Healthcare Planning

Table of Contents

Important Notice

This report is intended to serve as a basis for further discussion with your other professional advisors. Although great effort has been taken to provide accurate numbers and explanations, the information in this report should not be relied upon for preparing tax returns or making investment decisions.

Assumed rates of return are not in any way to be taken as guaranteed projections of actual returns from any recommended investment opportunity. The actual application of some of these concepts may be the practice of law and is the proper responsibility of your attorney.

Health Care Planning In Retirement

Health care planning is a key part of the overall retirement planning process. Although a healthy life-style and good genes can help, it is a fact of life that as we age we need more medical care. Federal government statistics highlight this reality:

Per-Capita U.S. Personal Health Care Spending[1]

Age Group	2004	2006	2008	2010	2012
0-18	$2,398	$2,747	$3,032	$3,300	$3,552
19-44	3,193	3,576	3,908	4,156	4,458
45-64	7,218	7,922	8,456	9,000	9,513
65-84	13,509	14,623	15,776	16,425	16,872
85+	26,339	28,521	30,827	31,903	32,411

Medicare

There are a number of ways that retired individuals pay for health care. Some are able to pay cash. Others are covered by health insurance plans provided by former employers or under coverage available through a spouse who is still working. For the majority of Americans age 65 and older, however, most health care is provided through the various elements of the federal government's Medicare program:

- **Medicare Part "A" Hospital Insurance:** Provides coverage for inpatient hospital care, post-hospital skilled nursing facility care, home health care, and hospice care.
- **Medicare Part "B" Medical Insurance:** Includes coverage for doctor's services and outpatient care as well as some preventive services to maintain your health or prevent certain illnesses from getting worse.
- **Medicare Part "C" Medicare Advantage Plans:** An alternative to the "classic" Medicare program. Under Medicare Advantage, health care is provided by private companies approved by Medicare. These plans include Part A and Part B and usually provide other coverage, including prescription drugs.

[1] Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Total Personal Health-Care Per-Capita Spending by Gender and Age Group, Calendar Years 2002, 2004, 2006, 2008, 2010, 2012 Level (dollars).

- **Medicare Part "D" Prescription Drug Coverage:** Helps cover the cost of prescription medications.

Medicare Supplement Insurance (Medigap) Policies

The original Medicare program will pay for many, but not all, health care services and supplies. Many retirees will also consider purchasing a "Medigap" policy, sold by private insurance companies, to help pay some of the health care costs (the "gaps") that the original Medicare program does not cover, including copayments, coinsurance, and deductibles.

Medigap policies provide standardized coverage (in most states identified by the letters A, B, C, D, F, G, K, L, M, and N)[1] and must follow federal and state laws designed to protect the consumer. Each standardized Medigap policy must provide the same basic coverage; cost is frequently the only difference between the same Medigap policy sold by different insurance companies. In some states, another type of Medigap policy, called Medicare SELECT, may be available. Medicare SELECT policies typically require you to use specific hospitals or doctors.

Planning For Incapacity

Retirement health care planning must also consider "incapacity." Major health problems such as a stroke, a heart attack, the onset of Alzheimer's disease or other forms of dementia, or simply becoming weak and frail from advancing age can result in your no longer being able to care for yourself or manage your own affairs. There are two key issues to consider:

- **Paying for "custodial" care:** Medicare and other types of health care insurance are designed to cover "acute" medical conditions. They do not pay for costs associated with "custodial" or "maintenance" care, such as might be needed by an individual whose health problems require nursing home care. With median U.S. nursing home costs for a semi-private room in 2018 of $245 per day ($89,425 per year),[2] the cost of such custodial care for even a short period of time can be enormous.

  Rather than pay these costs "out-of-pocket," many individuals purchase a Long-Term Care (LTC) insurance policy. For individuals without LTC insurance coverage, the jointly-run, federal-state Medicaid program may be able to pay for custodial care, once personal assets are exhausted.

[1] In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

[2] See the Genworth 2018 Cost of Care Survey, page 2.

