Younger-onset Alzheimer's: Legal and Financial Issues*

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Preface

Younger-onset Alzheimer's defined is defined by the Alzheimer's Association as Alzheimer's disease arising prior to age 65. This presentation of the disease raises the same but also different personal and family issues for the individual, his or her family, friends, employer and others involved in his or her life. In many respects, the issues are the same as those affecting older persons with Alzheimer's. The desirability of a durable power of attorney and health care proxy is clear regardless of age. In many other respects, however, the issues are different. The younger individual is more likely to be working at the time of onset and will need to decide on continuing or terminating work, and on how best to access any work-related disability insurance benefits and COBRA rights for temporary continuation of health insurance. She is more likely to have a working spouse, whose income will affect eligibility for some programs. He may have minor or dependent children. She may well have retirement accounts, but be too young to access them without the penalty that usually attaches. Eligibility for some government programs is limited to people who have reached age 50, 55, 62 or 65. Also, income and asset tests for benefit programs vary for people of different ages. The purpose of this paper is to highlight and begin to explore some of the more important of these special issues and concerns in relation to people with Alzheimer's Disease (or to a great degree many other severely disabling conditions) under age 65.

1. **Give priority attention at the earliest possible time to protective steps needed to provide for substitute decision-making upon later incapacity.**

a. What instruments?

i. **Durable power of attorney**, for legal and financial decisions.

ii. **Health care proxy**, for medical decisions once the individual is no longer able to make them on his own.

iii. **Medical directive or "living will"** to express preferences about care at end-of-life.

iv. **"HIPAA" medical information releases**, to give persons you wish access to otherwise private medical information, even prior to incapacity.

b. Do I have the capacity to execute such an instrument? Many people with Alzheimer's Disease far along enough to interfere with work and life activities may nonetheless still have the capacity to execute such documents. A diagnosis is never, in itself, a disqualifier. Generally, if you are able to answer the following questions in the affirmative, then you have sufficient capacity to sign:

i. Do I understand the general purpose and use of the instrument?

ii. Do I have the capacity to appreciate my relationship with the persons being named as:

(1) Attorney-in-fact and alternate/successors?

(2) Health care agent and alternate/successors?

(3) Person with authority access to private medical information?

For more information on competency and capacity, see my article at:

http://rfl-law.com/firm_articles/index.html

2. **Consider whether long-term care insurance may be appropriate in your planning, and if so, consider filing.** If signs and symptoms have reached to the point of raising concern in the individual or family, it may be too late to apply for long-term care insurance, but the possibility may be worth exploring. Chances of approval, or approval at preferred rates, are best if application is made before any genetic testing or other testing pertaining to memory loss.

3. **Having a Durable Power of Attorney and Health Care Proxy makes guardianship unnecessary in most cases. However, if the individual lacks the capacity to execute a durable power of attorney or health care proxy, a court-appointed guardian (for personal and medical decision-**

making), conservator (for financial decision-making), or both, may be needed.

a. ***Guardian*** (to protect health and other personal interests)

i. A guardian may be appointed for a person who is "incapacitated," that is, a person "who for reasons other than advanced age or minority has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety or self-care, even with appropriate technological assistance."

ii. A guardian's authority should be tailored to address the individual's specific needs. The guardian may be appointed on an open-ended basis or for a temporary period; with authority extending to virtually all areas of decision-making (as an unlimited or "plenary" guardian) or with authority limited to particular areas of need (as a "limited" guardian). The principle of "the least restrictive alternative" applies. This means that the guardian's authority should be no broader than necessary to protect the individual's key interests.

b. *Conservator* (to protect financial interests)

i. A **conservator** may be appointed "if the person is unable to manage property and business affairs effectively because of a clinically diagnosed impairment in the ability to receive and evaluate information or make or communicate decisions, even with the use of appropriate technological assistance; and the person has property that will be wasted or dissipated unless management is provided or money is needed for the support, care and welfare of the person or those entitled to the person's support and protection is necessary or desirable to obtain or provide money."

ii. Like guardians, conservators may be appointed on an open-ended or temporary basis, with full or limited authority.

c. If the person requires assistance with a particular financial decision (for example, transferring title of the residence to his spouse, or sale of a house), the court may use a simplified procedure to issue "protective orders" to deal with the specific issue instead of the full conservatorship process.

