The Aging Population

By William E. Sigler

We are increasingly getting more questions about issues relating to aging. You do not have to go very far to find the reason. Forty million Americans are age 65 or older. By 2030, 20% of Americans will be age 65 or older. This has had a number of consequences:

- Boomer children are increasingly looking for help with providing for their parents who are age 75 or older.
- The elderly are less likely to be living near children. Moreover, there are fewer children and more divorces. This means that surviving spouses are increasingly less likely to move in with their adult children.
- Government assistance programs, long-term care insurance, and the like have increasingly more complex eligibility requirements to navigate.
- Longer lives, more dementia and increases in the cost of care combine to create a concern among the elderly and their adult children that accumulated wealth will be depleted or that the older person will not be able to afford to live in a dignified and comfortable manner.

Income During Retirement

For most people, the primary source of retirement income is Social Security. Approximately 65% of recipients receive half or more of their income from Social Security. Approximately 30% receive 90% or more of their income from Social Security. Benefits are based on the average earnings of the highest 35 years of employment.

For those born in 1937 or earlier, full Social Security benefits are available at age 65. That age gradually increases until for those born between 1943 and 1954 the age to receive full Social Security benefits is 66. It then begins to increase again until 67 becomes the age to receive full Social Security benefits for those born in 1960 or later.

Benefits are reduced by approximately 1/4 to 1/3 for those who take benefits prior

to their full retirement age. If a person delays taking their benefits after reaching full retirement age the benefits will increase by approximately 8% annually until age 70. There is no reason to delay taking benefits after age 70.

For 2017, if you are under full retirement age and you work while receiving Social Security benefits, then those benefits will be reduced by $1.00 by every $2.00 earned over $16,920. In the year that you reach your full retirement age, benefits are reduced $1.00 for every $3.00 over $44,880. There is no earnings limit once full retirement age is reached.

Social Security benefits are also subject to income tax. In the case of federal income tax, the tax is based on your adjusted gross income (including pension payouts and retirement-account withdrawals but not counting Social Security benefits), plus any tax-free interest, plus 50% of your benefits. For 2017, if this amount is under $25,000 for a single person or $32,000 for a married couple filing jointly, then the Social Security benefits are not taxed. If that amount is between $25,000 and $34,000 for a single person or between $32,000 and $44,000 for a married couple filing jointly, then 50% of the Social Security benefits are subject to tax. Lastly, if that amount is over $34,000 for a single person or $44,000 for a married couple filing jointly, then 85% of the Social Security is subject to tax.

Medicare

People generally become eligible for Medicare at age 65. Medicare Part A pays for hospitalization, although there are deductibles, co-pays and limits on the number of consecutive days that are covered. It also pays for hospice care and provides a limited skilled nursing home benefit. But, it does not pay for long-term custodial care. There is no monthly premium for Medicare Part A. It is paid for by a 2.9% tax on wages.

Medicare Part B pays for doctors and some out-patient services. However, it only pays up to the approved rate. If the doctor charges more than the approved rate, then the patient must pay the difference. In order to be eligible for Medicare Part B, you must also be eligible for Part A and pay the monthly premium which in 2017 is $134 if your adjusted gross income is $85,000 or less in the case of a single person or $170,000 or less in the case of a married couple filing jointly. The premium goes up for those with adjusted income in excess of those thresholds until it reaches a maximum monthly premium of $428.60.

Medicare Part D provides prescription drug benefits. It is provided through private insurance plans. It is rather complex and provides four different levels of reimbursement. For 2017, the four levels are as follows:

1. There is a $400 deductible, so the participant pays 100% of this amount.
2. Between the $400 deductible and the initial coverage limit of $3,700, the participant pays 25% and the plan pays 75%.
3. There is no coverage between the initial coverage limit of $3,700 and the catastrophic coverage threshold of $7,425. This is referred to as the “donut hole.” In this coverage gap, there is a 50% discount on brand name drugs. In effect, 40% of the cost is paid by the participant and 10% is paid by the plan. In the case of generic drugs, 51% of the cost is paid by the participant and 49% is paid by the plan.
4. Above the $7,425 catastrophic coverage threshold, 80% of the cost is paid by Medicare, 15% is paid by the plan, and 5% is paid by the participant.

Long-Term Care

Medicare only pays for 20 days of nursing home care, and even then only after a minimum three days in a hospital. Moreover, it must be skilled nursing care. For days 21-100, there is a co-pay. There is no coverage at all after 100 days.

Medicaid is a joint federal-state program. Nationwide, Medicaid pays for over 62% of all long-term care costs. The Federal Government pays approximately 50% of the cost, although the percentage varies by state. To get the federal dollars, the states must meet minimum eligibility standards set forth in the Federal law.

Medicare does not pay the “private pay” rate. Instead, it pays a lower rate determined by the states. The rate varies from state to state.

Medicaid pays for the cost of custodial care in a nursing home. In other words, it does not cover assisted living or home care. In order to be eligible for benefits, an individual must be both categorically and financially eligible.

To be categorically eligible, the individual must need help with two of the six activities of daily living (i.e., toileting, bathing, transporting, cooking, feeding and dressing). Financial eligibility is more difficult. An unmarried individual must essentially spend all of his or her resources and devote all of his or her income to the cost of care. Medicaid will pay the resulting shortfall. A married applicant must

spend all of the applicant's income for his or her care, but the community spouse's income is generally not counted and that income is not considered available for the support of the institutionalized spouse.

