MASSACHUSETTS BAR ASSOCIATION

PROBATE LAW SECTION COUNCIL

May 1, 2009

Dear Massachusetts Elder:

We are very pleased that you are taking the time to participate in the Massachusetts Bar Association-Massachusetts Bar Institute Elder Law Education Program and to read the information in this booklet. In changing times, it is important to continually review plans that you have made for your retirement, your ongoing care, and to pass along your estate to the people you care about most.

The enclosed materials were assembled by the MBA Probate Section Council, in collaboration with the Massachusetts Chapter of the National Academy of Elder Law Attorneys and the individual attorneys listed in the acknowledgements. It has been compiled using the hard work and expertise of these attorneys and is updated annually to give you some very good ideas and guidance.

You should consult with a knowledgeable attorney to put your plans into practice. These materials are part of an annual Elder Law Education Program presented across Massachusetts by volunteer attorneys. Both the program and information are part of a wonderful tradition of public service at the MBA. We hope that you will find them interesting and helpful.

Respectfully,

John G. Dugan, Esq., chair
Probate Law Section Council
Massachusetts Bar Association

NOTE: This is the 2009 version of the resource guide; some presented information may be out-of-date.

Acknowledgments

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Massachusetts Chapter of the National Academy of Elder Law Attorneys

The mission of the National Academy of Elder Law Attorneys is to develop awareness of issues surrounding legal services for the elderly. The more than 600 attorneys members of the Massachusetts Chapter work for our elderly population in areas as diverse as: planning for catastrophic care costs; disability planning; age discrimination in employment and housing; benefits planning including Medicaid and Medicare; and guardianships, probate and estate planning.

The objective of both the national and Massachusetts chapters is to promote the highest standards of technical expertise while maintaining ethical awareness among attorneys who represent the most frail and vulnerable members of the society.

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Chapter One

Commonly Asked Questions in Elder Law

The following questions and answers are meant to answer the basics of elder law. Some of these questions and answers are explained at greater length in later chapters. If such a chapter is contained in this guide it is referenced so that you may easily find it.

A. What is elder law?

Elder law is a very individualized area of law that focuses on advance planning for life events as well as health and wealth management. It is a unique area of the law because it addresses individual and estate needs through a multi-disciplinary lens, often incorporating services of social workers, tax specialists, and other professionals. Some services provided by elder law attorneys are:

- Asset protection;
- Medicare and Medicaid planning;
- Harmonizing long-term care and financial planning;
- Utilizing long-term care insurance;
- Health care decision-making and using advanced directives;
- Estate planning through devices such as durable powers of attorney, living trusts, wills and real estate strategies; and
- Researching housing options and alternatives to nursing homes.

B. What are the essential estate planning documents I should know about?

- Wills;
- Health care proxies *(see questions E through G)*;
- Powers of attorney *(see questions H through J)*;
- Deeds with life estates and realty trusts *(see question M)*;
- Revocable and irrevocable trusts;
- Gift giving plans; and
- Asset protection plans.

C. What is the probate process?

Probate is a judicial process that takes place when someone dies with property in his or her name alone. Joint accounts and property held by husband and wife as tenants by the entirety are not "probate property," so they are not subject to the probate process. Joint property and property held as tenants by the entirety pass to the co-owner(s) immediately upon the death of a co-owner. In contrast, property held as tenants in common gives each co-owner an equal share with equal rights, and upon the death of any co-owner, his or her share passes to that individual's estate.

The probate process takes two different routes depending on whether or not the person who died had a will (a formal document often drafted by an attorney that complies with state laws and

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expresses an individual's wishes for dividing up of his or her property). A person either dies "testate", meaning with a will, or "intestate", meaning without a will.

In the probate process, if the individual dies testate, the will should be filed within 30 days of the date of death. However, it is often filed much later without penalty. An individual named as executor under the will must be appointed by the probate court in the county where the decedent resided. On the other hand, if a person dies intestate and with property, the property passes by the state laws of intestacy. Upon a petition to the probate court, an estate administrator is appointed.

Some of the laws of intestacy are that intestate property first passes one-half to a surviving spouse and one-half to the children, in equal shares. If no children but there are kindred (nieces, nephews, cousins), the spouse takes the first $200,000 and one-half of the remaining property and the kindred take the other one-half. If there are no issue (children) and no kindred, then the surviving spouse takes all. If there is no surviving spouse, then the children, or their issue if deceased, receive the intestate property in equal shares. If there are no spouse or children, then it passes to the next level of heirs starting with parents, then siblings, then nieces and nephews, etc.

D. What are federal and state estate taxes and how do they differ from gift taxes?

Estate taxes are assessed at one's death, whereas gift taxes are assessed at the time a gift is made or transferred during one's lifetime.

Estate taxes may be due from the estate of the last to die of a husband and wife, or from the estate of an unmarried individual. There is a 100 percent tax exemption for bequests between spouses, but when the surviving spouse then dies, a higher, graduated tax may be owed on the entire estate if planning is not done before the first spouse dies.

For both estate and gift tax purposes, it is essential to plan ahead. For example, the federal estate, gift, and generation-skipping transfer (GST) taxes form a transfer tax system that was formerly unified but became separated in 2004. The GST tax exists in order to make sure property does not skip a generation without a transfer tax. While the federal gift tax exemption will remain at $1 million for now, unlimited marital and charitable deductions may be made from this exemption. The estate and GST tax exemption will be valued as of the year of death of the individual, as follows:

2006–08	$2 million
2009	$3.5 million
2010	Unlimited
2011	$1 million

The current estate exemption for Massachusetts is $1 million. There is no Massachusetts gift tax. There is much confusion about tax-free gifts. A change in federal law allows each person to now make a tax-free gift of $13,000 (with small cost of living increase each year) to each appropriate individual, every year. A married couple can make joint gifts of up to $26,000 to each individual every year. Each gift is applied as a credit on the estate tax exemptions discussed above. If a person or couple is not concerned about estate taxes, then gifts in excess of $13,000 (or $26,000 a couple) per person may be given with no adverse consequences to the donor or donee, up to the lifetime exemption amount. A qualified accountant, or a certified public accountant (CPA), can advise you as to whether a gift tax return should be filed and can provide you with filing instructions.

E. What is a health care proxy?

A health care proxy is a signed document that permits you to designate, in advance, who will make your health care decisions in the event that you become incapacitated or unable to make your own health care decisions. The agent, or person you appoint must be 18 years of age or older, and if you are unable to communicate your wishes, he or she will be permitted to make a wide range of medical decisions on your behalf.

F. What are the differences between a health care proxy and a living will?

A living will is a document that specifies in advance any life-sustaining measures a person refuses to undergo if there is no reasonable expectation of recovery. Typically, a person may refuse the use of feeding tubes, respirators and cardiac resuscitation. The living will makes an incapacitated individual's treatment preferences known in a set of limited and specific circumstances and serves as a guide in medical decisions, but living wills are NOT legally enforceable. If the health care proxy is not limited to a specific set of circumstances, but allows an agent the flexibility to make treatment decisions in a wide range of situations, and a health care proxy is legally enforceable in Massachusetts. Therefore, the health care proxy is the recommended method for medical decision making in the event of incapacity.

G. Who will make medical decisions if no health care proxy exists?

If you become unable to make or communicate treatment decisions to health care providers and you do not have a proxy or agent, decisions will often be made by next of kin or a guardian. This is usually a slower process than if a health care proxy is in place. More importantly, treatment decisions made by a committee of family and health care professionals may not reflect your values and beliefs. In sum, the health care proxy assists in having your treatment preferences carried out in the most efficient manner possible.

H. What is "power of attorney" and what can it do?

A durable power of attorney is a written legal document created by an individual in order to authorize another person, or persons, to legally act on their behalf in handling their property. The person creating the power (the principal) specifies in the legal document the specific authority he or she wants the other person, the attorney-in-fact, to possess.

The attorney-in-fact (the person acting on behalf of the principal) will only have those powers specifically granted to him or her by the principal. The principal can authorize the attorney-in-fact to complete a broad range of activities, including signing checks, making investment decisions, entering into contracts, making gifts, creating trusts and transferring property. The principal can grant to the attorney-in-fact the power to do most things the principal could have done for him or herself. This is a very powerful estate planning tool, and should be used with discretion and care.

I. What is the difference between a "durable" and "non-durable" power of attorney?

A limited or non-durable power of attorney is for specific and limited authority for a specific situation, such as a sale of real estate. The limited or non-durable power of attorney is effective immediately, but it automatically terminates when the principal becomes incompetent. The non-durable power can be useless because it terminates when it is most essential. In other words, when the principal becomes incompetent the power terminates, so in order to manage the incompetent individual's es-

tate, their family would need to seek the appointment of a guardian or conservator from the probate court. Alternatively, if a durable power of attorney exists, the power to act on the principal's behalf continues even after the principal becomes incompetent. The power of attorney can be revoked by a competent principal at any time, but not by an incompetent principal.

