

FINANCING NURSING HOME CARE IN NEW JERSEY

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1. INTRODUCTION

Statistics show that approximately 43 percent of the population age 65 will spend time in a nursing home. Some will be there for relatively short periods of time. These are usually stroke victims who are doing rehabilitation. A significant percentage will remain in a nursing home for an extended period of time. These are usually Alzheimer's or Parkinson's patients.

A statistic widely quoted is that the average stay in a nursing home is 2.9 years. This statistic is somewhat misleading, because the persons receiving rehabilitation are often discharged in six months or less. The long-term patients may stay in the nursing home for many years.

Unfortunately, as the population ages, the cost of health care is increasing, and government entitlement programs are being cut back. The median cost of a nursing home in New Jersey today is closing in on \$100,000 per year. Some nursing homes are slightly less, and some are significantly more.

There are five sources for nursing home payment. They are: private pay, nursing home insurance, Medicaid, Medicare, and Veterans Administration.

2. MEDICAID

2.1. Administration

This is a program administered by the states and funded by both federal and state governments. Rules vary from state to state. In New Jersey, Medicaid is administered by the County Welfare Boards. Medicaid pays for nursing home care for eligible individuals.

2.2. Eligibility

2.2.1. Citizenship and Residency

Must be a U.S. Citizen or resident alien and a resident of New Jersey.¹ An individual is not allowed to enter New Jersey solely in order to receive Medicaid.²

2.2.2. Categorical

Must be 65 years of age or older³ unless blind or disabled.⁴ "Blindness" means visual acuity of 20/200 or less in the better eye with use of a correcting lens.⁵ "Disability" is defined as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment, which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.⁶

2.2.3. Medical Eligibility

Must also be eligible from a medical standpoint. This is done by a Medicaid nurse completing a necessary form stating the diagnosis, medication, etc.

2.2.4. Income

2.2.4.1. Cap

New Jersey has two Medicaid programs. If the institutionalized person's income exceeds \$1,737 per month during 2005, that person goes on a "Medically Needy" Medicaid program.⁷ Persons whose income is \$1,737 per month or less have the option to elect Medically Needy or Medicaid Only. There are a number of differences. For example, in Medically Needy, the institutionalized person is permitted to retain \$4,000 of assets, but has no in-patient hospital care under Medicaid. Under Medicaid Only, the person can retain only \$2,000 of resources⁸, but receives in-patient hospital care.

2.2.4.2. Types

All types of income are counted including wages, social security, pensions and annuities, alimony, interest and dividends.⁹

2.2.4.3. Name on Instrument Rule

The name on instrument rule applies in determining to whom income belongs. If there is a joint "and" account, income is deemed to belong one-half to each. If it is a joint "or" account, Medicaid takes the position that the entire account belongs to the applicant.¹⁰

2.3. Minimum Monthly Maintenance Needs Allowance

Medicaid Regulations provide for a Minimum Monthly Maintenance Needs Allowance which is composed of \$1,604 per month adjusted annually on July 1 of each calendar year, plus the community spouse's expenses for rent, mortgage, taxes, insurance and certain utilities in excess of \$481 per month. These figures are for the period July 1, 2005 through June 30, 2006.¹¹ The maximum MMMNA is \$2,377.50 in 2005.

2.4 Resources

2.4.1. Cap

Resources cannot exceed \$2,000 under Medicaid Only,¹² or \$4,000 under Medically Needy.¹³

2.4.2. Excluded Resources

2.4.2.1. Home

The primary residence and lot are excluded if occupied by the institutionalized person or the community spouse. Absence of more than six months creates a presumption that the home no longer serves as the principal residence.¹⁴

2.4.2.2. Automobile

One automobile is exempt.¹⁵

2.4.2.3. Personal Effects and Household Goods¹⁶

2.4.2.4. Wedding Ring and Engagement Ring¹⁷

2.4.2.5. Medical Equipment

Needed by an institutionalized person or a member of his household.¹⁸

2.4.2.6. Burial Fund

A prepaid funeral is permitted provided the funeral director places the payment in an irrevocable trust for this purpose or, provided that a life insurance policy is irrevocably assigned to the funeral director.¹⁹

2.4.2.7. Inaccessible Resources

Resources which cannot be liquidated are considered inaccessible resources.²⁰

2.4.2.8. Term Life Insurance²¹

Term life insurance is not countable since it has no cash value.

2.4.2.9. Whole Life Insurance with a maximum face of \$1,500²²

2.5. Pooling

Resources owned individually by the institutionalized spouse and the community spouse or owned jointly by the institutionalized spouse and the community spouse are pooled together to determine Medicaid eligibility. However, this rule does not apply to a spouse who entered a nursing home prior to September 30, 1989.²³ Transfers between such spouses, are permitted without resulting in any period of ineligibility.-

2.6. Transfer of Resources

2.6.1. Look-Back Rule

There is a 36-month look-back for transfers to individuals and a 60-month lookback for transfers to trusts.²⁴ This means that the disposal of resources, for less than fair market value, in the 36/60-month period prior to the month of application must be reported at the time of the Medicaid application. Transfers made beyond the look-back period are not penalized. Transfers within the look-back period are penalized.

2.6.2. Penalty

2.6.2.1. Transfer Penalty

To calculate the penalty, divide the amount of the transfer by the average cost of nursing home care in New Jersey, currently \$6,304.²⁵ By administrative rule in New Jersey, the penalty is applied only for whole months. The penalty is imposed commencing with the first month of the transfer. The penalty is the period for which the institutionalized spouse would be ineligible for Medicaid. Under federal law, the penalty is unlimited.²⁶

2.6.2.2. Transfers by Community Spouse

Transfers by the community spouse are also subject to the same penalty as transfers by the institutionalized individual.