4. **If you are working at the time of onset, you will have to decide about continuing and eventually terminating your work.**

a. About **continuing** to work:

i. Americans with Disabilities Act (right to reasonable accommodations for people still able to meet the requirements of their jobs).

ii. Potential eligibility for MassHealth under the CommonHealth

program for disabled adults working at least 40 hours per month; eligibility may be subject to a monthly premium but is not subject to an income or asset cap.

iii. Family and Medical Leave Act (right to short-term un-paid leave with right of return)

b. About **stopping** work:

i. Wage continuation

ii. Severance

iii. Unemployment Compensation

iv. Short-term disability insurance

(1) Claim

(2) Conversion (if claim would be premature)

v. Long-term disability insurance

(1) Claim

(2) Conversion (if claim would be premature)

vi. Regarding employer group life insurance, conversion to individual policy may be available

vii. Group health insurance continuation

(1) Cobra/MA "Mini-Cobra" temporary continuation of employer group coverage for worker, spouse and dependent children for 18 months (plus 11 months with disability as determined by Social Security) at group rates but without prior employer subsidy. (For disability extension, employer may charge up to 150% premium cost.)

(a) Federal law as to employers of 20+ workers

(b) MA "Mini-Cobra" as to employers of 2-19 workers

(c) Note that enrollment in Medicare is a qualifying event as to spouse and dependent children

(d) Be careful with the technical notice and election requirements

(2) Obtain coverage through policy of the spouse

(3) Conversion to individual policy

(4) Massachusetts Health Connector

(a) Commonwealth Choice - marketplace

(b) Commonwealth Care – subsidized

(c) MassHealth - See Section 9.e. below.

(d) Watch open enrollment periods (although usually waived if employment-related insurance is lost due to termination or voluntary quit.)

5. **Accessing IRA's, 401k's and other retirement accounts**

a. Taxable at any age. No exceptions.

b. Penalty prior to age 59½, unless an exception applies:

i. If you are disabled.

ii. if you or your spouse is unemployed at least 12 weeks and the withdrawal is needed to pay for health insurance for you or your immediate family.

iii. If the withdrawal is needed to pay for unreimbursed medical expenses in excess of 7.5% adjusted gross income.

iv. To pay for certain education expenses.

v. Even if other exceptions do not apply, if paid in substantially equal periodic amounts based on life expectancy.

6. **Accessing home equity**

a. Borrow, either from a bank or a family member:

i. Refinance for higher loan amount

ii. Home equity line of credit (HELOC)

iii. Second mortgage/home equity loan

b. Obtain a reverse mortgage (but evaluate this option with particular care as risks, limitations and high expenses are involved)

7. **Using available Long-Term Care Insurance**

a. Do I meet medical qualification for benefits, often expressed in terms of need for assistance with a specified number of activities of daily living?

b. If I qualify for benefits, should I start claiming as soon as I have a need for services, or should I wait and conserve them for nursing home placement?

i. Usually – claim as soon as you qualify.

ii. Many people underutilize benefits. Even if you will exhaust benefits, there is no advantage to exhausting them later rather than earlier. Better to support the individual at home as long as possible and to conserve family resources.

iii. As a result of a recent law change in Massachusetts, there is

no need to delay making claims to protect the LTCI exemption from MassHealth estate recovery.[1]

c. Does my care provider qualify? Aside from medical need, many policies will reimburse only if the care provider (individual or agency) meets certain requirements and qualifications set out in the policy.

i. These are often technical.

ii. Verify with the insurer (and not only with the care provider) that the care provider qualifies for payment or reimbursement before you make your selection of the care provider, even if you don't intend to start filing claims immediately.

8. **Privately arranged home care**

a. **Home Care Agencies**. Many people arrange for home care services through private "home care" agencies. Of course reputation for quality must be foremost in your selection, but also understand that home care agencies may be organized in fundamentally different ways, with very different legal and financial implications for you.

i. In some, the home care workers are directly employed and supervised by the agency. Such agencies are usually certified Medicare and MassHealth providers. In such cases, the agency must:

(1) withhold and pay federal and state income taxes.

(2) withhold and pay the employee's portion (4.2%) of Social Security taxes and also the Medicare tax (1.5%).

(3) pay the employer's portion of Social Security taxes.

(4) pay federal and state unemployment taxes.

(5) provide worker's compensation insurance.

ii. With other agencies, workers are not employed by the agency but only placed by it.