- **Managing personal affairs:** If an individual is no longer able to manage his or her personal affairs, someone else will need to step in and take over. In planning for this possibility, three key documents should be considered:
  - **Durable power of attorney:** A written document by which one person (the principal) empowers another person (the agent or attorney-in-fact) to act in his or her behalf; often used for management of financial affairs.
  - **Living Will:** Also known as a "Directive to Physicians", this document provides guidance as to the type of medical treatment to be provided (or withheld) and the general circumstances under which the directive applies.
  - **Durable power of attorney for health care:** Many states have laws allowing a person to appoint someone to make health care decisions for them if they become unable to do so themselves.

Seek Professional Guidance

Planning for health care and incapacity in retirement involves answering a number of complex questions. The guidance of trained professionals in insurance, medical benefits, as well as the counsel of an estate planning attorney, can be invaluable in designing and implementing an effective health care plan.

Medicaid

Medicaid is a jointly-funded, federal-state welfare program which provides medical care to individuals and families with very low resources and income. Each state administers its own program and, within guidelines set by the federal government, establishes its own rules regarding program eligibility and the type, duration, and scope of services provided.

Qualifying For Medicaid

Just being poor is no guarantee that an individual will qualify to receive Medicaid. An individual must belong to one of several specified groups as well as meet certain income and asset limitation tests.

To qualify for federal funds, states must provide care for certain, targeted populations. Included in the mandatory category are persons receiving federally assisted income maintenance payments, such as Supplemental Security Income (SSI), or Aid to Families With Dependent Children (AFDC).

A state may choose to provide healthcare services to certain "categorically needy" populations, individuals and families whose financial situation is similar to those in the mandatory group, but with different qualifying criteria. Medicaid benefits may also be offered to "medically needy" persons, those with incomes too high to qualify under any other category. Such individuals can "spend down" their excess income by incurring medical and/or remedial care expenses, reducing the excess income to a level below the maximum allowed under the state's plan.

What Medical Services Are Provided?

A wide range of services is provided to Medicaid beneficiaries. Some services are mandatory under federal rules, while others are optional. Provided services can include:

- Inpatient hospital services.
- Outpatient hospital services.
- Nursing facility services for beneficiaries age 21 and older.
- Prenatal and delivery services as well as postpartum care.
- Physicians' services and medical and surgical services of a dentist.

- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21, including vaccines.
- Payment of Medicare premiums (Part A and/or Part B) for certain needy elderly or disabled individuals.
- Long-term care (LTC).

Resource and Income Limitations

Generally, a single individual cannot have more than $2,000 in assets and still qualify for Medicaid. In this calculation, certain assets are "exempt" and are not counted:

Asset	Observation
Personal residence	Generally, with no more than $585,000 of equity. A state may raise this limit to $878,000.
Cash value life insurance	With a face value of up to $1,500.
Household goods, personal effects	Furniture, appliances, artwork, clothing, jewelry.
Automobile	One car, generally limited to a value of $4,500.
Burial funds	Generally limited to $1,500.
Burial space	Burial plot, grave marker, urn, crypt, mausoleum.
Business assets	Property employed in a trade or business, if essential to self-support.
Jointly owned residence	Exempt if other resident owners would be forced to move if property were sold.

Those applying for Medicaid must also meet certain monthly income limitations, which vary by state. These income limitations generally change from year to year.

Transferring Assets To Qualify For Medicaid

Some individuals, often those needing expensive nursing home care, will attempt to meet Medicaid's asset limitations by gifting or otherwise transferring assets to others for less than

fair market value. However, such transfers can result in a delay in benefit eligibility if made within a "look-back" period of 60 months before the application date.[1]

To avoid a period of ineligibility, an individual who anticipates needing care can either (1) transfer assets more than 60 months before applying for Medicaid benefits; or, (2) keep enough assets to pay for needed care for 60 months, transfer the remainder, and not apply for Medicaid benefits until 60 months have elapsed after the last transfer.

The period of ineligibility is generally determined by dividing the value of the assets transferred by the average monthly cost of nursing home care to a private patient in the local community. Ineligibility begins on the later of: (1) the date of the gift or transfer; or, (2) the date the individual would otherwise have qualified to receive Medicaid benefits.[2]

> Example: George lives in a state where the average monthly cost of nursing home care is $6,000 per month. If he transfers property worth $120,000, he will be ineligible for Medicaid benefits for 20 months ($120,000 ÷ $6,000 = 20).