Exemptions from the transfer penalties period are:²⁷

- (1) Transfer to the community spouse or for the sole benefit of the community spouse.
- (2) Transfers to a blind or disabled child or for the sole benefit of a blind or disabled child.
- (3) Transfer of a principal residence to:
 - (a) Community spouse.
 - (b) Child under 21, blind or disabled.

- (c) Child who is residing in the house for at least two years, and who had provided care for the parent, allowing the parent to stay at home.
- (d) Sibling who also has an ownership interest in the house, and who is residing in the house for at least one year.

2.6.3. Criminalization

Federal law provides²⁸ provides that any person who “for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under Title XIX,” has committed a criminal offense, “if disposing of the assets results in the imposition of a period of ineligibility for such assistance under Section 1917c.” Clearly, the advisor is the person guilty of a criminal offense, but the family acting on the advice would be guilty as aiders and abettors.

The Congressional Research Service in a letter dated July 11, 1997 to Senator Jack Reed has opined that the provision is unenforceable as an unconstitutional infringement of free speech.

In any event, the language is similar to language contained in Section 217 of the Health Insurance Portability and Accountability Act of 1996. The key language is “results in the imposition of a period of ineligibility.” In the case of *Peebler and Nay v. Reno*,²⁹ the Attorney General agreed that there was no criminal offense so long as the application for Medicaid was not filed during a period of ineligibility. In an Advisory Opinion dated August 8, 1997 addressed to Margaret A. Peebler and Tim Nay, known as Advisory Opinion 97-3, the Department of Health and Human Services advised that so long as the application for Medicaid is not filed during the period of ineligibility, there is no criminal offense.

In a U.S. District Court case, *New York State Bar Association v. Janet Reno, et al*,³⁰ the Court granted a permanent injunction against the enforcement of 42 U.S.C. 1320a-7b(a) on the grounds that it was an unconstitutional infringement of free speech. There is a risk that an effort may be made to enforce this statute in the future.

2.7. Community Spouse Resource Allowance

This guarantees the community spouse a minimum amount of resources without affecting the institutionalized spouse's Medicaid eligibility. For 2005, this is the greater of \$19,020 or one-half of the couple's non-exempt resources not to exceed \$95,100. These figures are adjusted on January 1 of each calendar year.³¹

2.8. Snapshot

The determination of a couple's resources is made at the time the institutionalized person enters the nursing home, or at the time of the Medicaid application, whichever first occurs. This determination is used to establish the Community Spouse Resource Allowance.³²

2.9. Taxation

In doing Medicaid planning, income tax, gift tax and estate tax consequences need to be considered, including medical deductions, personal dependent exemptions, carry-over basis, and step-up in basis.

2.9.1. Income Tax

2.9.1.1. Medical Deduction

The IRS permits an income tax deduction for medical expenses. Medical expenses include qualified long-term care services.³³ Qualified long-term care services are defined in the tax code³⁴ as “necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and personal care services, which: (a) are required by a chronically-ill individual, and (b) are provided pursuant to a plan of care prescribed by licensed health care practitioner.” A chronically-ill individual is a person certified by a licensed

health care provider as being unable to perform two activities of daily living for a period of at least 90 days. The activities of daily living are defined to mean “eating, toileting, transferring, bathing, dressing and continence.” The Conference Report notes “It is intended that an individual who is physically able, but has a cognitive impairment such as Alzheimer's disease, or other form of irreversible loss of mental capacity, be treated similarly to a person who is unable to perform at least two activities of daily living.”

A taxpayer can claim an itemized deduction for unreimbursed medical expenses to the extent such expenses exceed 7.5 percent of adjusted gross income. Qualified long-term care services, insurance premiums and other eligible medical expenses may be aggregated.

Except for insulin, expenditures for medicine and drugs are deductible only if prescribed by a physician.

Capital expenditures are deductible if they are medically necessary and represent an unrecoverable sunk cost. To the extent the purchase increases the value of an asset, the expenditure is non-deductible regardless of the degree of medical need. The IRS has published a list of home modifications that are deemed not to add to a home's value.³⁵

Personal care services are tax deductible, if provided pursuant to a plan of care prescribed by a licensed health care practitioner (i.e., physician, registered nurse, geriatric care manager). Expense must be primarily related to needed assistance with any of the disabilities for which the individual qualified as chronically ill or cognitively impaired. Examples include expenses related to a patient's dressing, grooming and bathing, if an individual is unable to perform those functions without assistance. There is no deduction for what might be termed “maid” services. These include cooking and general cleaning.

Payments for qualified long-term care services provided by an individual do not qualify as paid-for medical care if the service is provided by the spouse of the individual or by a relative, unless the service provider is a licensed professional with respect to the service.

2.9.1.2. Personal Dependent

If a person pays for more than 50 percent of the support of a relative, and the relative in calendar year 2005 has less than \$3,200 of gross income for the year and has not filed a joint return with his or her spouse, then the person paying the support may claim the relative as a dependent on the person's federal income tax return. For purposes of calculating the 50 percent requirement, tax-exempt interest income, disability income and Social Security income, of the relative is counted. However, for purposes of calculating the \$3,200 of gross income, tax-exempt interest income, disability income and Social Security income are not counted. If a person claims a relative as a personal exemption, the relative must not file a joint return.³⁶

For taxable years beginning in 2005, the personal exemption amount begins to phase out at, and is completely phased out after, the following adjusted gross income amounts.