(1) Such agencies are usually NOT certified Medicare and/or

[1] MassHealth has the right to get back money from the estates of certain MassHealth members after they die. In general, the money that must be repaid is for services paid by MassHealth for a member after the member turned age 55 or for a member who is any age and for whom MassHealth paid for care in a nursing home. A partial exemption from estate recovery (with respect to MassHealth payments for nursing home and certain other long-term care expenses) applies to people who have long-term care insurance and who meet certain other requirements. The coverage minimum to qualify for the exemption is $125,000 at the time of purchase. Under prior law, the minimum applied at the time of admission to a nursing home. It was thus often advisable to forego claims for home-and-community based services that would reduce available benefits for nursing home placement beyond the required minimum.

MassHealth providers, but instead are required only to be licensed as employment agencies by (in Massachusetts) the state Executive Office of Labor & Workforce Development. Licensing primarily involves protection of workers from exploitation by the agency itself. From the fact of a current license you can infer nothing about the quality of the program, standards in the selection of workers, or the nature and extent of any on-going training and supervision.

(2) While workers of such agencies may consider and describe themselves to be self-employed independent contractors, it is YOU and not either the agency or worker who may be the "employer" for most legal purposes.

(3) If the worker is <u>not</u> employed directly by the agency, but merely placed with you by the agency, or if you hire a worker privately without the involvement of an agency, then what happens? The law says that if you have the right to control the details of the work and have paid the worker more than $1,800 (for 2013) in any calendar year, then <u>you</u> are the employer, as a matter of law.[2]

(4) Home workers, including home health aides, personal care attendants, certified nursing assistants, practical nurses, and the like, are defined as household employees by law. Your characterization of them, or their characterization of themselves, as "independent contractors" or as "self-employed" does not change this result. Whether they work full-time or part-time for you also makes no difference. (Registered nurses, physical therapists, social workers and other like professionals can ordinarily be paid as independent contractors, because you do not have the right to control the details of their work.)

(5) If the home worker is technically an employee, then you must:

(a) withhold and pay the employee's portion (4.2%) of Social Security taxes and also the Medicare tax (1.5%).

(b) pay the employer's portion of Social Security taxes.

(c) pay federal and state unemployment taxes.

(d) provide worker's compensation insurance.

(6) If you do not meet these obligations, then you may be liable to the IRS for the employer's <u>and</u> employee's portions of Social Security taxes (plus interest and penalties) and for federal and state unemployment taxes, plus interest and penalties. Potentially much more substantially, you may be personally liable for damages if the worker claims an injury on the job (e.g., a back injury while providing physical assistance) since homeowner's insurance will usually not

[2] For more information on determining whether you have a household employee for federal income tax purposes, and your responsibilities if you do, see: http://www.irs.gov/pub/irs-pdf/p926.pdf

cover household workers who should be covered by workers' compensation.[3] Without insurance, everything you own is at risk.

b. **Private arrangements**. Families often consider care arrangements with individual care providers rather contract for services from an agency, on the basis of cost considerations or personal reference. However, understand the tax requirements for household workers and your financial exposure if the worker is hurt on the job. The same requirements apply to such private arrangements as apply to workers not employed by but only placed by an agency. See the discussion immediately above at section 8.a.ii.

9. **Explore all avenues of governmental services and benefits**

a. **Social Security Disability Insurance Benefits**

i. **Eligibility**

(1) Be under age 65.

(2) Have *"disability-insured"* status, which means that you must:

(a) Be *"fully insured."* In most cases pertinent to this topic, this means having earned at least 40 quarters of coverage under Social Security by having worked in "covered employment" and having paid FICA as an employee or self-employed person. The most commonly encountered workers who are not covered are employees of many state and local governments, who instead may (or may not) be eligible for benefits under other state and local governmental programs.

(b) Have earned at least twenty quarters of coverage during the forty quarters immediately preceding the onset of your disability.

(3) Meet disability criteria: "Unable to engage in any substantial gainful activity by reason of a severe physical or mental impairment or combination of impairments which has lasted or is expected to last for more than twelve consecutive months"

ii. **Application process**

(1) When to apply? Usually ASAP after onset of disability, in light of 5-month waiting period, 24-month wait for Medicare and limitation to twelve months for retroactive coverage. Remember that onset of disability usually means when you actually stop work, not the earlier date when you may have received your diagnosis, or the later date at which your compensation stops (if you are receiving continuing pay for accumulated vacation time or under a

[3] Homeowner's insurance policies in New Hampshire apparently may provide for household worker coverage. As far as I know, that is not the case in Massachusetts.

severance agreement, for example).