J. What is the difference between a "springing" and "present" durable power of attorney?

In Massachusetts, durable powers of attorney are governed by statute. There are two basic forms a durable power of attorney can take. The first is a present durable power of attorney authorizes the attorney-in-fact to act for principal instantaneously. The second is a springing durable power of attorney becomes effective only upon the incapacity or incompetency of the principal.

K. What is a homestead declaration?

A homestead declaration is a recorded form that protects the home of a debtor, debtor's spouse or debtor's minor children from creditors and their claims. To secure this protection, the homeowner must file a declaration with the registry of deeds where the deed to the property is recorded. The homestead declaration protects the equity in one's home from claims of creditors up to $500,000, which was increased on Oct. 26, 2004 from $300,000. A homestead recorded prior to Oct. 26, 2004 is retroactive to the date of the filing, except in regard to debts that were recorded prior to the date of the increase. The law permits only one homestead declaration for co-owners under age 62 and two or more homestead declarations for co-owners who are age 62 and above or disabled. Therefore, homeowners who are age 62 and above or who are disabled can protect up to $1,000,000 in equity in their homes if both owners file separate declarations of homestead.

L. What specifics should I know about a homestead declaration?

a. It is important to be aware that some property is **NOT** protected by a homestead declaration, such as:
   - A Medicaid lien if the owner requires nursing home care;
   - Federal, state, and local taxes, assessments, claims and liens;
   - First and second mortgages;
   - Debts, encumbrances, or contracts existing **PRIOR** to the filing of the declaration of homestead; or
   - Judgment that the spouse pay support for the other spouse or for minor children.

b. Also, note that if you recorded a homestead declaration before you were 62 years old, you must file a new declaration to gain the added protections the law gives elderly homeowners.

c. Lastly, you should know that if you deed your house to your children but reserve a life estate after making a homestead declaration, you will lose the homestead. At that point, the protection offered by a homestead declaration would protect only your reserved life estate.

M. What is a deed with a reserved life estate?

A deed is a document showing proof of ownership of real property. A deed with a reserved life estate is used when you wish to pass your real property to someone upon your death, but plan to live in and maintain control of the property until death. While you live in or control the deeded property, you are responsible for its upkeep. A benefit of this type of deed is that the remainder is passed im-

mediately upon your death to whomever you appoint, which avoids the probate process discussed above. A disadvantage is that the property cannot be fully sold without the assent of the life and remainder estate holders.

While a step up in basis for capital gains tax purposes will be realized upon the death of the life estate holder, the life tenant age 55 or older will lose the Section 121 capital gains tax exclusion if the real property is sold while the life tenant is living. Under current Medicaid estate recovery law, individuals who receive Medicaid in the community who are age 55 and older, or any age in a nursing facility, will have a lien placed on any property in which they have an ownership interest, including a life estate. If it is sold during their lifetime, the lien will be collected. If the life estate owner dies owning the property, their ownership ends, and therefore the lien will end, and there will be no recovery.

N. What is the difference between Medicaid and Medicare?

Medicare is a federal health insurance program associated with Social Security Insurance (SSI) benefits for people over 65 years or disabled. It is not a needs-based program. It assists in paying for medical expenses, such as hospital visits, prescriptions and hospice care; but it does not pay for some other services, such as extended nursing home care.

Medicaid is a joint federal and state assistance program that is available to anyone who meets the financial eligibility rules, as well as those eligible for SSI. Medicaid eligibility criteria differs by category, but for those age 65 and over, the asset limitation is $2,000 for an individual. The income limit for an applicant age 65 and over living in the community is $903 per month for standard community Medicaid, although excess income may be spent down on medical care to receive benefits. For nursing home coverage, all monthly income over $72.80 must be paid to the nursing home, although there are exceptions if there is a spouse still living in the community. Medicaid comprehensively pays for both physical and mental health maintenance needs of those receiving coverage. It also pays for long-term nursing home care for individuals and members of couples. *For more information, see Chapters 3 and 4.*

O. If I need nursing home care, but my spouse does not, will I still be eligible for Medicaid?

Yes. You will still be eligible for Medicaid assistance in paying for nursing home costs and amended statutes protect more of your assets. The laws work to find a balance between the belief that the healthy spouse should use his or her resources to fund the other spouse's nursing home care and the reality that such a financial burden may be devastating to the spouse still living at home. As of Jan. 1, 2009, the Community Spouse Resource Allowance (CSRA) has been increased so that the "community spouse" may keep all of the couple's assets up to $109,560. There are various techniques available to save additional funds.

P. What is a supplemental needs trust?

By way of background, it is important to note that trusts are used to hold a sum of money or property to be used for the benefit of a person or persons. The money or property held in the trust is managed by a trustee according to the grantor's instructions. A supplemental needs trust (SNT) is a specialized trust usually used to support the supplemental needs of a disabled individual not otherwise covered by government benefits and other sources of support. A SNT will often be established by parents of a child with a disability, and managed by the parents or a third party. For government benefit purposes, funds in the trust are not counted as the child's assets because the child has no

access to or control over the funds. Parents or any other person can continue to add funds to a SNT after its creation without fear of disqualifying the child from benefit programs. Trusts that are created or funded by an individual receiving benefits may require that there be a provision allowing Medicaid be paid back upon that individual's death.

Q. When should long-term care insurance be considered?

Long-term care insurance is best suited for individuals who are not eligible for Medicaid, but do not have the financial means to pay entirely out of pocket for the costs of long-term care. It is best to purchase long-term care Insurance well before one actually needs it to avoid expensive premiums. Policies purchased at age 65 cost $1,800 per year for four years of coverage, while the same policy purchased at 79 costs $5,900 per year.

One way to purchase long-term care insurance is through a life insurance policy or an annuity, where withdrawals from such policies can help pay for long-term care needs can yield tax-free benefits. *For more information on long-term care insurance, refer to Chapter 6.*

R. What tax exemptions are available to Massachusetts homeowners?

If you are a homeowner and a legal resident of Massachusetts, there are programs available in your city or town which may provide either an exemption or a deferral of real estate taxes. In Massachusetts a homeowner may obtain a deferral or exemption if you are: elderly, a veteran of the armed forces, blind, a widow or widower or a minor child of deceased parents. *See Chapter 10 for detailed eligibility rules.*

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CHAPTER TWO

Aid and Attendance Veterans' Benefits

What You Should Know About Special Benefits for Home Care and Assisted Living for Veterans and Spouses of Deceased Veterans

INTRODUCTION

Veterans benefits are confusing and difficult to follow with regard to the plans and who is eligible for them. Many elders have served our country or have spouses who have done so and are struggling with or will have to struggle with at sometime in the near future what they are eligible for in regards to assistance. This guide is our attempt to assist clients in understanding the complexities of veterans benefits and enlighten them as to how to work their way through the basics so that they may be able to find the programs that suit their needs. You cannot fully rely on the information set out in this transitional guide.

A. What is the Aid and Attendance Allowance?

1. This program provides benefits for veterans and surviving spouses, who meet certain criteria in regards to their income and assets. The Aid and Attendance program is a special pension available to veterans and their surviving spouses. If eligible, veterans or their surviving spouses may be able to receive financial assistance to help pay for care they may require with their daily living activities such as dressing, undressing, bathing, eating and other every day activities of life. Coverage includes individuals who, because of mental or physical incapacity, require such assistance either in their homes, in an assisted living facility, or in a nursing home. It is a federal program available to veterans and their widows in every state.
2. The benefits available are as follows: a veteran may be eligible for up to $1,644 per month, while a surviving spouse is eligible for up to $1,056 per month, and a couple is eligible for up to $1,949 per month. All benefits are tax-free. These figures are the maximum available through the Aid and Attendance pension. This may be combined with additional veterans or other benefits or programs, though depending on the program there may be some offset.
3. The basic requirements for eligibility are:
    a. The veteran must have served at least 90 days active duty;
    b. Served one day during a time of war and have been other than dishonorably discharged;
    c. For those who did not serve in active duty there are other qualifying features under Mass. G.L. ch. 4, § 7;
    d. A widow must have been married to the veteran at the time of death; and
    e. A widow must be over age 65.
4. The veteran must have served at least one day during one of the following periods and served a total of at least 90 days of continuous military service.
    - **World War II:** Dec. 7, 1941 through Dec. 31, 1946
    - **Korean War:** June 27, 1950 through Jan. 31, 1955
    - **Vietnam War:** Aug. 5, 1964 (Feb. 28, 1961 for those who served "in country" before Aug. 5, 1964) through May 7, 1975

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- **Gulf War:** Aug. 2, 2000 through a date yet to be set by law.