Filing Status	AGI - Beginning of Phase Out	AGI Exemption - Fully Phased Out
Married Individual Filing Joint Returns and Surviving Spouses (§1(a))	\$218,950	\$341,450
Heads of Household (§1(b))	\$182,450	\$304,950
Unmarried Individuals (other than Surviving Spouses and Heads of Household) (§1(c))	\$145,950	\$268,450

Married Individuals Filings	\$109,475	\$170,725
Separate Returns (§1(d))		

2.9.1.3. Medical Deduction - Relative

Under the Federal tax code³⁷ a person can claim a medical deduction for medical expenses paid on behalf of a relative, if the person provided over half of the relative's total support for the calendar year. The person can deduct the medical expense of the relative, even if the person cannot claim the personal dependent exemption because the relative received \$3,200 or more of gross income in calendar year 2005.

A relative is defined³⁸ as “a child or descendant of a child; stepchild; brother, sister, by whole or half-blood; stepbrother, stepsister; father, mother or ancestor of either (grandparent, great-grandparent, etc.); stepfather, stepmother; nephew, niece; brother or sister of father or mother (uncle, aunt); brother-, sister-, father-, mother-, son-, or daughter-in-law.”

The taxpayer claiming the exemption must, in combination with other taxpayers (i.e., children), provide more than half of the support of the dependent individual for the calendar year. The taxpayer claiming the dependent must have individually provided more than 10 percent of the individual's support. The taxpayer must sign a Multiple Support Agreement Form 2120 if:

- (1) The taxpayer provided less than half of the dependent's support for the calendar year; but
- (2) The group provided more than half of the support; and
- (3) No one person furnished more than half of that support; and
- (4) The taxpayer contributed more than 10 percent of the support; and
- (5) Each person in the group contributed more than 10 percent signs a written declaration (Form 2120 can be used) that he/she won't claim that individual as a dependent for any tax year beginning in the calendar year.³⁹

All of the declarations must be attached to the return of the taxpayer claiming the dependency deduction.⁴⁰

2.9.1.4. Dependent Care Credit

This is available to a child on behalf of a dependent parent although the parent has more than \$3,200 of gross income in calendar year 2005. However, the parent must be physically or mentally incapable of providing self-care (i.e., cannot provide for his or her own hygiene or nutritional needs, or needs the full-time attention of another person for the parent's safety or the safety of another. The purpose of the credit is to reimburse for care expenses related to the taxpayer leaving home to take employment. Taxpayers are usually better off taking the care expenses as a medical expense deduction.

2.9.1.5. Carryover Basis

In determining which assets to transfer and which assets to retain, consideration must be given to the fact that the donee of a gift receives a “carryover basis.”⁴¹ This means that the cost basis of the donee is the same as the cost basis of the donor. Therefore, when the transferred assets are sold, the donee must pay capital gains tax. The best strategy is, usually, to transfer unappreciated assets to the donee, and reserve appreciated assets for the donor. That way, any gain on the sale of the appreciated assets can be offset by deducting the cost of the nursing home from income tax.

2.9.1.6. Step Up in Basis

Assets forming a part of the estate of a decedent are included in that person's estate for federal estate tax purposes. The beneficiary of the estate receives a "step up" in basis with respect to those assets so that the beneficiary's new basis is the fair market value of the assets as of the date of the death of the decedent.⁴² The strategy, therefore, is to not sell the home during your lifetime so that your children receive a step up in basis with respect to that property on your death.

2.9.1.7. Retirement Plan

If either spouse has a retirement plan, such as an IRA or savings plan, the withdrawal of funds from that account is a taxable event. If some period of private payment to the nursing home is required, it makes sense to use the money in the retirement plan for this purpose. The medical deduction for the qualified long-term services can be used to offset the taxable income resulting from the withdrawal from the retirement plan.

2.9.1.8. Deferred Annuity

If either spouse has a deferred annuity, the withdrawal of funds from the annuity is a partially taxable event. That portion of the payment representing the initial purchase price of the annuity is a return of principal and is non-taxable, but the accrued income is taxable. If some period of private payment in the nursing home is required, it makes sense to use the money in the annuity for this purpose. The medical deduction for the qualified long-term services can be used to offset the taxable income resulting from the withdrawal from the retirement plan.

2.9.1.9. Interest on Series E, Series EE and Series I Bonds

At the time Series E, EE or I bonds are redeemed, income tax is due on the accumulated interest.⁴³ The same is true if the bonds are transferred to another person. Generally, it would be better not to cash in the bonds until such time as the proceeds of sale of the bonds are needed to pay for the nursing home. This is because the medical deduction for the nursing home expense will offset the taxable income from the redemption of the bonds.

2.9.1.10. Domestic Help

Withholding is required if an employee's cash compensation exceeds \$1,000 per quarter. The employer is also liable for unemployment tax (FUTA). The key issue is whether or not the person is an "independent contractor" or an "employee." If an independent contractor, the provider must pay self-employment tax. If an employee, withholding is required unless the taxpayer can establish that someone else is the employer, such as an agency. Registered nurses and licensed practical nurses are generally classified as independent contractors. Nurses' aides and other personal attendants are usually classified as employees.

2.9.1.11. Gain on Sale of Home

2.9.1.11.1. General

There is an exclusion⁴⁴ from gross income for the sale of a principal residence, if the property was owned and used by the taxpayer as the taxpayer's principal residence for two of the five years preceding the date of the sale. The amount of the gain excluded is \$250,000 for a taxpayer filing individually and \$500,000 for taxpayers filing jointly. In the case of married couples, the ownership requirement can be met by either spouse, but both spouses must meet the use requirement, and neither spouse has claimed the exclusion during the two-year period ending on the date of the sale. This provision is applicable to sales on or after May 7, 1997.

