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Legal Matters®

Elder Law
summer 2017

Four legal steps to take right after receiving an Alzheimer's diagnosis

If you or a loved one has been diagnosed with Alzheimer's disease, it is important to start planning immediately. There are several essential documents to help you once you become incapacitated, but if you don't already have them in place you need to act quickly after a diagnosis.

Having dementia does not mean that an individual is not mentally competent to make planning decisions. The person signing documents must have "testamentary capacity," which means he or she must understand the implications of what is being signed. Simply having a form of mental illness or disease does not mean that you automatically lack the required mental capacity. As long as you have periods of lucidity, you may still be competent to sign planning documents.

Here are some essential documents for a person diagnosed with dementia:

- **Power of Attorney.** A power of attorney is the most important estate planning document for someone who has been diagnosed with Alzheimer's disease or some other form of dementia. A power of attorney allows you to appoint another person to make decisions on your behalf once you become incapacitated. Without this document, your family will be unable to pay your bills or manage your household without going to court and getting a guardianship, which can be a time-consuming and expensive process.



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- **Health Care Proxy.** A health care proxy, like a power of attorney, allows you to appoint someone else to act as your agent, but in this case it is for medical decisions. It will ensure that your medical treatment instructions are carried out. In general, a health care proxy takes effect only when you require medical treatment and a physician determines that you are unable to communicate your wishes concern-

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Long-term care benefits for veterans and surviving spouses



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Long-term care costs can add up quickly. But for veterans and the surviving spouses of veterans who need in-home care or are in a nursing home, help may be available. The Veterans Administration (VA) has an underused pension benefit called Aid and Attendance that provides money to those who need assistance performing everyday tasks. Even veterans whose income is above the legal

limit for a VA pension may qualify for the Aid and Attendance benefit if they have large medical expenses for which they do not receive reimbursement.

Aid and Attendance is a pension benefit, which means it is available to veterans who served at least 90 days, with at least one day during wartime. The veteran does not have to have service-related disabilities to qualify. Veterans or surviving spouses are eligible if they require the aid of another person to perform an everyday activity, such as bathing, feeding, dressing or going to the bathroom. This includes individuals who are bedridden, blind or residing in a nursing home.

To qualify, the veteran or spouse must have less than \$80,000 in assets, excluding a home and vehicle. In addition, the veteran's income must be less than the Maximum Annual Pension Rate (MAPR). Following are the MAPRs for 2017:

- Single veteran: \$21,531
- Veteran with one dependent: \$25,525
- Single surviving spouse: \$13,836

- Surviving spouse with one dependent: \$16,506

Income does not include welfare benefits or Supplemental Security Income. Moreover, income may be reduced by subtracting unreimbursed medical expenses actually paid by the veteran or a member of his or her family. This can include Medicare, Medigap, and long-term care insurance premiums; over-the-counter medications taken at a doctor's recommendation; expenses such as nursing home fees; the cost of an in-home attendant who provides some medical or nursing services; and the cost of an assisted living facility. These expenses must be unreimbursed (in other words, insurance must not pay the expenses). They should also be recurring, meaning that they should recur every month.

How it works. The amount of Aid and Attendance benefit a person receives depends on his or her income. The VA pays the difference between the veteran's income and the MAPR. For example, assume that John, a single veteran, has income from Social Security of \$16,500 a year and a pension of \$12,000 a year, so his total income is \$28,500 a year. He pays \$20,000 a year for home health care, \$1,122 a year for Medicare, and \$1,788 a year for supplemental insurance, so his total medical expenses are \$22,910. If you subtract his medical expenses from his income (\$28,500 - \$22,910), John's countable income is \$5,590. That means he could qualify for \$15,941 (\$21,531 - \$5,590) in Aid and Attendance benefits.

To apply, contact a VA office near you.

We welcome your referrals.

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Four legal steps to take right after an Alzheimer's diagnosis

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ing treatment.

• **Medical Directive or Living Will.** Medical directives and living wills explain what type of care you would like if you are unable to direct your own care. A medical directive can include a health care proxy or it can be a separate document. It may contain directions to refuse or remove life support in the event you are in a coma or a vegetative state, or it may provide instructions to use all efforts to keep you alive, no matter what the circumstances.

• **Will and Other Estate Planning Documents.** In addition to making sure you have people to act for you and your wishes are clear, you should make sure your estate plan is up to date. If you don't have an estate plan, you should draw one up. Your

estate plan directs who will receive your property when you die. Once you are deemed incapacitated, you will no longer be able to create an estate plan. A plan usually consists of a will, and often a trust as well. Your will is your legally binding statement on who should receive your property, while a trust is a mechanism for passing on your property outside of probate.