(2) How to apply?

(a) Office appointment to make application or apply on-line.

(b) Complete Disability Report. Can also be done on-line.

(c) "Compassionate allowance" initiative. Diagnosis of "early-onset Alzheimer's" results in expedited medical evaluation although not assured favorable decision. (Note the use of "early-onset" terminology in contrast to the generally preferred "younger-onset" terminology. IN THE SOCIAL SECURITY CONTEXT, BE SURE TO USE THE "EARLY-ONSET" TERMINOLOGY.)

iii. **Benefits**

(1) Monthly cash benefits:

(a) *Workers' disability insurance benefits*. Level of benefits depends on your lifetime earnings record. The current average monthly benefit for a disabled worker is $1,111. The maximum benefit is about $2,513.

(b) *Spouse's benefits* (based on the worker's earnings record), if the spouse is EITHER:

(i) Age 62 or older; or

(ii) Any age if caring for your child who is under age 16 or disabled and entitled to disability benefits on the worker's record.

(c) *Child's benefits* for each of your children who is:

(i) Unmarried.

(ii) Younger than 18 OR age 18 or 19 but still in high school as full-time students OR 18 and older and severely disabled (the disability having started before age 22).

(d) Each family member entitled to spouse's or child's benefits may be eligible for a monthly benefit up to half the worker's disability benefit amount. However, spouses taking benefits prior to their own regular retirement age (age 66 for persons born between 1943 and 1954, for example) receive reduced benefits. Also, a limit of between 150% and 180% of the worker's benefit generally applies to the total benefits payable to a family.

(e) If the spouse is eligible for retirement benefits based on his or her own work record as well, the impact of age of retirement on benefits is complex. Best to sit down with someone in your Social Security District Office.

b. **Medicare**

i. Eligibility after the earlier of (1) your having received 24 months of cash benefits under Social Security Disability Insurance (including any retroactive benefits) or (2) reaching age 65, whichever comes first.

ii. With Medicare, you are also eligible to purchase supplemental "Medigap" insurance, such as Medex Bronze.

iii. With Medicare, you are also eligible to purchase government-subsidized "Part D" insurance for prescription drugs.

c. **Supplemental Security Income**. Individuals with very limited earnings histories, and other family members, especially children 18 or older, with very low income and very limited assets (basically under $2,000), may also be eligible for monthly cash benefits from Social Security under the Supplemental Security Income (SSI) program.

d. **Veteran's Administration special monthly pension: Aid and Attendance**

i. Monetary support of up to $1,704 per month to a veteran, $1,094 per month to a surviving spouse, or $2,020 per month to a couple for certain veterans and surviving spouses who cannot function completely on their own and require the regular attendance of another person to assist in eating, cooking, bathing, dressing, leaving home, etc. Also potentially qualifying are individuals who are blind, patients in a nursing home because of mental or physical incapacity, and residents in assisted living facilities who require assistance on a regular basis to protect themselves from daily environmental hazards. Often overlooked is the potential eligibility of a healthy veteran caring for a sick spouse, who may qualify for up to $1,338 per month.

ii. A Veteran under 65 must be disabled and ordinarily must have had at least 90 days of active military service, with at least one day during a period of war.

iii. Eligibility is limited to Veterans who lack "sufficient means" to provide for their own care. The VA applies asset and income measures depending on age and other circumstances.

(1) $80,000 in assets (aside from the residence) is a commonly understood measure of sufficient means. Note: transfers of assets to establish eligibility are currently not disqualifying for VA services. HOWEVER, BEWARE OF POTENTIAL IMPACT ON MASSHEALTH ELIGIBILITY.