2.9.1.11.2. Joint Returns

In the case of joint returns, the exclusion applies if either spouse meets the ownership and use requirements.

2.9.1.11.3. Property Owned by Spouse or Former Spouse

In the case of a divorce decree, the individual is treated as using the property during any period of ownership during which the individual's spouse or former spouse is granted use of the property under a divorce or separation instrument.

2.9.1.11.4. Determination of Use During Periods of Out-of-Residence

Care

A taxpayer who owns property during the five-year period, but who resides in any facility, including a nursing home licensed by a state, counts the time residing in the nursing home as use of the property.

2.9.1.11.5. Residences Acquired in Rollovers Under Section 1034

If a residence is acquired under a Section 1034 rollover, the time periods during which the taxpayer owned and used the former property are counted.

2.9.1.11.6. Repeal of Non-Recognition of Gain on Rollover of

Principal Residence

Section 1034 (relating to rollover of gain on sale of principal residence) is repealed.

2.9.2. Gift Tax

If transfers are made in excess of \$11,000 per person per year, then a Gift Tax Return will have to be filed by April 15th of the calendar year following the date of the gift. There is an annual exclusion for gifts of \$11,000 per person per year or less.⁴⁵ If a spouse consents, the annual exclusion gift may be increased to \$22,000 per person per year. In addition, there is a gift tax exemption of \$1,000,000 for an individual and 2,000,000 for a married couple,⁴⁶ so no tax will be due for gifts which do not exceed the amount of this gift tax exemption. There is no tax due from the recipient of the gift. The \$11,000 annual exclusion gift will be indexed for inflation in the future.

New Jersey does not have a gift tax. However, New Jersey does have an inheritance tax for assets which are left to persons other than a spouse or lineal ascendants and descendants. If a transfer is made to someone other than a spouse or lineal ascendants and descendants within three years of the date of death, this constitutes a transfer which falls within the scope of the New Jersey Inheritance Tax. In that situation an Inheritance Tax Return must be filed and the appropriate tax paid.⁴⁷

2.9.3. Estate Tax

There is a federal estate tax exemption equivalent of \$1,500,000 which means that federal estate tax is not due for estates of \$1,500,000 or less. The exemption equivalent will increase in accordance with the following schedule:⁴⁸

2005	\$1,500,000
2006-2008	\$2,000,000
2009	\$3,500,000
2010	Repealed
2011	\$1,000,000

2.9.4. New Jersey Estate Tax

There is a New Jersey estate tax exemption equivalent of \$675,000, which means that New Jersey estate tax is not due for estates of \$675,000 or less.⁴⁹

2.10. Use of Trusts and General Powers of Attorney in Planning for Medicaid Eligibility

2.10.1 Advantages of Using a Trust over Outright Gifts to Other Individuals

2.10.1.1. Control

The trust allows the grantor to direct, in advance, how the transfer of property is to be managed administered and distributed thereby allowing some control.

2.10.1.2. Tax Benefits

Qualification of the trust as a grantor trust allows the grantor to be taxed on the income earned by the trust at the grantor's marginal income tax rate even if the income is not distributed to the Grantor.

2.10.1.3. Step-up in Basis

If the trust assets are included in the grantor's estate, the trust principal will be included in the grantor's estate at death and will receive a step-up in basis at that time.⁵⁰

2.10.1.4. Exclusion from Capital Gain on Sale of Principal Residence

The \$250,000 - \$500,000 exclusion from capital gain on the sale of a principal residence can be preserved through a properly-structured trust.

2.10.2. Trust Buster Statute

The statute provides “Any provision in a contract of insurance, will, trust agreement or other instrument which reduces or excludes coverage or payment for goods and services to an individual because of that individual's eligibility for or receipt of Medicaid benefits shall be null and void, and no payment shall be made under this act as a result of such provision.” This statute has never been tested in court. This statute appears only to apply to instruments which provide for mandatory distributions which are then cut back when the individual applies for Medicaid. Example: “Upon the beneficiary applying for Medicaid, all income payments to him shall terminate.”⁵¹

2.11. Medicaid Transfers by Power of Attorney

It is necessary to explore the capacity of the client to make transfers. If the client lacks the necessary mental capacity, the transfers may, nevertheless, be accomplished through a Power of Attorney, if the document so authorizes. Under New Jersey law gifts are not permitted by an attorney-in-fact except to the extent that the Power of Attorney expressly and specifically so authorizes.⁵²

The next problem with a Power of Attorney is whether the agent has authority to make gifts to himself. The agent is a fiduciary. If the Principal wants the agent to be able to self-deal when making transfers for Medicaid purposes, the Power of Attorney should explicitly authorize such gifts. However, authorization of an agent to make gifts to himself under a Power of Attorney, might be considered a general power of appointment.⁵³ The power of appointment would then cause the assets of the principal to be includable in the agent's gross estate for federal estate tax purposes. I.R.C. §2041(a)(2). One solution would be to have the Power of Attorney name a special agent with authority to make transfers to the regular agent. An alternative might be through obtaining court approval. A third way might be to put conditions in the Power of Attorney as to when the agent might have the right to self-deal.

2.12. Medicaid Planning by Guardians

Guardians are authorized to make transfers for the purpose of obtaining Medicaid eligibility. In the case of *In the Matter of Mildred Keri*,⁵⁴ the Supreme Court held that a guardian may make transfers for purposes of obtaining Medicaid eligibility for a ward. The Court imposed a five-point test:

- The spend down plan must not interrupt or diminish an incompetent person's care.
- The plan involves transfers to natural objects of the person's bounty.