5. Eligibility must be proven by filing the proper Veterans Application for Pension or Compensation. This application will require a copy of DD-214 or separation papers, a medical evaluation from a physician, current medical issues, net worth limitations and net income, along with out-of-pocket medical expenses. It is not required that the veteran has previously been receiving disability or a military pension.
6. What is considered in regards to an individual's net worth can be a bit of an ambiguous standard in the application process, and it is best to consult with an expert if you are unsure of how your assets may be viewed in the administrative process. Veteran's Administration (VA) workers have the liberty to use their personal judgment when considering an individual's assets compared with their needs and how far the assets would realistically last in paying for the individual's needs before running out.
7. A family home or vehicle is not counted when estimating net worth, so long as the individual resides in the community, this may not be the case if the individual resides in an assisted living facility or nursing home and there is no community spouse. Similar to Medicaid, life insurance that does not have a cash surrender value is not countable. All liquid assets, or assets that may be liquidated, are considered countable. Such assets include CDs, annuities, stocks, bonds, savings accounts, checking accounts, IRAs and Keoughs. Assets owned solely by a spouse are not countable.
8. An applicant's assets are assessed on a sliding scale test of age verses assets. The generally used figure is about $80,000, but this is not a red-line test. An older applicant may need to further reduce their assets in order to be eligible. There are no transfer penalties similar to many other community benefits for the disabled or elderly. Therefore, an individual may be over the asset limitation and transfer the excess assets to a spouse, child or family trust; and the individual would then be eligible once the transfer is complete.
9. The program is driven by a formula between income and the out of pocket medical cost of the individual. All income must be included in the calculation, this includes: Social Security, pension, interest, dividends, rental income, and annuity payouts. If married, a spouse's income is also considered. All un-reimbursed, recurring medical expenses are considered. These costs include; nursing home costs, assisted living costs, home health services, health insurance premiums, Medicare premiums and prescription costs.
10. The following documents will be needed to complete the process:
    - An application filled out on behalf of the individual who is in need of benefits (21-526 form or 21-534 form);
    - Discharge/separation papers (DD-214 form)*;
    - Birth certificate;
    - Proof of residency;
    - Proof of marriage (if applicable);
    - If you are a court-appointed guardian of the veteran or surviving spouse, a certified copy of the court order of the appointment is required;
    - Death certificate, if the veteran has passed away;

- Physician's affidavit as to inability to care for one's self, and current diagnosis/status;
- Income/asset information (evidence of your Social Security income);
- Proof of medical expenses;
- Work history if you are under 65;
- Direct deposit information for benefit check;
- A list of doctors and hospitals visited in the last year; and
- Consent to release information forms so the VA may request any additional information they may determine they require.

*If you do not have these papers you may request them from www.archives.gov. You may file the rest of the application and forward this information when it is received.

11. To actually receive payment from the Aid and Attendance program it may take anywhere from four to six months. Payments are made retroactively from the first day of the month following when the application is filed. It is important to note that the application must be filed no later than the third week of the month prior to the month you anticipate receiving benefits. For example if you would like to be eligible for benefits on Feb. 1, then you must file the application, no later than the week of Jan. 25.

Example:

$3,000 (veteran's monthly income) – $2,600 (medical expenses) = $400 (net income)

$1,644 (possible benefit) – $400 (net income) = $1,244 VA benefit per month

12. If you need assistance with the application process, your may consult your local Veterans Administration office on this and other benefits you may be eligible for. However, it should be noted that many local offices are untrained on this benefit, and some are even unaware of it. If the individual filing has any mental incapacity, it is likely that the Department of Veterans Affairs will require that a fiduciary be appointed, as they may declare the individual incompetent to handle their own financial affairs. It is important to note that a power of attorney will not be accepted by the Veterans' Administration. If an applicant is unable to sign their name, then the applicant may make an "X", if accompanied by two witnesses who will sign the application as well.

B. State veterans' cemeteries

1. Massachusetts has two state Veterans' Memorial Cemeteries located in Agawam and in Winchendon. There is no fee for a veteran's burial in a state veterans' memorial cemetery. A nominal fee will be charged for the burial of spouses, widows/widowers and qualified dependents.
2. Eligibility is established if the veteran meets one requirement under a. and one requirement under b. below:**
   a. Service term
      - The veteran was discharged or released from active duty service under honorable conditions; *or
      - The veteran served at least 20 years in the National Guard or United States Reserves and is in receipt of a military pension or has documentation verifying she or he will

receive retirement pay at age 60 (in accordance with Title 10, Chapter 1223, of the U.S. Code); or

- Any member of the armed forces of the United States who dies on active duty and whose home of record is Massachusetts.

* With certain exceptions, service beginning after Sept. 7, 1980, as an enlisted person, and service after Oct. 16, 1981, as an officer, must be for a minimum of 24 months, or the full period for which the person was called to active duty (examples include those serving less than 24 months in the Gulf War or reservists who were federalized by presidential recall).

b. Residency

- The veteran's home of record on his or her discharge form (DD Form 214) indicates that he or she was a resident of Massachusetts at the time they entered into active duty; or
- The veteran resided in a state other than Massachusetts when he or she entered military service and resided in Massachusetts at least one day after discharge from active duty; or
- The veteran was a resident of Massachusetts at the time of his or her death.

3. For more information on family member eligibility or federal veterans cemeteries, please contact the Massachusetts Department of Veterans' Services or the U.S. Department of Veterans Affairs *(contact information below)*.

C. Other veterans' benefits

1. Medal of honor pension: The VA administers pensions to recipients of the Medal of Honor. Congress set the monthly pension at $1,194, effective Dec. 1, 2008.
2. Annuities: Massachusetts and its Department of Veterans' Services offers an annuity in recognition of the service of distinguished 100 percent service-connected disabled veterans, and to the parents of distinguished veterans (Gold Star parents) and the un-remarried spouses of distinguished veterans who gave their lives in wartime service. The annuity is in the amount of $2,000, payable bi-annually in August and February.

D. Veterans' services contact information

Boston Veterans' Services Office
43 Hawkins St., Boston, MA 02114
Tel: (617) 635-3037
Fax: (617) 635-395

Application forms are available online at www.vabenefits.vba.va.gov/bln/dependents/spouse.htm
Veterans' Administration benefits: (800) 827-1000

MASS • ALFA — Massachusetts Assisted Living Facilities Association
460 Totten Pond Road, Suite 600, Waltham, MA 02451
Tel: (781) 622-5999
Fax: (781) 622-5979
www.massalfa@massalfa.org

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U.S. Department of Veterans Affairs
National Cemetery Administration
(800) 827-1000
www.cem.va.gov

Massachusetts Veterans' Memorial Cemeteries
Agawam, MA 01001
(413) 821-9500

and
111 Glenallen St., Winchendon, MA 01475
(978) 297-9501
www.mass.gov/veterans

National Veterans' Cemeteries
For eligibility criteria or application, visit the National Cemetery Administration at www.cem.va.gov or call (800) 827-1000 to talk to a VA benefits coordinator.

Massachusetts National Cemetery
Connery Ave., Bourne, MA 02532
(508) 563-7113

Military Honors at Funeral
Contact the branch of service to request military honors for a funeral.

Army:	(888) 325-1601
Air Force:	(781) 377-4850
Coast Guard:	(617) 223-3485
Marine Corps:	(866) 826-3628
Navy:	(860) 694-3475

E. Mass. G.L. ch. 4, § 7 defining "Veteran"

Forty-third, "Veteran" shall mean; (1) any person, (a) whose last discharge or release from his wartime service as defined herein, was under honorable conditions and who (b) served in the Army, Navy, Marine Corps, Coast Guard, or Air Force of the United States, or on full time National Guard duty under Titles 10 or 32 of the United States Code or under sections 38, 40 and 41 of Chapter 33 for not less than 90 days active service, at least 1 day of which was for wartime service; provided, however, than any person who so served in wartime and was awarded a service-connected disability or a Purple Heart, or who died in such service under conditions other than dishonorable, shall be deemed to be a veteran notwithstanding his failure to complete 90 days of active service; (2) a member of the American Merchant Marine who served in armed conflict between Dec. 7, 1941 and Dec. 31, 1946, and who has received honorable discharges from the United States Coast Guard, Army, or Navy; (3) any person (a) whose last discharge from active service was under honorable conditions, and who (b) served in the Army, Navy, Marine Corps, Coast Guard, or Air Force of the United States for not less than 180 days active service; provided, however, that any person who so served and was awarded a service-connected disability or who died in such service under conditions other than dishonorable, shall be deemed to be a veteran notwithstanding his failure to complete 180 days of active service.