(2) Income limits (2012): $20,447 for a single veteran, $24,239 for a veteran with a spouse or dependent, $13,138 for a surviving spouse, and $15,672 for a surviving spouse with a dependent, after deducting all allowable medical related expenses for themselves and their spouses (including the cost of skilled

nursing, assisted living, home health care, Medicare or other insurance premiums).

e. **Massachusetts Home Care Program**

i. Provides support services to elders with daily living needs to help maintain independent community living, and also support and respite services in caregivers.

ii. Services include largely non-medical services such as homemaker, personal care, day care, home delivered meals, chore and transportation; and respite services for care-givers.

iii. Coordinates with MassHealth and other programs.

iv. Administered by the Executive office of Elder Affairs in coordination with local private non-profit Aging Services Access Point agencies (ASAPs), such as Springwell.

v. Eligibility is based on age (60 years or older or under 60 with a diagnosis of Alzheimer's disease and a need for respite services), financial status, and extent of need for assistance in carrying out out basic activities of daily living such as personal hygiene and grooming, dressing and undressing, self-feeding, functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.), bladder and bowel management and ambulation.

f. **Medicaid/MassHealth**

i. Referred to generally (and in New Hampshire) as Medicaid, and in Massachusetts as MassHealth, this is a state-administered, federally regulated program under which states receive Federal financial assistance in providing certain health and rehabilitation related services to people meeting certain personal and financial requirements. Eligibility and services vary depending on age, marital status, the make-up of the household, and the kind of service required. The details provided in this section relate specifically to the Medicaid program as implemented in Massachusetts.

ii. Services

(1) Comprehensive medical, hospital, rehabilitation, mental health services.

(2) Home health care.

(3) Personal care attendant services.

(4) Adult day health.

(5) Group adult foster care (assisted living).

(6) Family care.

(7) PACE (Program of All-Inclusive Care for the Elderly) and ESP (Elder Service Plan) programs for people 55 and older.

iii. Eligibility

(1) Depends generally on:

(a) Family circumstances (whether unmarried, married living together, married living apart (for reasons other than health care)

(b) Age (whether at least 55, 60, or 65+ depending on the specific MassHealth program)

(c) Level of need for care

(d) Financial circumstances

(2) Eligibility in younger-onset circumstances:

(a) ***Married couple at home, under age 60, with Alzheimer's Disease not yet necessitating special services:***

(i) No asset limit on eligibility.

(ii) Annual joint income limit of $19,560. (No deductible available. HOWEVER, SEE DISCUSSION OF COMMONHEALTH, BELOW.)

(b) ***Married couple at home, with Alzheimer's Disease now more advanced, and ill spouse is age 60 or older.*** If medical condition is such that the ill spouse "would need nursing home services were it not for certain services" at home, may qualify for services under the Frail Elder Home and Community-Based Services Waiver.

(i) Ill spouse has no more than $2,000 in own name; however, assets are transferrable to well spouse, without limit or penalty.

(ii) Assets and income of well spouse are disregarded.

(iii) Income of ill spouse is not more than $25,560.[4]

(iv) Neither spouse has transferred assets to establish MassHealth eligibility. (Transfers to the spouse and certain others are allowed.)

(c) ***<u>New</u> "Money Follows the Person" (MFP) Residential Supports and Community Living Waivers.***[5] These new

[4] 133% of the Federal Benefit Rate, which for 2013 is $710 monthly.

[5] MassHealth has received approval from the Centers for Medicare & Medicaid Services for two new 1915(c) home- and community-based services waivers related to MassHealth's "Money Follows the Person" demonstration. These waivers enable eligible individuals aged 18 or older to transition from facility-based long-term-care settings to community settings where they can receive their medically necessary MassHealth services. Regulations to implement these new

programs, subject at this time to limited enrollment, are intended for persons who have been in a nursing facility for at least 90 days but who are able to be safely served in the community within the terms of the waiver.

(i) Ill spouse may have no more than $2,000 in own name; however, assets are transferrable to well spouse, without limit or penalty.

(ii) Assets and income of well spouse are disregarded.

(iii) Income of ill spouse is limited to $25,560.

(iv) Neither spouse has transferred assets to establish MassHealth eligibility. (Transfers to the spouse and certain others are allowed.)

(d) ***Married couple with ill spouse in a nursing home.***

(i) Assets

1. Assets of spouses are counted together, regardless of ownership (result generally NOT affected by a prenuptial agreement)

2. Community spouse is generally entitled to a resource allowance (in 2013) of $115,920 (but may be higher in special circumstances)

(ii) Income of the community spouse – DISREGARDED. NO EFFECT ON ELIGIBILITY.

(iii) Treatment of income of the institutionalized spouse:

1. Deduction allowed of up to $2,898 (2013) (or more in special circumstances or with a court order) for the support of a low-income community spouse, as a Minimum Monthly Maintenance Needs Allowance.