- The plan does not contravene an expressed prior intent or interest.
- The plan clearly provides for the best interests of the incompetent person.
- The plan satisfies the law's goal to effectuate decisions an incompetent person would make if he or she were able to act.

It is wise to consider making transfers, which are consistent with the estate planning goals of the client. If inconsistent transfers are made, they may result in litigation from beneficiaries of the estate who consider themselves to be treated unfairly.

3. LONG-TERM CARE INSURANCE

Long-term care insurance can be helpful to clients who are healthy enough and affluent enough to afford it. As Elder Law attorneys, we must all be aware that Medicaid and other public assistance programs may not continue to exist in the future as we know them today. It would be a disservice to our clients to advise them to rely on these programs in the future. Clients who can afford long-term care insurance and who may be insurable, should be urged to consider purchasing the insurance. Premiums for nursing home insurance can be controlled to a certain extent by the client. The features which affect the premium cost, which can be selected by the client, are the maximum daily benefit, the elimination period, the benefit length, the inflation rider and the amount of home care covered. There are two factors that the client cannot control, which greatly affect the premium. These are the client's age at application and health history. For this reason, clients should purchase long-term care insurance at the earliest possible time. Most experts consider that the best time to purchase long-term care insurance is about age fifty.

Congress provided tax deductions⁵⁵ and tax relief for "qualified long-term care insurance contracts." New Jersey has regulations concerning long-term care insurance contracts.⁵⁶

It is estimated that only 6 to 8 percent of the elderly have private long-term care insurance.⁵⁷ There are four reasons why people do not buy long-term care insurance:

- Lack of Awareness - The industry has not done a good job in marketing this product.
- Denial - Seventy-seven percent of people surveyed by the American Council of Life Insurance believed they would be healthy in retirement.⁵⁸
- Cost - It is estimated that only 10 to 20 percent of the elderly can *afford* such insurance.⁵⁹
- Insurability - Many people wait until they have a diagnosis before applying for long-term care insurance. At that point, they are no longer insurable. Agents estimate that approximately 25 percent of persons applying are rejected for health reasons.

3.1. Nursing Home Insurance Factors

3.1.1. Coverage

Policies need to be carefully analyzed to see if there are exclusions for alcohol and drug abuse related services or mental health related services. New Jersey requires that all policies include coverage for Alzheimer's and other organic brain disorders.

3.1.2. Premiums

Premiums for long-term care insurance are high. However, the cost of the premiums is relatively low compared to the cost of payment for a nursing home. Each family must make the premium fit within its family budget.⁶⁰ Long-term care insurance coverage for a \$100 per day nursing home benefit and a \$50 per day home health care benefit with a lifetime 5 percent compounded inflation rider, twenty day elimination period and four years of coverage averaged \$798 per year for a person aged 50, \$1,881 per year for a person age 65 and \$5,889 for a person age 79. Obviously, the earlier the policy is purchased, the more affordable the premium.

Most long-term care insurance policies are guaranteed renewable. This means that coverage cannot be canceled by an insurance company, nor can premiums be raised on an individual basis, because of increasing age or declining health. Premiums can be raised only on a class basis affecting all policyholders with that insurance company in that class, and then only with the approval of the state insurance department. In practice, premiums are seldom, if ever, raised on this basis.

3.1.3. Daily Coverage

Persons buying long-term care insurance usually purchase a policy which reimburses their long-term care costs up to a selected maximum amount per day. For example, in this area many people purchase \$175 per day of coverage. The actual average cost of a nursing home in New Jersey in 2005 probably ranges from \$250 to \$300 per day for the basic rate. Ancillary charges such as medications and incontinent care are extra. The difference is made up by the individual's Social Security, pension or other income.

Some policies are written as a pool of money. An individual might purchase \$255,500 of coverage. This is the equivalent of \$175 per day coverage for four years ($\$175 \times 365 \text{ days} \times 4 \text{ years} = \$255,500$).

3.1.4. Gatekeepers

Companies can sell qualified or non-qualified policies. Qualified policies offer certain safe harbor tax benefits. The primary advantage of a tax-qualified policy is that the benefits paid under the policy are clearly not taxable income. The disadvantage of a tax-qualified policy is that the figures for coverage are more difficult to achieve. Many agents sell only tax-qualified policies.

For a long-term care insurance policy to be a qualified contract, it must provide for benefit eligibility to be determined by meeting a chronically-ill individual standard. The term "chronically-ill individual" means an individual who has been certified by a licensed health care practitioner as being unable to perform at least two of the activities of daily living (ADLs) and whose disability is anticipated to last for a period of at least 90 days due to a loss of functional capacity; or, requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.⁶¹ There are two triggers under the new law. The ADL Trigger and the Cognitive Impairment Trigger.

3.1.4.1. ADL Trigger

The activities of daily living (ADLs) include eating, toileting, transferring, bathing, dressing and continence. The long-term care insurance policy must take into account at least five of such activities. The inability of the insured person to perform two of the five or two of the six ADLs without substantial assistance triggers eligibility under the policy.⁶² The 90-day period is not a waiting period. The 90 days can be prospective and does not affect the elimination period.

3.1.4.2. Cognitive Impairment Trigger

Severe cognitive impairment means a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short- or long-term memory; orientation to people, place or time; and deductive or abstract reasoning. The deterioration or loss must place the individual in jeopardy of harming himself or others and, thereby, require substantial supervision by another individual. A person who is physically able but has cognitive impairment such as Alzheimer's Disease or another form of irreversible loss of mental capacity is treated similarly to an individual who is unable to perform (without substantial assistance) at least two ADLs.