"Wartime service" shall mean service performed by a "Spanish War veteran," a "World War I veteran," a "World War II veteran," a "Korean veteran," a "Vietnam veteran," a "Lebanese peace keeping force veteran," a "Grenada rescue mission veteran," a "Panamanian intervention force veteran," a "Persian Gulf veteran" or a member of the "WAAC" as defined in this clause during any of the periods of time described herein or for which such medals described below are awarded.

"Spanish War veteran" shall mean any veteran who performed such wartime service between Feb. 15, 1898 and July 4, 1902.

"World War I veteran" shall mean any veteran who, (a) performed such wartime service between April 6, 1917 and Nov. 11, 1918, or (b) has been awarded the World War I Victory Medal, or (c) performed such service between March 25, 1917 and Aug. 5, 1917, as a Massachusetts National Guardsman. [Definition of "World War II veteran" in clause 43 effective until Nov. 11, 2005. For text effective Nov. 11, 2005, see below.]

"World War II veteran" shall mean any veteran who performed such wartime service between Sept. 16, 1940 and Dec. 31, 1946, except that for the purposes of Chapter 31 it shall mean all active service between the dates of Sept. 16, 1940 and June 25, 1950. [Definition of "World War II veteran" in clause 43 as amended by 2005, 130, Sec. 1 effective Nov. 11, 2005. For text effective until Nov. 11, 2005, see above.]

"World War II veteran" shall mean any veteran who performed such wartime service between Sept. 16, 1940 and July 25, 1947, and was awarded a World War II Victory Medal, except that for the purposes of Chapter 31 it shall mean all active service between the dates of Sept. 16, 1940 and June 25, 1950.

"Korean veteran" shall mean any veteran who performed such wartime service between June 25, 1950 and Jan. 31, 1955, both dates inclusive, and any person who has received the Korea Defense Service Medal as established in the Bob Stump National Defense Authorization Act for fiscal year 2003.

"Korean emergency" shall mean the period between June 25, 1950 and Jan. 31, 1955, both dates inclusive.

"Vietnam veteran" shall mean, (1) any person who performed such wartime service during the period commencing Aug. 5, 1964 and ending on May 7, 1975, both dates inclusive, or (2) any person who served at least 180 days of active service in the armed forces of the United States during the period between Feb. 1, 1955 and Aug. 4, 1964; provided, however, that for the purposes of the application of the provisions of Chapter 31, it shall also include all active service between the dates May 7, 1975 and June 4, 1976; and provided, further, that any such person who served in said armed forces during said period and was awarded a service-connected disability or a Purple Heart, or who died in said service under conditions other than dishonorable, shall be deemed to be a veteran notwithstanding his failure to complete 180 days of active service.

"Lebanese peace-keeping force veteran" shall mean any person who performed such wartime service and received a campaign medal for such service during the period commencing Aug. 25, 1982 and ending when the President of the United States shall have withdrawn armed forces from the country of Lebanon.

"Grenada rescue mission veteran" shall mean any person who performed such wartime service and received a campaign medal for such service during the period commencing Oct. 15, 1983 to Dec. 15, 1983, inclusive.

"Panamanian intervention force veteran" shall mean any person who performed such wartime service and received a campaign medal for such service during the period commencing Dec. 20, 1989 and ending Jan. 31, 1990.

"Persian Gulf veteran" shall mean any person who performed such wartime service during the period commencing Aug. 2, 1990 and ending on a date to be determined by presidential proclamation or executive order and concurrent resolution of the Congress of the United States.

"WAAC" shall mean any woman who was discharged, and so served, in any corps or unit of the United States established for the purpose of enabling women to serve with, or as auxiliary to, the armed forces of the United States and such woman shall be deemed to be a veteran.

None of the following shall be deemed to be a "veteran:"

a. Any person who at the time of entering into the armed forces of the United States had declared his intention to become a subject or citizen of the United States and withdrew his or her intention under the provisions of the Act of Congress approved July 9, 1918;
b. Any person who was discharged from the said armed forces on his or her own application or solicitation by reason of his or her being an enemy alien;
c. Any person who has been proved guilty of willful desertion;
d. Any person whose only service in the armed forces of the United States consists of his or her service as a member of the Coast Guard auxiliary, or as a temporary member of the Coast Guard Reserve or both; or
e. Any person whose last discharge or release from the armed forces is dishonorable.

"Armed forces" shall include Army, Navy, Marine Corps, Air Force and Coast Guard.

"Active service in the armed forces," as used in this clause shall not include active duty for training in the Army National Guard or Air National Guard or active duty for training as a reservist in the armed forces of the United States.

CHAPTER THREE

Medicaid

What You Need to Know About the Medicaid Eligibility and Transfer Rules

INTRODUCTION

For most elders, the prospect of long-term care in a nursing home is, to say the least, unpleasant. Elders are also often concerned that the cost of long-term care will deplete their estates. The cost of nursing home care in Massachusetts, now estimated at between $100,000 and $130,000 per year (the daily rate is often over $320), only serves to compound these fears.

The cost of the monthly premiums to purchase long-term care insurance to pay for the cost of long-term care can be beyond the means of middle-income elders and often times is not available to elders due to pre-existing medical conditions.

Many elders receive assistance from the federal Medicare program to help pay medical expenses and the cost of prescription drugs. Medicare, however, does not pay for extended nursing home care. Medicaid, called MassHealth in Massachusetts, on the other hand, is a joint federal-state program, which pays for nursing home care for individuals that meet their financial eligibility rules.[1]

Understanding the complex Medicaid rules is the key to informed long-term care planning and asset protection.

In determining the financial eligibility of an individual applying for Medicaid, Medicaid looks at the applicant's assets and income. *(See Example 1.)*

ASSETS Anything an applicant owns, such as:	INCOME All money an applicant receives, such as:
Cash	Social Security
Mutual Funds	Dividends
Auto	Pensions
Real Estate	

EXAMPLE 1:
Countable and Non-countable Assets

Richard owns a house worth $150,000, a car worth $4,000 and mutual funds worth $50,000. Medicaid does not consider the value of Richard's house or car when calculating Richard's countable assets. Medicaid does consider the $50,000 Richard owns in mutual funds as countable assets.

A. Asset limitation

Medicaid places a limit on the amount of assets an applicant age 65 or older can own and still be eligible for Medicaid. The asset limitation is $2,000 for an individual. Medicaid divides an applicant's assets into three categories:

1. Non-countable assets;
2. Inaccessible assets; and
3. Countable assets.

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Only countable assets are considered with respect to the $2,000 asset limitation. The assets of a couple, age 65 and older when one member is in a nursing home, may be treated differently. *(See Special Rules for the Principal Residence.)*

B. Non-countable assets

Non-countable assets are not included in the calculation of an applicant's assets. Non-countable assets include:

- A principal residence in Massachusetts *(see Special Rules for the Principal Residence)*;
- Household belongings and furnishings;
- Personal belongings, such as clothing and jewelry;
- Burial plots for the applicant and members of his or her family;
- Pre-paid burial contracts;
- A $1,500 bank "burial account" for miscellaneous funeral and burial expenses;
- Life insurance with a face value up to $1,500; and
- One automobile for use by the applicant or his or her family *(see Example 1).*

C. Special rules for the principal residence

MassHealth will categorize an applicant's home, valued up to $750,000, as a non-countable asset if it is located in Massachusetts and the applicant, living in a nursing home, intends to return to the home if his or her medical condition improves. MassHealth may place a lien on the property for services rendered, which would be paid back, upon either the sale of the home or probate of the individual's estate.

If the applicant does not intend to return home, the applicant's home can also be classified as non-countable if any of the following conditions are met:

1. The applicant owns a long-term care insurance policy, meeting certain requirements, at the time he or she entered the nursing home; or
2. Any one of the following persons lives in the home:
   - The applicant;
   - The applicant's spouse;
   - A child under age 21;
   - A disabled or blind child of any age;
   - A relative who is dependent on the applicant;
   - A child who lived in the home for at least two years before the applicant moved into a nursing home and provided care which permitted the applicant to remain at home; or
   - A sibling who has an equity interest in the home and has lived there for at least one year before the applicant moved into a nursing home.

D. Inaccessible assets

Like non-countable assets, inaccessible assets are also not included in the calculation of an applicant's assets. Inaccessible assets are those to which the applicant has no legal access, such as expected inheritances before probate is completed or divorce assets prior to a final decree *(see Example 2).*

Example 2:
An inaccessible asset can become countable

Karen's sister Betty died six months before Karen applied for Medicaid. Under Betty's will, Karen is entitled to one-half of Betty's estate, which is worth $200,000. Karen has not yet received any money from Betty's estate. The $100,000 Karen expects to receive from Betty's estate is an inaccessible asset. Once Karen receives the $100,000, it becomes a countable asset.

E. Countable assets

All assets not considered non-countable or inaccessible are counted towards the $2,000 asset limitation. In some cases both jointly-held assets and assets in a trust will be viewed as countable assets.