Annuities

The purchase of a commercial annuity is considered in the same light as a gift or transfer of assets for less than fair market value, unless certain requirements are met. In general, an annuity is not counted as an asset if it is: (1) irrevocable; (2) non-transferrable; (3) actuarially sound, compared to the beneficiary's life expectancy; and; (4) provides for equal payments during the annuity's term.

Additionally, there can be no payment deferral or balloon payments and the state must be named as the primary remainder beneficiary (in some cases the secondary remainder beneficiary) for the amounts paid by Medicaid for the beneficiary's care.[3]

[1] Under federal rules, some transfers, such as those made for the benefit of a spouse, a blind or disabled child, or a disabled individual under age 65, will not trigger a period of benefit ineligibility.

[2] Under the Deficit Reduction Act of 2005, the 60 month look-back period applies to transfers made on or after February 8, 2006. For transfers before that date, a 36 month look-back period generally applied (60 months in the case of certain trusts).

[3] Annuities purchased before February 8, 2006, the effective date of the Deficit Reduction Act of 2005, were subject to individual state rules.

Trusts

If an individual, or his or her spouse, or anyone acting on the individual's behalf, establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for determining Medicaid eligibility.

In general, payments actually made to or for the benefit of the individual are treated as income to the individual. Amounts that could be paid to or for the benefit of the individual, but are not, are treated as available resources. Amounts that could be paid to or for the benefit of the individual, but are paid to someone else, are treated as transfers for less than fair market value. Amounts that cannot, in any way, be paid to or for the benefit of the individual are also treated as transfers for less than fair market value.[1]

Certain trusts, for disabled or institutionalized individuals, are not counted as being available to the individual. These trusts must provide that the state receives any funds, up to the amount of Medicaid benefits paid on behalf of the individual, remaining in the trust when the individual dies.

Spousal Impoverishment

The high cost of nursing home care can rapidly exhaust the savings of almost anyone. Because of this, Congress has enacted laws to prevent what has been called "spousal impoverishment," which can leave the spouse who is still living at home (the "community spouse") with little or no income or resources. These provisions help ensure that the community spouse will be able to live out his or her life with independence and dignity. These spousal impoverishment rules apply when one member of a couple enters a nursing home or other medical institution and is expected to remain there for at least 30 days.

When the couple applies for Medicaid, an assessment of their combined (regardless of ownership) resources is made. The couple's home, household goods, an auto, and burial funds are not included in the accounting. The result is the couple's combined countable resources. This total is then used to determine a "Protected Resource Amount" (PRA) for the community spouse.[2] After the PRA is subtracted from the couple's combined resources, the

[1] Transfers from trusts for less than fair market value are subject to the same 60-month "look-back" period applicable to other transfers.

[2] The PRA may also be determined by either a court order or by a state hearing officer.

remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the state's resource standard, the individual is eligible for Medicaid.

The community spouse's income is not considered available to the spouse who is in the medical facility and the two individuals are not considered a couple for income eligibility purposes. The state uses the income eligibility standard for one person rather than two. If most of the couple's income is in the name of the institutionalized spouse, and the community spouse has insufficient income in his or her own right to live on, a separate calculation is made which allocates a portion of the institutionalized spouse's income to support the community spouse and any other family members living in the household.

Estate Recovery

When a Medicaid beneficiary dies, federal law requires the states to seek recovery of amounts paid by the state for many of the services provided to Medicaid beneficiaries, unless undue hardship would result. Generally, recovery is made from property held in the beneficiary's name only. Some states may seek also recovery from a life estate, assets held in a revocable "living" trust, or jointly held assets. Assets that pass to a surviving spouse are exempt from recovery as long as that spouse is alive.

Long-Term Care Partnership

In a Long-Term Care Partnership, a state government and private health insurers work together to make available to residents of that state LTC insurance policies that are "linked" to Medicaid. If a buyer of a partnership LTC policy later faces long-term care needs that exceed the policy's limits, he or she may apply for assistance from the state's Medicaid program under more relaxed eligibility rules. In what is termed an "asset disregard," the policy owner may keep a larger amount of assets than would normally be allowed under standard Medicaid rules. These relaxed eligibility rules apply only to the amount of assets than an individual can retain; all other normal Medicaid eligibility requirements apply.