The IRS defines substantial assistance as “hands-on assistance and stand-by assistance.”⁶³ “Hands-on assistance” means the physical assistance of another person without which the individual would be unable to perform the ADL. “Stand-by assistance” means the presence of another person within arms’ reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual, if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat, if the individual chokes while eating). An individual is chronically-ill only if a licensed health care practitioner has certified that the individual is unable to perform (without substantial assistance from another individual), at least two ADLs for a period anticipated to last at least 90 days due to loss of functional capacity. A licensed health care practitioner is a physician, registered professional nurse, licensed social worker, or other individual who meets requirements that may be prescribed by the IRS.⁶⁴

3.1.5. Inflation Provisions

Between 1985 and 1995 nursing home costs in New Jersey increased approximately 9.7 percent per year. Costs of nursing homes increase constantly. Some homes increase annually, some more often. A daily benefit of \$175 purchased today may be sufficient now, but may be inadequate five years from now when the client enters a nursing home. Therefore, inflation coverage should be considered.

Some policies have inflation riders which offer increases based on the Consumer Price Index (CPI). Insureds are offered the right to purchase additional coverage at their attained age. Premiums increase when high coverage is elected. Other companies offer policies with an inflation rider which increases coverage automatically at 5 percent per year, either on a simple or a compounded basis. Automatic inflation riders keep premiums level as benefits increase. Nursing home costs increase on a compounded basis, so an inflation rider, which increases on a compounded basis, is best.

3.1.6. Pre-Existing Conditions

New Jersey LTC regulations define a “pre-existing” medical condition as any condition for which the applicant received advice or treatment during the six (6) month period prior to making application. Further, if an applicant is accepted, a company cannot impose a pre-existing medical condition waiting period on the insured person for more than six months from the effective date of coverage. Persons with diagnosed Alzheimer's or Parkinson's Diseases will always be denied coverage. However, persons with histories of cancer, heart disease or similar conditions are often able to obtain coverage. The insurance companies generally like to see a period of time during which it is clear that the condition is controlled. In some instances, the coverage is obtained at regular rates. In other instances, the coverage is granted, but the client is rated, which means that the client pays a higher insurance premium or is offered a shorter benefit length or a longer deductible.

3.1.7. Benefit Length

The benefit length is the period of time which the insurance company will pay after the client starts receiving benefits for long-term care. Coverage is available for two years, three years, four years, five years, six years or unlimited. The longer the term of coverage selected, the more expensive the premium. Attorneys often advise clients to obtain three or four years of coverage. This enables the client to do public assistance planning and, under current law, all or most of the lookback period is covered by insurance. Because Medicaid, as we know it today, may not be available in the future, it may be well to advise clients to purchase as long a term of coverage as they are able to afford.

3.1.8. Guaranteed Renewability

It is important that a policy be guaranteed renewable. If a client purchases a policy when healthy, and is later diagnosed as having a condition such as Alzheimer's, the client needs to have the assurance that his coverage cannot be canceled or his premium individually raised. Federal law now requires that qualified policies be guaranteed renewable.⁶⁵

3.1.9. Home Health Care

Most companies have comprehensive, “bundled” policies which include home health care. Some companies have home health care riders which can be added to the basic nursing home/assisted living facility coverage. At least one company has a policy which covers only home health care. Clients do not want to spend time in nursing homes. They would much prefer to stay at home. It is important to obtain home health care coverage so that the family can afford to keep the client at home.

3.1.10. Waiver of Premium

Some policies waive the payment of premiums when benefits are being received or have been received for a given period of time, typically 90 days. Premiums normally resume once benefits stop being paid.

3.1.11. Case Management

Some long-term care insurance policies offer a benefit option referred to as “case management.” Under case management a professional oversees the care and the services the insured would receive. The case manager may be an insurance company employee. This is managed care for long-term care insurance, and should be carefully analyzed. Other policies allow the client to choose his own case manager.

3.1.12. Adult Day Care and Respite Care

Most LTC policies provide benefits for adult day care services and respite care. Respite benefits allow for immediate coverage while an informal caregiver (wife, daughter, etc.) gets a break.

3.1.13. Quality of the Insurance Company

The quality of the insurance company is important. After paying premiums for a number of years, the client expects the insurance company to pay the claim when made. Because of the experience of Executive Life, Mutual Benefit Life and other insurance carriers which have experienced financial difficulties, it is wise for the attorney to counsel the client to look at the ratings of the insurance companies. Ratings services include the following:

1. Moody's Investors Service
99 Church Street
New York, New York 10007
Telephone: (212) 553-1658
Fax: (212) 553-4062
Website: www.moodys.com
2. Standard and Poor's
25 Broadway
New York, New York 10004
Telephone: 212-208-1527
Fax: 212-208-8571
3. Duff and Phelps
55 East Monroe Street
Suite 3500
Chicago, Illinois 60603
Telephone: 312-368-3157

4. A.M. Best
Ambest Road
Oldwick, New Jersey 08858
Telephone: 908-439-2200
Fax: 908-439-3296
5. Weiss Ratings
4176 Burns Road
Palm Beach Gardens, Florida 33410
Telephone: 561-627-3300 or 1-800-289-9222
Fax: 561-625-6685

3.2. Policy Features

The features of the policy which determine cost are:

3.2.1. Daily Benefit

The daily benefit is the maximum amount of money which the insurance company will pay to the insured for each day of long-term care services.