F. Jointly-held assets

Medicaid presumes that all funds held in joint bank accounts belong to the applicant. This presumption can be overcome if the non-applicant joint owner can demonstrate that he or she contributed part or all of the funds to the account. *(See Example 3.)*

Other assets held jointly, such as real estate, stocks, bonds and most mutual funds are presumed to be owned proportionately by the persons on the account. This presumption can also be overcome. *(See Example 4.)*

Example 3:
Who contributed to a joint account?

Andy owns a joint bank account with his daughter, which totals $10,000. His daughter contributed $8,000 of that amount when she was going through a divorce. When Andy applies for Medicaid, it is presumed that Andy owns all of the $10,000 in the joint account. If, however, Andy can prove that $8,000 of this account is attributable to his daughter, only $2,000 will be counted as Andy's assets.

Example 4:
A joint account presumption

Edna and Charley are joint owners of a stock and bond mutual fund with a value of $20,000. The monthly statement does not specify the percentage of each person's ownership. If Edna applies for Medicaid it will be presumed that she owns 50 percent of the mutual fund, or $10,000.

G. Trusts[2]

If a Medicaid applicant is the beneficiary or grantor of a trust, and the applicant may receive payments of principal from the trust, any amount of principal that the trustee has the discretion to distribute to the applicant is considered a countable asset. Even principal that can be distributed by a trust not created by the applicant may be countable under certain circumstances. The assets are considered countable even if distributions from the trust to the applicant are never made. *(See Example 5.)*

If the applicant, or his or her spouse, is the grantor of a revocable trust, all assets in the trust are considered countable assets. The result is the same even if the applicant or spouse is not a beneficiary of the revocable trust.

Treatment of trusts is a very complex area of law due to requirements of a federal law, the Omnibus Budget and Reconciliation Act of 1993 (OBRA 93), and state regulations and court decisions relating to that law. Questions regarding the creation of, and transfers to and from trusts should be carefully reviewed with an elder law attorney. *(See Example 6.)*

Example 5:
A beneficiary of trust assets

Sam is the beneficiary of a trust, which he set up himself. The trust holds $100,000 in assets and the trustee has the authority to make any amount of distributions of interest and principal to Sam on a regular basis. Sam applies for Medicaid. Medicaid will consider the entire $100,000 as a countable asset for Sam.

Example 6:
Revocable trust assets

In addition to the asset limitation, Medicaid places a limit on the monthly income an applicant can receive and not be required to spend the balance on medical care before Medicaid will pay for remaining medical expenses. Medicaid treats income differently for those seeking eligibility who live in the community (not in a nursing home), and those who live in a nursing home or higher level of medical care.

H. Income limitations

In addition to the asset limitation, Medicaid places a limit on the monthly income an applicant can receive and not be required to spend the balance on medical care before Medicaid will pay for remaining medical expenses. Medicaid treats income differently for those seeking eligibility who live in the community (not in a nursing home), and those who live in a nursing home or higher level of medical care.

In 2009, the countable income limit for an applicant 65 or older living in the community is $903[3] per month and generally $1,215[4] for an applicant under 65 before Medicaid eligibility is affected (rates are effective as of March 1, 2009). Medicaid considers both earned income (wages) and unearned income (Social Security, pensions, etc.), less any medical benefit premiums paid, when it calculates an applicant's total income. If an applicant age 65 or over living in the community has income in excess of this limit, he or she may still be eligible for Medicaid through a spend-down procedure. The applicant's total Medicaid countable income which exceeds $522[5] plus a $20 disregard per month must be spent on medical needs before Medicaid will cover the remaining medical bills each month. However, the entire calculation is actually done on a six-month average. When (and if) the applicant's medical expenses reach the excess amount, Medicaid will pay the remainder of the applicant's medical bills for that six-month period. And this process will be repeated every six months to maintain eligibility. *(See Example 7.)*

For single applicants without dependents living in nursing homes, the spend-down works much the same way except that the amount that must be spent on medical care costs is any income in excess of $72.80 per month plus a credit for any medical insurance premiums paid. Medicaid covers the difference between what the resident has in net countable income and the cost of the nursing home care. *(See Example 8.)*

The income of couples may be treated differently. *(See next section.)*

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Example 7:
A spend-down breakdown

Charlotte is single, lives in her home, and receives Social Security in the amount of $1,000 per month. She must spend $458 ($1,000 – $522 + $20) each month on medical expenses ($1,000) before Medicaid will pay the remainder. Since the actual calculation is done on a six-month basis, Charlotte must spend $2,748 ($458 x 6) each six-month calculation period before Medicaid will pick up the balance.

Example 8:
A nursing home spend-down

From Example 7, Charlotte now enters a nursing home. She also now pays a Medicare supplement health insurance premium of $220 per month. She must pay $707.20 ($1,000 – $220 – $72.80) of her Social Security to the nursing home each month. Medicaid will pay for the balance of her nursing home and medical care.

I. Community Spouse Resource Allowance (CSRA)

Under the Medicaid rules, a couple's assets are pooled for the purpose of determining eligibility. At the time a married applicant is institutionalized (the first day of a stay in a long-term care facility or hospital which lasts 30 days or more), Medicaid calculates the couple's total countable assets. The couple's assets are pooled without regard to which spouse actually owns the assets. The spouse still living in the community (the community spouse) is allowed to keep a portion of the couple's countable assets. This portion of the countable assets is called the community spouse resource allowance (CRSA).

As of Jan. 1, 2009, the maximum CSRA, without a hearing, is $109,560. In appropriate circumstances in which the community spouse requires more income to remain in the community, the community spouse may seek to increase the CRSA at an appeal hearing. This is often the case when the community spouse has high medical expenses or lives in a costly assisted living facility. An experienced elder law attorney should be consulted to determine whether such a hearing is appropriate.

In situations where one member of a couple refuses to cooperate with Medicaid, such as a refusal to supply the necessary documents, Medicaid may disregard the uncooperative spouse's assets. However, in this situation, the uncooperative spouse will not be able to take advantage of the community spouse asset allowance or the community spouse maintenance needs allowance.

In order to distribute assets between a couple to ensure that an institutionalized spouse has only $2,000 in his or her name, Medicaid allows a 90-day period after an eligibility determination within which transfers between spouses may be made. *(See Example 9.)*

Example 9:
Asset transfer between spouses

Assume that Mrs. Jones is entitled to a CSRA of $109,560. The Jones' have spent-down their cash assets, leaving Mrs. Jones with $79,000 in her name alone. There remains, however, $20,000 in assets in Mr. Jones' name. The Jones' are allowed 90 days within which to transfer the $20,000 from Mr. Jones' name into Mrs. Jones' account.

J. Annuities

Another means of protecting excess assets above the allowable limit for the community spouse is done through the process of purchasing an annuity. The annuity allows for the community spouse to turn the excess countable assets above the allowable CSRA into a non-countable income stream because the community spouse does not have any income limit. The annuity must meet a few very specific requirements to qualify: it must be immediate, not have a balloon payment at the end, be irrevocable, have a guaranteed number of years of payment not to exceed the purchaser's life expectancy, and generally be commercially reasonable. An annuity may be purchased for a term as short as two to five years.

K. Minimum monthly maintenance needs allowance (MMMNA)

The spouse of an individual in a nursing home is entitled to a portion of the institutionalized spouse's income under certain circumstances. This sharing of income is allowed when the community spouse has monthly income below a minimum level set by Medicaid. This minimum monthly income level is called the minimum monthly maintenance needs allowance (MMMNA).

Currently, the minimum level is $1,750 plus an excess shelter allowance (rate in effect until July 1, 2009). The excess shelter allowance is the community spouse's actual monthly housing costs, including mortgage payments, rent, property taxes and homeowners insurance, less 30 percent of the minimum amount. The 2009 maximum MMMNA is $2,739, unless exceptional circumstances can be established. These figures usually increase each year due to a cost-of-living allowance.[6]

For detailed questions on MMMNA, please consult with an attorney or the Massachusetts Office of Medicaid at (617) 573-1770.

L. Transfer rules

Medicaid was designed to provide medical related coverage to those individuals and families who do not have enough assets to take care of themselves. Through a number of rules, the program discourages individuals from intentionally impoverishing themselves to qualify for Medicaid. On Feb. 8, 2006, the transfer rules and penalties were significantly tightened, requiring longer planning periods to avoid disqualification periods of eligibility for long-term care coverage.

The most important of these rules involves transfers made within the 60 month period (formerly 36 months to an individual and 60 months to a trust) prior to applying for Medicaid. This is called the look-back period.