2. Dependents' allowances for minor or dependent disabled children.

3. Health insurance deduction.

4. Personal needs allowance of $72.80.

5. Balance paid to the nursing home as "patient pay amount."

g. **CommonHealth**

i. A state program that provides services similar to MassHealth Standard for, among other groups, non-working disabled adults under

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programs went into effect April 1, 2013. See 130 CMR 519.007(G).

age 65 who are ineligible for MassHealth Standard because their income is too high. As particularly appropriate for many people with younger-onset Alzheimer's Disease, services include:

(1) home health care.

(2) personal care and private duty nurse services.

(3) rehabilitation and therapy services (physical, occupational, speech).

(4) mental health services.

(5) hospice services.

(6) medical equipment and supplies.

(7) adult foster care (also called adult family care).

(8) adult day health care.

ii. Eligibility

(1) Annual FAMILY income not over 133% Federal Poverty Guidelines (FPG) that vary with family/household size. For 2013, these limits are, for example, $20,628 for a couple; $25,975 for a family of three; and $31,322, for a family of four) OR

(2) Annual FAMILY income over 133% FPG but who can meet a one-time-only six-month family deductible[6] based on medical, dental, remedial,[7] home care, personal care and certain other medical and non-medical expenses not covered by insurance (but including the cost of Medicare and health insurance itself). The deductible amount depends on family income and family size. For example, the one-time deductible amount for a family of four with family income of $40,000 would be $14,534 over a six-month period.

(3) The six-month period for the deductible starts ten calendar days before MassHealth Central Processing Unit receives the MassHealth application (called a MassHealth Benefit Request or MBR), and ends six months later.

(4) Bills must be for services already received.

(5) Bills used to meet the deductible may include the following:

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[6] The deductible is based on family size (spouse and dependent children), and on the income of all family members, even if the individual with Alzheimer's Disease is the only one for whom eligibility is sought.

[7] A "remedial expense" relates to a nonmedical support service made necessary by the medical condition of any individual in the family group. It can include, for example, expenses necessary make the house or car accessible to the individual or any other individual in the family group.

(a) Bills paid during the deductible period (other than by insurance), regardless of dates of service; and

(b) Unpaid bills received during the deductible period, regardless of dates of service.

(c) Bills used to meet the deductible may not be paid or be subject to payment or reimbursement by Medicare, the Veterans' Administration, Workers' Compensation or any other health insurance or coverage. Bills paid either by the individual or by another person on the individual's behalf can be counted toward the deductible.

iii. Cost.

(1) CommonHealth members with family incomes above 150% of the Federal Poverty Guidelines have to pay monthly premiums based on a sliding fee scale, and depending on whether or not the individual also has Medicare or other health insurance. For example, the monthly premium for an individual in a family of four with total family income of $46,100 and no other insurance would be $40; family income of $92,200, a monthly premium of $202; family income of $138,300, a monthly premium of $404.

(2) Premiums are reduced if the individual is also eligible for Medicare or other health insurance, particularly in lower income ranges.

10. **What's the story with "Medicaid planning"?**

a. By Medicaid planning, I mean taking or planning specific actions to hasten or facilitate future eligibility for MassHealth or insulate an estate from MassHealth estate recovery. Such disparate activities as household repairs, debt reduction, transfers and Will revisions might be involved. Clients may ask, or wonder without asking, whether it is appropriate for them to engage in Medicaid planning and, if so, to what extent. Answering the question involves consideration of personal feelings about individual and social responsibility, but also objective factors in relation to avoiding impoverishment and protecting the spouse and family, especially where special medical, financial or personal needs are involved. Every individual and family will have its own right answers.

b. Consider two groups, at the opposite ends of the wealth spectrum.

i. The current financial circumstances of many individuals and couples are such that they already meet the financial eligibility criteria for MassHealth. For them, planning may be limited to changes in the estate plan and counseling to avoid pitfalls in the run-up to filing, particularly in avoiding what technically might be characterized as disqualifying transfers of assets.

ii. Planning for future eligibility is also not pertinent to the

concerns of most individuals of great wealth, which I am defining for present purposes as people in a position to pay privately for whatever care they need without fear of impoverishment. While hypothetically such persons could plan for future Medicaid eligibility, what would be necessary is the transfer of all right, title and interest in most of their assets, and the loss of access to and control over most of the rest. In the real world, people of great wealth tend not to be interested in giving up everything they have for the possibility of going onto Medicaid at some future time.