3.2.2. Elimination Period

The elimination period is like a deductible. It is the number of days which the client is willing to pay privately before the insurance begins. Insurance is available which will pay from the first day of care. Other options are a twenty-day elimination period up to a 100-day elimination period or even 365-day elimination period. The longer the elimination period, the lower the premium. A 100-day elimination period usually makes sense. It can reduce the premium substantially at older ages, and Medicare and Medi-Gap Insurance may cover the 100 days, if the patient meets the Medicare requirements for a skilled nursing facility. If not, the client self-insures.

3.2.3. Benefit Length

The benefit length is the number of years the insurance company will pay the nursing home. The term begins *after* the client enters the nursing home.

3.2.4. Inflation Rider

A 5 percent compounded inflation rider is the most expensive, but affords the best coverage because the increases in nursing home rates are compounded.

3.3. Taxation

3.3.1. Income Tax Deduction

Under HIPAA, qualified long-term care insurance premiums are deductible from federal income tax as a medical expense up to certain limits.⁶⁶

While payment for medical services provided by relatives does not ordinarily qualify for a medical expense deduction under I.R.C. §105(b), reimbursements through insurance to a relative for such care do qualify.⁶⁷ For example, if Dad, who has Alzheimer's, hires his daughter, a licensed practical nurse, to care for him, payments from father to daughter are not tax deductible. However, if the insurance company pays the daughter, the payments are not counted as income to the father.

Eligible long-term care insurance premiums for a qualified long-term care insurance contract up to the following dollar limits for 2005 qualify as tax deductible medical expenses.⁶⁸

<u>Attained Age by Yr. End</u>	<u>Annual Limit on Prem. Ded.</u> ⁶⁹
40 or less	\$270.00
More than 40 but under 51	\$510.00
More than 50 but under 61	\$1,020.00
More than 60 but under 71	\$2,720.00
Over 70	\$3,400.00

Unfortunately, this deduction is largely illusory, because it is subject to the overall 7-1/2 percent floor of adjusted gross income on deduction of medical expenses. Most people who are healthy enough to purchase long-term care insurance do not have enough other medical expenses to deduct so that they can hit the 7-1/2 percent threshold. It is likely that the tax deduction will be attained only if one spouse is ill and the other spouse has the insurance.

3.3.2. Exclusion From Taxation of Benefits Under Qualified Contracts

Amounts received as benefit payments under a qualified long-term care insurance contract are treated as amounts received for personal injury or sickness, and as reimbursement for expenses actually incurred for medical care and are, therefore, excluded from income for tax purposes.⁷⁰ On flat indemnity policies, there is a limitation of \$240 per day for 2005. Amounts greater than this are tax-free to the extent they cover actual costs. The \$240 figure will be increased to reflect inflation. It is not clear whether benefit payments made under non-qualified contracts are excludable from gross income.

4. MEDICARE⁷¹

4.1. Requirements

Medicare will pay for nursing home care provided two requirements are met:

- *Hospital.* The patient must spend three days in the hospital and must be admitted to a nursing home within 30 days after discharge from the hospital.
- *Skilled Care.* The patient must be admitted to the nursing home for skilled care on a daily basis. Skilled care is defined as services that are so inherently complex that they can only be provided effectively by skilled individuals or under the supervisor of skilled personnel.⁷²

4.2. Coverage

Medicare will pay for up to 100 days. However, there is co-insurance from the 21st to 100th day. For 2005, the co-insurance rate is \$114.00 per day, which must be paid by either the patient or a Medi-gap policy. The 100 days of coverage are not guaranteed. This is a maximum, not a minimum. If the patient is receiving rehabilitation and hits a plateau, Medicare will be stopped.

5. VETERANS BENEFITS

5.1. Federal

A Veteran with a service-connected disability of 70 percent or more is entitled to free lifetime nursing coverage regardless of means. Veterans who do not have a service-connected disability are means-tested as to payment. The VA does contract with public and private nursing home facilities, in addition to using VA facilities.⁷³

5.2. State

5.2.1. General

New Jersey Veterans Administration operates three old soldiers' home for New Jersey Veterans and their families. They are located in Paramus, Edison and Vineland. Veterans, spouses of Veterans, surviving spouses, and certain parents may be eligible.⁷⁴

5.2.2. Fee

The Adjutant General determines an "Established Rate" each year. The individual pays a portion of the cost of care based on their monthly income and ability to pay.⁷⁵ The VA monthly nursing home fee is 80 percent of the resident's net income, not to exceed the Established Rate. In addition, 12 percent of the remaining 20 percent of the resident's net income (maximum \$20 per month) is set aside in a Welfare fund at the institution, and the remaining balance is placed in a personal needs account for the resident. Net income is calculated after the deductions discussed below. Income includes all income except for service-connected disability compensation. Residents who sell their house or acquire additional financial assets after admission are required to use 50 percent of those assets for care.⁷⁶

Certain deductions are permitted to the community spouse. For example, the community spouse receives a flat \$475 exemption for food, transportation, clothing, telephone and home maintenance. In addition, deductions requiring verification are permitted for rent, first mortgage payments, real estate taxes and insurance, heat and electric, water and sewer, life insurance for burial accounts, and other extraordinary expenses.

5.2.3. Guardianship or Advanced Directive

A Guardianship or Advanced Directive is required for admission.

5.2.4. Resources

The resource limit for a single person is \$15,000, and for a married couple is \$40,000.

5.2.5. Look-Back

The Veterans look-back period is effectively 18 months.