The purpose of the look-back period is to review financial records and penalize the applicant or spouse for gifts or sales, for less than fair market value, made prior to applying for Medicaid, when it is arguably foreseeable that coverage will be needed. A disqualifying transfer will exist if the applicant transfers a countable asset or principal place of residence for less than fair market value in this look-back period. *(See Example 12.)*

The period of ineligibility for Medicaid for a disqualifying transfer is obtained by dividing the fair market value of what was transferred by the average daily cost of a nursing home in Massachusetts, established by MassHealth regulations. The average daily nursing home cost in Massachusetts is $267 per day.

Example 10:

How the look-back period works

Florence owns a house with a fair market value of $150,000. On April 1, 2006, Florence transfers the house to her daughter as a gift. On June 1, 2006 Florence needs nursing home

care and applies for Medicaid. The gift of the house is counted as a disqualifying transfer because it was made within the 60-month look-back review period prior to Florence's application for Medicaid.

Example 11:
Determining the ineligibility period

In the previous example, Medicaid would take the fair market value of Florence's house, and divide it by the daily cost of a nursing home in Massachusetts.

$150,000 ÷ $267 per day = 562 days of ineligibility

or

$150,000 ÷ $8,010 per month = 18.7 months of ineligibility

A second important rule added by the new law requires that if the gift occurs within five years of the date that coverage is needed for nursing home care, the disqualification period will not start running until the individual actually gifts away the excess assets, is receiving nursing home care, files a Medicaid application for long term care, and is denied eligibility solely due to the transfer. The ineligibility period for large transfers can be considerable if the gifting is made less than five years prior to the need for nursing home care.

If an applicant delays his or her application for Medicaid for more than 60 months after making a disqualifying transfer, it is not necessary to report the transfer to Medicaid. In this manner, applicants can essentially cap their ineligibility at a maximum of 60 months.

Applying for Medicaid at the wrong time after a large transfer can cause a much longer than necessary disqualification period. Under the new law, transfers directly into a trust now have the same look-back period as transfers to individuals.

This transfer disqualification rule does not apply to applicants for community level Medicaid benefits, but will apply if the applicant living in the community subsequently enters a nursing home. Also, transfers made to an applicant's blind or disabled child, or under certain other special circumstances are not disqualifying transfers. For transfers made before Feb. 8, 2006, the ineligibility period for disqualifying transfers to an individual is limited to 36 months, and may be for a shorter period based upon the amount gifted. This description of how the new rules are applied to gifting may change as they are integrated in actual practice.

Example 12:
Timing is important when looking at when to apply for Medicaid

Mike owned a house with a fair market value of $600,000. On April 1, 2006, Mike transferred the house to his son as a gift. On June 1, 2006, Mike applied for Medicaid. Medicaid looked-back 60 months from the date of Mike's application and recognized the disqualifying transfer. Medicaid calculated the ineligibility period ($600,000 ÷ $267 per day) to get a 2,247 day ineligibility period. This ineligibility period will last approximately 6.2 years. If Mike had waited until April 1, 2011 to apply, the transfer would not have been included in the look-back period and he would have been eligible over a year earlier.

M. Distinguishing all transfers as gifts

A long-standing regulation at 130 CMR 520.19(F) states that Medicaid will not penalize an individual for transfers made for less than fair market value if they were transferred for a purpose other

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than to qualify for MassHealth. Despite this regulation, Medicaid routinely considers all transfers disqualifying gifts, with a resulting penalty period.

This regulation has not been interpreted favorably to support that the intent of the applicant was not to transfer assets so as to be eligible for Medicaid. However, with the new Medicaid laws elder law attorneys will need to attempt to change the Medicaid mind-set towards such transfers, where gifted funds were for express purposes such as paying for grandchildren's tuition, wedding plans, down payments for children's homes, etc.

N. The spend-down process

When a single applicant has countable assets, which exceed the amount allowed by Medicaid, he or she will want to reduce these assets below the $2,000 limit. The process, by which an applicant reduces his or her assets to $2,000, is called a spend-down. There are many ways to achieve a spend-down, which may include purchasing non-countable assets, paying debts, purchasing an annuity and even gifting assets knowing that there will be a controlled period of disqualification.

Regardless of the options used to achieve the spend-down, the applicant will usually want to qualify for Medicaid as quickly as possible.[7] A married couple has a greater range of options to achieve eligibility (and to save more assets) than a single individual.

Example 13:
How the spend-down process works

Jack is single, requires nursing home care, and has countable assets which total $34,000. In order to become eligible for Medicaid, Jack will need to spend-down $32,000. (Jack is allowed to keep $2,000). Jack chooses to spend-down his assets in the following way:

Balance to be spent down	$34,000
Purchase of a pre-paid burial contract	10,000
Purchase of a burial plot	2,000
Pay off credit card debt	10,000
Attorney's fees	8,500
Burial account	1,500
Total remaining (allowable)	$2,000

O. Estate recovery

Medicaid has the right to recover the value of benefits that it provided on a recipient's behalf after age 55 for community benefits, or any age for long-term care or nursing home benefits. Recovery, however, is limited to a recipient's probate estate. Medicaid can only pursue claims against the recipient's probate estate if there is no surviving spouse, a child under age 18 or a disabled child of any age.

If the recipient owns a house, Medicaid may place a lien on the house for the amount of funds expended on the recipient's behalf after the recipient reaches age 55.

This lien may be placed on the house even before the recipient's death provided that all the following conditions are met:

1. The recipient permanently resides in a nursing home and is not expected to return home;
2. The recipient receives notice of the lien; and

3. There is no surviving spouse, child under age 18 or disabled child of any age residing in the house.

These pre-death liens are simply notice liens. Medicaid has no claim against the real estate until the recipient dies. If the house is sold during the recipient's life, however, Medicaid can seek recovery from the proceeds of the sale.

Massachusetts attempted to adopt an expanded definition of the estate for estate recovery purposes. Originally, it was to be applied to persons with a date of death of July 1, 2003, or after. The legislature then voted to repeal the implementation of expanded estate recovery, although it is possible that the expanded estate recovery could be added back into state law in the future.

P. Medicaid application

Due to the long look-back period and use of asset protection techniques that we have described in this guide, the Medicaid application is often difficult and time consuming to complete. Applications are submitted to a local office of the Division of Medical Assistance's Long-Term Care Units. Decisions on completed applications usually take four to six weeks.

The supporting documents needed for a successful application are substantial and include a birth certificate, health insurance cards and premium information, 36 months of bank statements, three years of tax returns, investment information and insurance policies, all income checks, expense information and trust documents.

Withdrawals of assets occurring in the 60 month period preceding the application must be explained or disqualification periods may result. If the financial picture involves numerous bank accounts or transfers, many practitioners compare the process to the complexity of a multi-year tax audit. Under these circumstances, the use of an experienced elder law attorney in the preparation and submission of Medicaid applications is strongly recommended.

Conclusion

Careful long-term care planning with an experienced elder law attorney prior to a hospitalization or medical crisis ensures that families understand their rights. This planning allows families to evaluate their options and often permits families to protect the family home and other substantial assets. The law change in February of 2006 has only added to an already complex planning process.

Generally, the more planning that is done before a medical crisis, the more assets that can be saved. Good planning involves protecting the independence, integrity, and wishes of the elder individual or couple, as well as protecting assets. At no time has the need been greater to secure the early intervention of an experienced elder law attorney to review long term care planning issues well in advance of hospitalization or nursing home placement.

An experienced elder law attorney will be able to conduct a complete review of your personal and financial situation and make appropriate recommendations to address your health care needs and provide you with a framework of recommendations to protect your assets according to your own personal wishes.

Contact information

If you are a current member of MassHealth or have questions about eligibility or an application, you can call the State's toll-free number at (888) 665-9993. This service is available 24-hours a day, seven days a week. Here, you can find information on case status, key eligibility dates, plan information, items needed to process your case, examples of acceptable verifications, form address information and more.

1 Medicaid is also available to blind and disabled individuals who meet the eligibility guidelines.

2 Specific rules pertaining to trusts vary according to the date the trust was established and the specific terms of the trust.

3 Department of Health and Human Services federal poverty standards. spe.hhs.gov/poverty.

4 Department of Health and Human Services federal poverty standards. aspe.hhs.gov/poverty.

5 130 C.M.R. 520.030.

6 *See* www.massgov/masshealth and www.massresources.org.

7 In some circumstances, a disqualifying transfer may be an effective Medicaid planning tool.

NOTE: This is the 2009 version of the resource guide; some presented information may be out-of-date.

CHAPTER FOUR

Medicare Part D

What You Need to Know

INTRODUCTION

Medicare Part D is a helpful addition to your medical insurance but it is possibly difficult plan to understand. Part D is very important to learn about because many elders will use it to pay for their prescriptions. This resource guide is meant to assist you in understanding the intricacies of Medicare Part D so that you know the basics and are able to find the best plan to meet your needs. Please note that this topic is vast and you should seek consultation should you need clarification.