c. Consider two more groups, falling between these two extremes. What they have in common is that they cannot realistically pay for care privately without risk of impoverishment.

i. The less wealthy have assets that exceed the levels allowing for current eligibility, but also financial needs and circumstances that will allow for eligibility using approaches short of irrevocable transfers solely for asset protection. We sometimes speak of these approaches as involving "constructive spend-down." They include such varied actions as pre-paying funeral and burial arrangements, pay-off of debt, making renovations needed for health, safety or accessibility, separation of non-bank joint assets, transfers to special needs or other trusts for disabled children, transfer of the residence to a care-providing child, and, in limited cases, the purchase of an immediate annuity by the community spouse. These strategies have in common that none, if done appropriately, need involve a transfer penalty.

ii. Some people fall into a fourth category, of having more assets than can be dealt with by means of constructive spend-down, but not so much as not to be at risk of impoverishment or at least very serious financial degradation as a result of long-term care. Such persons will sometimes consider disqualifying transfers, despite the five-year look-back, in conjunction with constructive spend-down.

d. Here is more on the ramifications of different kinds of transfers for MassHealth eligibility.

i. Transfers of assets within five years of applying for MassHealth are in most cases subject to examination by MassHealth, which will enforce a period of ineligibility (which may be less or greater than five years) unless the transfer comes within a legal exception:

(1) To the spouse.

(2) To a child under age 18.

(3) To a child who meets the disability criteria for Social Security Disability Insurance, Supplemental Security Income or MassHealth.

(4) With regard to the principal residence, to a "care-providing child" (a child of the individual living in the home and providing care essential to maintaining the individual in the community for at least two years immediately preceding nursing home placement.

(5) To a sibling living and having an ownership interest in the residence.

ii. Some transfers in trust do not result in a transfer penalty.

(1) Transfer of assets passing by will in trust (so called testamentary trusts) for the benefit of the surviving spouse. are not subject to a transfer penalty.

(2) Assets transferred to an Irrevocable Income-Only Trusts

(3) Third-party Qualified Special Needs Trust (for the benefit of the individual's disabled child, funded by the parent applying for MassHealth).

(4) First-party ("self-funded") Qualified Special Needs Trust (for the benefit of the individual's disabled child, funded by the child.)

iii. However, other transfers in trust such as a transfer to an irrevocable income-only trust, or to a trust solely for the benefit of persons other than the individual or spouse, do result in penalty.

iv. Many other types of financial transactions may result in the assessment of a penalty, depending on the circumstances.

(1) Changes in title, for example, tenant-in-common to joint or individual.

(2) Changes in kind of financial institution, for example, bank to non-bank.

(3) Transfers of real estate subject to a retained life estate.

v. Immediate annuities meeting specific requirements of the MassHealth regulations are exempt from the penalty provisions.

e. Concerns about transfers

i. Loss of control, autonomy.

ii. Risk of failure of strategy due a change in the law.

iii. Risk to transferred assets:

(1) Misappropriation or other malfeasance.

(2) Loss or diminishment in value of transferred assets due to negligence even well-intentioned investment decisions or negligence.

(3) Loss of access to transferred assets due to the death, disability, divorce, bankruptcy, long-term unemployment or other mishap to the child or other person or persons to whom the assets were transferred.

11. **For all the specialness of planning in this context, don't neglect general estate planning concerns that nonetheless remain pertinent and**

must be addressed.

a. Have your affairs in order for the protection of:

i. Spouse

ii. Children, especially children with special needs or who are otherwise dependent

b. Concerns about probate and minimizing costs of settling affairs, consideration of use of revocable living trusts.

c. Tax concerns

i. Federal exemption – $5,250,000 million for 2013.

ii. State filing threshold – $1 million

d. Ordinary estate planning tools (in addition to durable powers of attorney and health care proxies, as discussed above):

i. Wills

ii. Trusts

iii. Beneficiary designations for life insurance, retirement accounts

Concluding Note

Individuals and families finding themselves suddenly and unexpectedly having to the deal with the impact of Alzheimer's Disease or related disorders, especially when in the prime of life, are faced with challenges on so many levels. The issues involved in the legal and financial domains are complex and unfamiliar. Dealing with them in a comprehensive and ongoing way, starting as soon as possible after onset, is essential for the effective protection of the individual and family. To be effective, care planning must be coordinated with legal and financial planning. The case for a team approach to planning, centered on the needs of the individual and his family, could not be plainer.