6. CONCLUSION

Financing nursing home care in New Jersey is a complex enterprise. The rules change quickly and are not always written. Medicaid case workers often feel they have an obligation to protect the public purse, rather than to assist the applicant by suggesting various strategies. Case workers are sometimes poorly trained and do not know various planning techniques. Planning for Medicaid financing of nursing home care offers an excellent opportunity for elder law attorneys to be of assistance to their clients.

¹N.J.A.C. 10:71-3.2.

²N.J.A.C. 10:71-3.4.

³N.J.A.C. 10:71-3.9.

⁴N.J.A.C. 10:71-3.10.

⁵N.J.A.C. 10:71-3.12 (c).

⁶N.J.A.C. 10:71-3.12 (a).

⁷Medicaid Communication 05-03.

⁸N.J.A.C. 10:71-4.5.

⁹N.J.A.C. 10:71-5.1.

¹⁰N.J.A.C. 10:71-4.1 (d) 2.

¹¹N.J.A.C. 10:71-5.7 (c). 69 Fed. Reg. 7336 (Feb. 13, 2004).

¹²N.J.A.C. 10:71-4.5 (c).

¹³Medicaid Communication No. 95-11.

¹⁴N.J.A.C. 10:71-4.4 (b) 1 i.

¹⁵N.J.A.C. 10:71-4.4.

¹⁶N.J.A.C. 10:71-4.4 (3).

¹⁷N.J.A.C. 10:71-4.4 (b) 3 ii.

¹⁸N.J.A.C. 10:71-4.4 (b) 3 iii.

¹⁹N.J.A.C. 10:71-4.4 (9).

²⁰N.J.A.C. 10:71-4.4 (b) 6.

²¹N.J.A.C. 10:71-4.4 (b) 4.

²²*Id.*

²³N.J.A.C. 10:71-4.6.

²⁴N.J.A.C. 10:71-4.10 (a).

²⁵N.J.A.C. 10:71-4.10 (m) 1.

²⁶HCFA Transmittal No. 64 § 3258.4.

²⁷N.J.A.C. 10:71-4 10 (d).

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- ²⁸42 U.S.C. 1320a-7b(a)
- ²⁹965 F. Supp. 28 (1997)
- ³⁰U.S. DC NDNY 97-CV-1768
- ³¹N.J.A.C. 10:71-4.8 (a) and Medicaid Communication No. 05-03.
- ³²N.J.A.C. 10:71-4.8 (a).
- ³³I.R.C. § 213.
- ³⁴I.R.C. §7702B
- ³⁵Rev. Rul. 87-106, 1987-2 C.B. 67.
- ³⁶I.R.C. § 151 (c) (1) (A) and I.R.C. § 151 (c) (3); Rev. Proc. 2004-71.
- ³⁷I.R.C. §152(c) and IRS Publication 502
- ³⁸I.R.C. §152(a), (b)1 and Treas. Reg. §1.151-3(a)
- ³⁹I.R.C. § 152 (c).
- ⁴⁰Treas. Reg. § 1.152-3 (c).
- ⁴¹I.R.C. § 1015.
- ⁴²I.R.C. § 1014 (b) (9).
- ⁴³I.R.C. § 454 (c).
- ⁴⁴I.R.C. §121
- ⁴⁵I.R.C. § 2503 (b); Rev. Proc. 2004-71.
- ⁴⁶I.R.C. §§ 2501 and 2505.
- ⁴⁷N.J.A.C. 18:26-5.7.
- ⁴⁸Economic Growth and Tax Relief Reconciliation Act of 2001, P.L. 107-16.
- ⁴⁹ N. J. S. A. 54 : 38-1
- ⁵⁰I.R.C. § 1014 (b) (9).
- ⁵¹N.J.S.A. 30:4D-6F
- ⁵²N.J.S.A. 46:2B-8.13a.
- ⁵³I.R.C. §2041(b).
- ⁵⁴*In the Matter of Mildred Keri*, 181 N.J. 50 53 A.2d 909 (N.J. August 2004).
- ⁵⁵The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

⁵⁶N.J.A.C. 11:4-34.1 to 34.13.

⁵⁷J. M. Wiener, L. H. Illston & R. J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, 6 (Brookings Institutions, 1994).

⁵⁸Longevity and Retirement Survey Fact Sheet, American Council of Life Insurance. Survey conducted between August 12 and September 10, 1997.

⁵⁹J. M. Wiener, L. H. Illston & R. J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, 14 (Brookings Institutions, 1994).

⁶⁰Health Insurance Association of America LTC Market Survey, 1996.

⁶¹I.R.C. §7702 B.

⁶²I.R.C. §7702B(c)(2).

⁶³IRS Notice 97-31.

⁶⁴I.R.C. § 7702 B (c) (4).

⁶⁵I.R.C. § 7702 B (b) 1 (C).

⁶⁶I.R.C. § 213 (d) (1) (D).

⁶⁷I.R.C. § 213 (d) (11).

⁶⁸I.R.C. § 213 (d) (1) (D).

⁶⁹I.R.C. §213(d)(1)(D)

⁷⁰I.R.C. § 7702 B (a) (2).

⁷¹42 U.S.C. 1395 through 1395xx; 42 C.F.R. Pts. 405 through 489.

⁷²42 U.S.C. 1395 through 1395xx; 42 C.F.R. Pts. 405 through 489.

⁷³42 C.F.R. 409.31(b)(3), 409.33(b), 409.35

⁷⁴N.J.A.C. 5A:5.1 *et seq.*

⁷⁵N.J.A.C. 5A:5-5.2 and 5A:5-5.3

⁷⁶N.J.A.C. 5A:5-5-1(d)