A. What is Medicare Part D?

Medicare Part D is an add-on to the Federal Medicare Insurance program that fills a past void. Part D assists Medicare recipients in paying the costs of their prescription medications. With rising costs of prescription drugs, this expense has become one of the greatest financial burdens for many elderly individuals, often eating into savings after income is exhausted. Reacting to this growing concern, the U.S. Congress developed Part D in order to assist Medicare participants with the cost of their prescription drugs.[1] Part D plans are available to anyone who is eligible for Medicare in the U.S. and U.S. territories. Generally speaking, that means individuals who are 65 years of age or older, or individuals with certain disabilities. Coverage may not be denied due to health reasons. Although Part D participation is completely voluntary, if you currently have Medicare and Medicaid you will automatically be enrolled in a prescription drug program in order to prevent any lapse in your Medicaid prescription drug coverage.[2]

There are two types of Medicare Part D plans that will provide insurance coverage for prescription drugs. One is the Medicare Prescription Drug Plan, the other option is to join a Medicare health plan (like an HMO or PPO) which includes prescription drug coverage as part of the plan. The Part D prescription coverage works very differently from other Medicare sections. All of Part D plans are through private pay insurance plans, so there are many plans to choose from.

Different Medicare prescription plans will cover different medications, for example, some cover generic and brand-name drugs.[3] Thus, depending upon what medicine you need, there will be different plans that best cover your needs. Therefore, it is wise to look at each plan's formulary, which is an evolving list of drugs covered by the plan. Your plan must inform you of changes in coverage and cost adjustments at least 60 days prior to any drug being removed from the formulary. It is Important to note that you have the right to appeal a change and to request that your medicine be allowed as an exception to continue until the next free enrollment period.[4]

B. How do I enroll in Medicare Part D?

Since January of 2006, Part D has annual open enrollment from Nov. 15 through Dec. 31st.[5] Coverage begins on January 1 following enrollment. In addition, you may enroll in Part D within three months before or three months after you turn 65, or within 63 days of losing coverage from some other form of insurance. If you are disabled you may enroll within three months before or three months after your 25th month of disability. If you do not enroll during these milestone time slots, you may have to pay a late enrollment fee when you join.

C. Choosing a plan

Although all plans must meet the government's minimum requirements, there are differences between the plans, including what prescriptions are covered and what pharmacies may be used. Note that some plans work with mail delivery services which may be an advantage or an inconvenience depending on your transportation situation. If you currently have prescription drug coverage, then you will want to compare your current plan with the plans that are being offered under Part D.[6]

There are useful online tools to help you chose the plan that best fits your needs. To find the costs of the Medicare drug and health plans in your area, go to www.medicare.gov, and select "compare Medicare prescription drug plans." You may also go to the Medicare Web site and scroll down to the "formulary finder," which will go through a series of questions, such as where you live and what medications you take. This is a great way to find a comprehensive list of the best plans that cover your prescriptions.

Once you fully explore your options there are several ways you may join a plan. You can contact a company of your choice and request an application to fill out and mail back. Alternatively, you can enroll through the Medicare Web site since all plans have enrollment on the Internet. You can also apply over the phone by calling the provider of the plan that you are interested in.

D. Cost-sharing

Like all other insurance plans, Part D plans will spread the cost of coverage across the board among all those who join the plan. Part D plans use four different models for cost sharing. The amount that you are responsible for paying will depend upon how many medications you use during the year and how much money you spend on them. Though the details of individual plans may vary, below is an outline of how the cost-sharing will work in a standard Medicare Part D plan.

1. Premiums

There will be monthly charges that you will pay in order to participate in the plan. Generally you can expect to pay a monthly premium of about $37 ($445 a year).[7] If your annual income is below $14,355 for an individual or $19,245 for a married couple living together, you may not have to pay monthly premiums or deductibles. In the future years costs may rise and premiums may change at anytime, but you must be given six months notice before the change takes effect.[8]

2. Deductible

This is the amount you must pay for your prescriptions before your insurance becomes effective/ goes into effect. In the standard Medicare plan, the deductible ends when you have paid a total of $295 toward eligible medicine. Eligible medications include only those which are covered by your plan. As with premiums, if your annual income is below a certain level the deductible fees will be waived.

3. Co-insurance

This is the term used for splitting the costs of your prescriptions on a percentage basis. Meaning, under the standard Medicare plan, you will be paying 25 percent of your prescription costs and the plan will pay the remaining 75 percent, until the combined total reaches $2,510. If you reach this total, depending on your plan you may have a gap in coverage where you are required to pay 100 percent before your insurance will pick back up and cover a portion of it.

4. Coverage gap

This is the period of time when the plan will make no contribution to drug costs and you will be responsible for 100 percent of your drug expenses, directly out-of-pocket. Under the standard Medicare plan this gap will occur from the time your total prescription costs reach $2,700 until they reach $4,350 and you are considered to have "catastrophic" costs and your insurance will start to cover prescriptions again. For a higher premium you may choose a plan with gap coverage included, meaning you will never experience a hole, or a lapse in coverage.

5. Catastrophic coverage

Once your drug costs become very high, they are considered to be catastrophic. Under the standard plan, catastrophic coverage begins when you have paid $4,350 in out of pocket expenses, for medications in a one-year span.[9] You will not have to pay more than $3,216 during the gap, not including the plan's premiums. Once your expenses have reached this stage of the plan then most of your costs will be paid with no ceiling limits. You will be responsible for only a small portion of your medication costs; usually either five percent or a small flat fee per prescription, depending upon the plan you join. Not all medications are considered a part of your true out-of-pocket expenses.[10] Once you reach "catastrophic" you will pay about $2.40 to $6 per prescription.

E. A sample plan, a.k.a. "the standard plan"

"The standard plan" is the one set up by Congress that sets out the guidelines and minimum requirements that all independent insurance companies that become involved in Medicare Part D must adhere to. As the amount of money you spend on prescriptions grows during the year you will move through all or at least some of the steps outlined below.

Typical course:

- Pay monthly premium of about $28.
- Until you exceed the $295 deductible, you will pay 100 percent of the costs of your medication.[11]
- After you have paid more than $295 on your prescriptions, your "co-insurance" begins and you will only be responsible for paying for a portion of your prescription costs and the insurance company will pay for the difference until you reach the "gap." This initial benefit period requires you to pay 25 percent of the next $2,405, or $601.25.
- You reach the "gap" when total cost of medication is $2,700 ($295 + $2,405). After this amount you are responsible for 100 percent of your costs. The next $3,453.75 of medication costs are to be paid by you. Once you, personally, have spent a total of $4,350 (including deductible and co-insurance) on prescriptions for the year, then you have reached the "catastrophic" stage.
- "Catastrophic coverage" begins after you, personally, have spent $4,350 on medication. During this phase the plan will cover approximately 95 percent of your medication costs for the remainder of the year, no matter how great those costs become. You will be responsible for the greater of either; five percent of the cost of each prescription, or a $2.40 co-pay for each generic drug prescription and a $6 co-pay for each brand name drug prescription.

Example 1:

Lenny is 30 years old and seriously disabled. He spends about $1,000 a month on prescription drugs and his expenses are only expected to grow over the years. Lenny's total medication costs for the year are $12,000. Under the "standard plan," Lenny will be responsible for paying: a $336 annual premium, a $295 deductible, a $601.25 co-insurance payment, a gap of $3,453.75 and five percent of his catastrophic costs, which comes to $292.31. Lenny's total out-of-pocket costs for his medications for the year will be about $3,836.25 and Medicare D will pay the remaining $7,357.69.

Comment on Example 1: *For those individuals like Lenny who take many medications that cost him up to $12,000 a year, joining a Medicare Part D plan will significantly reduce his medication costs. Under this plan, Lenny is still facing high medication costs, and for many elderly this is still going to be a heavy weight upon their purses, but the plan is intended to attempt to at least lessen that weight.*

Example 2:

Martha, 80, has a chronic bronchial condition and serious circulation problems. Martha spends $375 a month on various medications. Martha's total medication costs for the year are $4,500. Under the "standard plan," Martha will be responsible for paying the following: a $336 annual premium, a $295 deductible, a $601.25 co-insurance payment and a gap of $1,800. There is no catastrophic coverage because Martha's prescriptions do not currently reach that level of cost. Martha's total out-of-pocket costs for her medications for the year will be $3,032.25 and Medicare D will pay $1,803.75.