In addition to executing these documents, it is also important to create a plan for long-term care. Long-term care is expensive and draining for family members. Developing a plan now for what type of care you would like and how to pay for it will help your family later on. Your attorney can assist you in developing that plan and drafting any necessary documents.

New protections for nursing home residents

Obama-era rules designed to give nursing home residents more control of their care are gradually going into effect. The rules give residents more options regarding meals and visitation as well as making changes to discharge and grievance procedures.

The federal Centers for Medicare and Medicaid finalized the rules, which are the first comprehensive update to nursing home regulations since 1991, in November 2016. The first group of new rules took effect in November. The rest will be phased in over the next two years.

Here are some of the rules newly in effect:

- **No more “visiting hours.”** The new rules allow residents to have visitors of the resident’s choosing at the time the resident wants, meaning that the facility cannot impose visiting hours. There are also rules about who must have immediate access to a resident, including a resident’s representative.

- **Freedom to snack.** Nursing homes must make meals and snacks available when residents want to eat, not just at designated meal times.

- **Choice of roommate.** Residents can choose their roommate as long as both parties agree.

- **Complain without fear.** Each nursing home must designate a grievance official whose job it is to make sure grievances are properly resolved. In addition,

residents must be free from the fear of discrimination for filing a grievance. The nursing home also has to put grievance decisions in writing.

- **More transfer and discharge protections.** The new rules require more documentation from a resident’s physician before the nursing home can transfer or discharge a resident based on an inability to meet the resident’s needs. The nursing home also cannot discharge a patient for nonpayment if Medicaid is considering a payment claim.

CMS also enacted a rule forbidding nursing homes from entering into binding arbitration agreements with residents or their representatives before a dispute arises. However, a nursing home association sued to block the rule and a U.S. District Court granted an injunction temporarily preventing CMS from implementing it. The Trump administration is reportedly planning to lift this ban on nursing home arbitration clauses.

In November 2017, rules regarding facility assessment, psychotropic drugs, medication review and care plans, among others, will go into effect. The final set of regulations covering infection control and ethics programs will take effect in November 2019.



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Hospitals now must provide notice about observation status

All hospitals must now give Medicare recipients notice when they are in the hospital under “observation.” The notice requirement is part of a law enacted in 2015 that just took effect.

Signed by President Barack Obama in August 2015, the law was intended to prevent surprises after a Medicare beneficiary spends days in a hospital under “observation” and is then admitted to a nursing home. This is important because Medicare covers nursing home stays entirely for the first 20 days, but only if the patient was first admitted to a hospital as an inpatient for at least three days. Many beneficiaries are being transferred to nursing homes only to find that because they were only under observation and were therefore hospital outpatients all along, they must pick up the tab for the subsequent nursing home stay — Medicare will pay none of it.

The law, the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, does

not eliminate the practice of placing patients under observation for extended periods, but it does require hospitals to notify patients under observation for more than 24 hours of their outpatient status within 36 hours, or upon discharge if that occurs sooner. The Act required hospitals to begin giving patients this notice as of March 8, 2017. Some states, including California and New York, already require such notice.

To avoid violating the law, hospitals that accept Medicare patients will now have to explain to patients under observation that because they are receiving outpatient, not inpatient, care, their hospital stay will not count toward the three-day inpatient stay requirement and that they will be subject to Medicare’s outpatient (Part B) cost-sharing requirements for hospital stays.

The law does not make hospital observation stays count towards Medicare’s three-day requirement, as some in Congress have called for doing.

Short-term care insurance: An alternative to the long-term care variety

A little-known insurance option can be an answer for some people who might need care but are unable to buy long-term care insurance. Short-term care insurance provides coverage for nursing home or home care for one year or less.

As long-term care premiums rise, short-term care insurance is gaining in popularity. This type of insurance is generally cheaper than its long-term care counterpart because it covers less time. Purchasers can choose the length of coverage they want, up to one year. According to the American Association for Long-Term Care Insurance, a typical premium for a 65-year-old is \$105 a month.

People who can't qualify for long-term care insurance because of health reasons may be able to qualify for short-term care coverage. This kind of insurance doesn't usually require a medical exam and sometimes only has a few medical questions on the application. Another benefit of short-term care insurance is that there usually is not a deductible. The policies begin paying immediately, without the waiting period usually found in long-term care policies.

Short-term care policies are not the answer for everyone, however. They may not cover all the levels of care that a long-term care policy would cover. As with any insurance product, buyers need to make sure that they understand what coverage



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they are purchasing. These policies are also not regulated to the same extent that long-term care insurance policies are, so there are fewer consumer protections.

Short-term care policies may be beneficial for individuals who waited too long to purchase long-term care insurance (short-term care can typically be purchased up to age 89). They can also help fill gaps in Medicare coverage or cover the deductible period before long-term care insurance begins paying. The policies may also be appealing to single women because there is no price difference for women and men, as there is for long-term care insurance.