Patient Protection and Affordable Care Act (PPACA)

Beginning in 2014, PPACA expanded eligibility for Medicaid to individuals not currently eligible for Medicare (generally, individuals under age 65). This expansion embraced

children, pregnant women, and adults without dependent children, with incomes up to 133% of the federal poverty level (FPL). Coverage is provided through an essential health benefits package purchased through a state's American Health Benefits Exchange.

Seek Professional Guidance

Qualifying for Medicaid services requires meeting complex legal and regulatory requirements. The guidance of trained financial professionals is highly recommended.

See the general information made available by the federal government's Centers for Medicare and Medicaid Services at: http://www.medicaid.gov/.

Long-Term Care

Long-term care (LTC) is the term used to describe a variety of services in the area of health, personal care, and social needs of persons who are chronically disabled, ill or infirm. Depending on the needs of the individual, long-term care may include services such as nursing home care, assisted living, home health care, or adult day care.

Who Needs Long-Term Care?

The need for long-term care is generally defined by an individual's inability to perform the normal activities of daily living (ADL) such as bathing, dressing, eating, toileting, continence, and moving around. Conditions such as AIDS, spinal cord or head injuries, stroke, mental illness, Alzheimer's disease or other forms of dementia, or physical weakness and frailty due to advancing age can all result in the need for long-term care.

While the need for long-term care can occur at any age, older individuals are the typical recipients of such care.

Individuals with Disabilities, by Age[1]

Age Range	No Disability	With a Disability
5-17 Years	95%	5%
18-34 Years	94%	6%
35-64 Years	87%	13%
65-74 Years	75%	25%
75 Years and over	51%	49%

What Is The Cost of Long-Term Care?

Apart from the unpaid services of family and friends, long-term care is expensive. The following table lists national average costs (regional costs can vary widely) for typical long-term care services. One federal government study found that the "average length of time since admission for all current nursing home residents was 835 days."[2]

[1] Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates, Sex by Age by Disability Status for the Civilian noninstitutionalized population, male and female.

[2] The National Nursing Home Survey: 2004 Overview. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Service	2018[1]
Assisted living facility	$4,000 per month ($48,000 per year)
Nursing home (Private room)	$267 per day ($97,455 per year)
Nursing home (Semi-private room)	$235 per day ($85,775 per year)
Home health aide	$22 per hour
Homemaker/companion	$21 per hour

Paying for Long-Term Care – Personal Resources

Much long-term care is paid for from personal resources:

- Out-of-Pocket: Expenses paid from personal savings and investments.
- Reverse Mortgage: Certain homeowners may qualify for a reverse mortgage, allowing them to tap the equity in the home while retaining ownership.
- Accelerated Death Benefits: Certain life insurance policies provide for "accelerated death benefits" (also known as a living benefit) if the insured becomes terminally or chronically ill.
- Private Health Insurance: Some private health insurance policies cover a limited period of at-home or nursing home care, usually related to a covered illness or injury.
- Long-Term Care Insurance: Private insurance designed to pay for long-term care services, at home or in an institution, either skilled or unskilled. Benefits will vary from policy to policy.

Paying for Long-Term Care – Government Resources

Long-term care that is paid for by government comes from two primary sources:

- Medicare: Medicare is a health insurance program operated by the federal government. Benefits are available to qualifying individuals age 65 and older, certain disabled individuals under age 65, and those suffering from end-stage renal disease. A limited amount of nursing home care is available under Medicare Part A, Hospital

[1] Source: Genworth 2018 Cost of Care Survey.

Insurance. An unlimited amount of home health care is also available, if made under a physician's treatment plan.

- Medicaid: Medicaid is a welfare program funded by both federal and state governments, designed to provide health care for the truly impoverished. Eligibility for benefits under Medicaid is typically based on an individual's income and assets; eligibility rules vary by state.

In the past, some individuals have attempted to artificially qualify themselves for Medicaid by gifting or otherwise disposing of assets for less than fair market value. Sometimes known as "Medicaid spend-down", this strategy has been the subject of legislation such as the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Among other restrictions, OBRA '93 provided that gifts of assets within 36 months (60 months for certain trusts) before applying for Medicaid could delay benefit eligibility.