Individuals in Michigan are allowed to keep $2,000 when they apply to Medicaid for long-term care. If they are over that amount, then they must spend it down on care. Couples that both require Medicaid for long-term care are allowed to keep $4,000 in assets. If there is one spouse that requires care, and one that does not, then the spouse that does not need care is referred to as the "community spouse." For 2017, the community spouse is allowed to keep 50% of their assets up to $120,900 in countable assets. This is referred to as the "community spouse resource allowance." The community spouse is allowed to keep 100% of their marital assets up to $24,180.

The maximum amount of home equity allowed when applying for Medicaid is $560,000. Despite the fact that the home is not a countable asset, Medicaid can look for repayment in probate court from the proceeds of a sale after it stops paying for care. Other "noncountable" assets include, for example, certain personal and household items, one car, a small amount of life insurance, and a prepaid funeral contract.

An individual may not make gifts in order to qualify for Medicaid. Any gifts within five years of the application for Medicaid can result in a period of ineligibility. The number of months of ineligibility is determined by dividing the value of the gift by the average monthly cost of nursing home care as declared by the state. Currently, the average cost of nursing home care in Michigan for Medicaid purposes is $1,182 per month. The ineligibility period does not begin until the applicant is "otherwise eligible."

In addition to the asset eligibility requirements, a nursing home resident's income must also not exceed a certain level. In "income cap" states, a nursing home resident will not be eligible for Medicaid if the resident's income exceeds $2,205 a month, unless the excess income above this amount is paid to a special trust called a "Miller Trust" or a "qualified income trust." Michigan is not an "income cap" state. This means that you can spend down your excess income on your care until you reach the Medicaid threshold. If an individual is married, then the spouse's income does not typically count toward the income cap, but it is important to maximize the available income protection through the monthly needs allowance rules.

Basically, this means that if your spouse's income falls below a certain threshold, you are entitled to give your spouse a portion of your income to supplement his or her needs, and for that transferred amount not to count against your Medicaid eligibility. For 2017, the maximum amount of income that Medicaid allows a community spouse to keep in Michigan is $3,023 per month, and the minimum amount is $2,003. All of the individual's income must go towards their cost of care, aside from $60 which is for a personal needs allowance.

Using resources to buy annuities payable to the community spouse may be a way to reduce countable resources while increasing the income for the community spouse. However, the annuities must meet certain requirements:

1. The annuity must not be paid out longer than the actuarial life of the annuitant.
2. The annuity must be paid in equal installments with no balloon payment at the end.
3. The annuity must be paid to the state after the death of the annuitant to the extent that the state has paid Medicaid benefits for the institutionalized spouse.

A technique that may be available on the benefit side involves creating an irrevocable trust naming one or more persons other than yourself or your spouse to manage the trust assets as the trustee. A "trust protector" may be appointed who has the right to change the trustee at any time if the trustee is not handling the assets properly. The principal generally stays in the trust until your death, at which point the trust assets pass directly to your heirs without the necessity for probate. In the meantime, all of the income from the trust is paid to you. After the expiration of the five year look back, the principal of the trust will no longer count for Medicaid eligibility purposes.

Long-Term Care Insurance

Long-term care insurance can be purchased to cover a portion of the cost of long-term care. Benefits are usually payable if the insured needs assistance with at least two "activities of daily living" and has a cognitive impairment such as dementia. Policies vary, but benefits are usually paid when necessary for care whether in a nursing home, assisted living facility or as home care.

Benefits are typically in the form of a daily dollar amount, such as $300 per day

not to exceed the actual cost of daily care. The total benefits available are determined by multiplying the maximum days for which benefits may be paid by the daily rate. In some policies, the daily benefit may increase annually at a specified percentage to reflect the rising cost of health care.

Although benefits may be paid for life, those types of policies are becoming increasingly difficult to obtain. Generally, benefits are paid for a limited period of time, such as three or five years. Most policies are reimbursement policies that pay only if the insured has out-of-pocked costs of care. There are some indemnity policies that pay a set benefit without regard to the actual cost of care as long as a claimant meets the criteria that trigger the payment of benefits, e.g., the need for assistance with at least two activities of daily living. Most policies have an elimination period during which benefits are not paid, such as 90 or 120 days.

The long-term care insurance market has been very turbulent. For a variety of reasons, the claims have been much more expensive for the insurance carriers to cover than projected. This has led to consolidation within the industry and policies being more costly than before. As a consequence of these factors, not as many people have been buying policies as compared to when they first came out. Unfortunately for those considering long-term care insurance, the policies tend to be pricier as you get older and unavailable after a certain age.

Some insurance companies have been responding with hybrid products. Typically, these are a combination of life insurance and long-term care insurance. This may result in compromises. As a result, the policies may not be quite as good as either a straight life insurance policy or a long-term care policy. However, for those who are concerned about paying a lot of money for long-term care insurance and either dying or allowing the policy to lapse without getting anything back, these hybrid policies may be attractive.

On any of these kinds of policies it is wise to include a provision for a third party lapse notification. Many older people forget or misplace their renewal notices resulting in the policies lapsing. As a result, when the policy is needed and the children file a claim, they find that the policy is no longer in force. A third party lapse notification requires the insurance company to notify a third party before allowing the policy to lapse.

If you are interested in discussing the issues addressed herein, please contact one of our Estate Planning professionals.

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