Transfer of Assets

a. Inter-spousal Transfers

The Institutionalized Spouse is allowed to transfer resources to the Community Spouse without limit or penalty. (Beware of possible gift and/or estate tax problems with large estates.)

b. Penalty Period

If an institutionalized individual applying for Medicaid his or her spouse disposed of resources for less than fair market value to someone other than their spouse or a disabled child then the Applicant will be ineligible for Medicaid for a period of time, which will be the period of time equal to the uncompensated value of the transfer divided by the “regional rate,” a figure set by Trenton annually. For 2011 this figure is \$7,282. For example, if the applicant transfers an asset with a value of \$60,000 and the regional rate is \$7,282, the applicant would be ineligible for Medicaid for 8.2 months ($\$60,000 \div \$7,282 = 8.24$). The penalty period will not begin to toll until the applicant is otherwise eligible for Medicaid and has applied.

c. Transfer of the Homestead

Transfers of the homestead are treated the same as transfers of other non-exempt assets, even if the homestead was exempt at the time of the transfer, unless the homestead is transferred (1) to the spouse; (2) to a child who is under 21 or certified blind or certified permanently and totally disabled; (3) to a sibling with an equity interest in the home who was residing in the home for at least one year immediately before the date of the institutionalization; or (4) to an adult (non-disabled) child commonly known as the “caretaker child,” who was residing in the home for at least two years immediately prior to the date of institutionalization and who has provided care which permitted the parent to reside in the home rather than in an institution. Transfers of the homestead to one of these individuals will not result in any period of ineligibility for Medicaid. However, a professional should be consulted to analyze the effects of such a transfer on any future estate/gift tax planning.

D. Private Payment of Long-Term Care

1. If you are paying privately for long-term care, be aware of the potential for large medical deductions. Skilled nursing homes should be totally deductible since the primary purpose is medical. Home care, day care and assisted living may be partially or totally deductible, depending on the services provided. These deductions may allow income tax planning by offsetting income, especially withdrawals from IRA or other similar plans.

2. Also note that if the estate is in excess of \$5,000,000, payment of long-term care costs from principal will reduce the estate. Because Federal Estate taxes will take a percentage of every dollar over \$5,000,000 it may be

determined that private pay with full utilization of any tax benefits is a preferable alternative to Medicaid planning. In 2013, if Congress does not act, the estate tax threshold will be lowered to \$1,000,000.

3. Continuing Care Retirement Communities, or CCRCs as they are commonly known, offer residents a combination of housing, services, amenities and care in return for a monthly fee and, in many cases an entrance fee. CCRCs focus on the physical, social and emotional well-being of residents by promoting a vibrant lifestyle in a community setting. At the same time, CCRCs offer services such as assisted living, memory support care and skilled nursing care on site, so that residents may continue to stay within the same community, close to their spouse, friends and neighbors, even as their care needs change.

WARNING:

THIS INFORMATION IS CORRECT AS OF

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These materials are purely informational and not intended as legal advice. Please consult a Certified Elder Law Attorney to determine how this information might apply to your particular situation.