The Deficit Reduction Act of 2005 (DRA) further tightened the requirements to qualify for Medicaid by extending the "look-back" period for all gifts from 36 to 60 months. Under this law, the beginning of the ineligibility (or penalty) period was generally changed to the later of: (1) the date of the gift; or, (2) the date the individual would otherwise have qualified to receive Medicaid benefits. This legislation also clarified certain "spousal impoverishment" rules, while making it more difficult to use certain types of annuities as a means of transferring assets for less than fair market value.

Advance Health Care Directives

End-of-Life Decision Making

Modern medicine can now keep a person alive in situations that, in years past, would have resulted in the individual's death. Frequently, a patient in such a condition is unable to communicate his or her wishes with regard to the type of medical care to be provided. In the absence of any other guidance, the attending physician will typically use all available means to keep the individual alive, even when death is certain, with no hope of recovery.

However, many individuals feel that once death is inevitable, life should not be artificially prolonged through the use of such technology. The decision to start or withdraw such life-sustaining support, although always difficult, can be made easier with advance planning.

The term "advance health care directives" is commonly used to describe two key documents (sometimes combined into one) designed to address these end-of-life decisions:

- Living Will.
- Durable Power of Attorney for Health Care.

Individual state law governs the use of these documents, and such legislation can vary widely. Individuals who live in more than one state may need to execute a living will and a durable power of attorney for health care for each state.

Living Will

A living will, also known as a "directive to physicians," is a written statement of the individual's health care wishes should he or she become seriously ill and unable to communicate. The document is designed to provide guidance to someone else appointed to make health care decisions for the individual, or to the attending physician if there is no health care agent. A living will might include:

- Directions as to pain medication.
- Directions as to when to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care, including cardiopulmonary resuscitation.

- A discussion of any religious beliefs that might impact medical treatment.
- Instructions for funeral and burial services.

Because it is impossible to foresee the future, the living will should be written in the broadest possible manner, to cover a wide range of situations.

Durable Power of Attorney for Health Care

In a durable power of attorney for health care, sometimes known as a "health care proxy," an individual (the principal) appoints another person (the agent) to make health care decisions if the principal is incapable of doing so.[1] A durable power of attorney may employ a "springing" power, which means that the power "springs" into life when the principal becomes incapacitated.[2] Additional powers granted to the agent could include:

- Access to medical records.
- Authority to transfer the principal to another facility or to another state.
- Ability to authorize a "Do Not Resuscitate" (DNR) order.
- Postmortem powers to dispose of the remains, to authorize an autopsy, or to donate all or part of the principal's body for transplant, education, or research purposes.

Other Points

- **Talk about the issues:** the individual should spend time talking with family, friends, clergy, and physician about his or her wishes in end-of-life decisions.
- **Make the documents available:** if a living will and/or a durable power of attorney exist, be sure that those involved know where to locate the documents.

[1] Many states have provision in their laws for the appointment of a surrogate such as a spouse, domestic partner, or other close family member to make health care decisions for the principal, in situations where no durable power of attorney for health care exists.

[2] Under the Health Insurance Portability and Accountability Act (HIPAA), a physician is prohibited from discussing a patient's medical condition without the patient's consent. Thus, if an individual becomes incapacitated, the person named as agent under a durable power of attorney for health care may not have access to the principal's health-care information. Without this information, the agent would be unable to legally establish that the principal had become incapacitated, and would not be able to trigger any "springing" power. A HIPPA authorization can be used to give the agent access to the principal's health-care information.

- **Revocation:** an individual can generally revoke a living will or durable power of attorney at any time.

Additional Resources

Non-profit organizations such as the following provide support and education on end-of-life issues:

- **National Hospice and Palliative Care Organization:** (703) 837-1500; on the internet at: www.nhpco.org

Seek Professional Guidance

The counsel and guidance of legal, religious, and medical professionals is essential to the successful preparation of advance health care directives.

Record of Reports

3/28/2019 8:46 PM Coordinated Universal Time

Client Name: _____ Presentation Date: _____