Comment on Example 2*: For individuals like Martha who spend a significant amount of money a year on medications ($4,500), but not in the extreme range that Lenny falls into, joining a Medicare Part D plan will provide at least partial savings. Martha will be responsible for paying 60 percent of her medication costs, with the Medicare Part D plan covering the remaining 40 percent.*

F. Financial assistance to pay for Medicare Part D

Individuals who have low incomes, little savings and minimal assets may be eligible to receive assistance in paying for their Part D plan.[12]

In order to apply for assistance you must fill out an application form provided by your local Social Security administrative office.[13] If you have both Medicaid with prescription drug coverage and Medicare, Medicare and Supplemental Security Income (SSI), or if your state pays for your Medicare premiums, then you will automatically get extra help — you do not need to apply.[14]

For single individuals assistance may be attainable when one's income is less than $14,355 per year, and for married couples assistance may be attainable when their combined income is less than $19,245 per year.[15] Even if your annual income is higher that the amounts set out above certain other factors may make you eligible for some assistance.[16] Your combined savings, investments and real estate are not worth more than $23,000, if you are married and living with your spouse, or $11,500 if you are not currently married or not living with your spouse. (DO NOT include the home you live in, vehicles, personal possessions, burial plots or irrevocable burial contracts.).[17] Depending upon your needs, premiums, deductibles, co-insurance payments and gap coverage payments may be reduced or eliminated.

Below is an example similar to those provided by the government Medicare site:

Example 3:

James is a single individual who earns $9,000 in annual income. James fills out an application for assistance with paying for Part D is found to be eligible for the maximum amount of assistance. Based on this, he will pay no premium, no deductible, $1 for each generic prescription[18] and $3 for each brand-name one.[19] Even if James prescription expenses extend into the "gap" or farther into "catastrophic" he will pay nothing for his medications.

G. Dual eligibility and nursing homes

If you are currently in a nursing home facility there are some important facts that you should know regarding your Medicare prescription benefits.

1. While in a nursing home you may change your Part D plan monthly.[20]
2. Nursing homes generally work with specific pharmacies, so make sure that the plan you choose or are automatically enrolled in, works with the corresponding pharmacy.[21]
3. As a nursing home resident receiving benefits under Part D, you should not have any out-of-pocket costs as long as your plan covers the medications that you need and your nursing home purchases those drugs at a pharmacy that is within your plan's network.[22]
4. If your Part D does not cover a prescription that you need while you are in a nursing home, you have enhanced rights as a nursing home Part D recipient. Medicare Part D plans are required to provide a 90- to 180-day one-time supply of the drug you are requesting when you either join a new plan or enter a new health care setting.[23] During this period, which is referred to as a "transitional period," your doctor should be able to assist you in switching your medication to a similar one that is covered by your plan, or in applying for an exception from your plan. If you are living in a nursing home and you are waiting to hear on an exception decision your pharmacy must fulfill an emergency supply of the medicine that you need.[24]
5. Nursing homes should provide you with your needed medication even if your insurance will not authorize an exception.[25]

H. Penalties for late enrollment

If you are eligible to apply for Medicare Part D and you do not have other coverage, or are not automatically enrolled, or you are on Medicare A and B, you must enroll in a Medicare Part D plan within three months before, or three months after, becoming eligible or you will suffer penalties.[26] It is wise to sign up for Part D even if you do not feel that you need assistance with their infrequent prescriptions, because then you avoid the late fees and it is easier to obtain coverage later if you need it.[27] If you fail to enroll during that six month window, you are penalized one percent of the premium for each month that you delayed and could have been enrolled.[28]

I. Grievances

If you have a complaint about your Medicare drug plan you may have the right to file a complaint, known as a grievance.[29] You have 60 days from the occurrence of the event that led to your grievance to file a formal complaint with the plan. Some reasons you may want to file a complaint are that the company that provides your plan is sending you unsolicited mail regarding other offers; you are

being made to wait a long period to receive you prescriptions; the customer service of your plan is unaccommodating to your needs; the plan failed to provide the notices that are required; the plan is not following the rules set out by Medicare; or the plan is violating the rules of appeal.[30]

J. Obtaining drug coverage for exceptions and the appeal process

If you are taking medications that you believe should be covered by your plan and your plan will not cover them, you have several options:

1. Request a decision called a "coverage determination" from your plan, in which they must review the medication and detail why it is not being covered, and why it is costing you more than it should according to the plan.[31] When a decision is made the insurance provider can either reimburse you or give a full explanation as to their decision process and denial.[32] You, your doctor, or an appointed representative,[33] may write your request to the plan. Once your plan receives your request they have 72 hours, for a request for retroactive coverage, and 24 hours, for an expedited request for coverage, in which to notify you of their decision.[34] For expedited decisions you will need a supporting statement signed by a doctor that explains why you need the medicine you requested.[35]
2. Appeal a decision that is against your favor. There are five different levels of appeal:[36]
    a. Appeal to your plan directly by filing a standard request in writing within 60 days from the date that the coverage determination was made.[37] Once your plan receives your appeal, they have one week to make a decision regarding a request for coverage or for retroactive payback, and 72 hours for a decision regarding an expedited request.[38]
    b. Request a review by an independent entity, which will perform a formal reconsideration of the previous decision made by the plan. If the independent entity agrees with your request, then your plan must follow that decision.
    c. Request a hearing on the decision of the independent entity with an administrative law judge (ALJ). You have 60 days from the date of the independent decision to make such a request.[39] Once the ALJ receives your request for a hearing they generally have 90 days in which to make a decision.[40]
    d. Request a review by the Medical Appeals Council (MAC) if the ALJ agrees with your plan's decision. You have 60 days from the date of the ALJ decision to make such a request. Once the ALJ receives your request for a hearing they generally have 90 days in which to make a decision.
    e. Request a review by a federal court if the MAC agrees with your plan's decision. Again, you have 60 days from the date of the MAC decision to make such a request.[41] Once the federal court receives your request for a hearing they generally have 90 days in which to make a decision.

K. Avoiding scams

Sadly, the elderly are often a target for professional scams. One way to help avoid scams is to sign up for the National Do-Not-Call Registry, so that private insurance companies will not be able to call you at home or on your cell phone. Also, to be cautious, do not give out any personal information over the phone to anyone regarding a plan unless you call them.[42] Do not allow anyone into your home that you did not invite because Medicare representatives are prohibited from going to your

home without an invitation. Also, Medicare Part D plans are not allowed to charge an enrollment fee for applying, if they attempt to, you should report them immediately. Though it can be hard, do not be pressured by solicitors to make a decision quickly. If you are unsure of a company soliciting your, call your local Medicare office to see if and they have information on the company and its plan.[43]

L. Conclusion

Medicare Part D is a complex program that may be confusing, but it can provide much needed assistance. Do not hesitate to seek assistance in understanding and choosing a plan. (*See Chapter 11 for helpful phone numbers and Web sites.*)

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1 U.S. Department of Health.

2 *Id.*

3 *2008 Medicare Handbook.*

4 *2008 Medicare Handbook.*

5 "The Basics of Medicare Part D," general guide.

6 Credible coverage is coverage from another plan or other Part D plan that meets the Medicare standards. You will receive notice from your current plan in the form of a letter that will inform you of whether your coverage is considered to be credible. If your coverage is credible you may wait to enroll in Medicare Part D and you will not be penalized later.

7 The majority of premiums range between $7–$65 dollars a month according to the SHINE organization.

8 It is possible to arrange for these premiums to be directly deducted from your monthly Social Security check, or you may simply be billed by the plan directly.

9 True out of pocket cost — is often referred to as TROOP.

10 Drugs that are not a part of your plan are not counted as part of your true out-of-pocket expenses and are thus not factored into the numbers and expenditures. In addition, the following kinds of drugs are not part of Medicare Part D plans and are therefore not covered by any plans: drugs used for anorexia, weight loss/gain, fertility drugs, cosmetic purpose drugs (Rogaine), cold/cough medicine, prescriptive vitamins and mineral (iron supplements) except for prenatal vitamins and fluoride, non-prescriptive drugs (over the counter medicine), inpatient drugs, Barbiturates (sleeping pills such as Ativan), Benzodiazepines (anti-depressants such as Prozac). Also, drugs purchased from other countries, such as Canada, are not counted as out-of-pocket costs and will not be covered by Part D.

11 True out of pocket cost — is often referred to as TROOP.

12 Assets include any and all property that the government may review when you apply for assistance with Medicare Part D. Cash or any property that can be turned into cash within 20 days may be considered countable. Your home (primary residence only) is not considered countable, nor is burial property and funeral funds. The following are some examples of assets the government would find countable; checking accounts, savings accounts, certificates of deposit, IRAs, 401(k)s, stocks, bonds and other items of a similar nature.

13 "Application for Help with Medicare Prescription Drug Plan Costs," known as Form SSA-1020.

14 Social Security Administration, SSA Publications No. 05-10129. *Help Available to Pay Costs of Medicare's New Prescription Drug Program*. April, 2005.

15 These figures are based upon 2008 figures offered by the government and may be adjusted per year in order to accommodate for inflation and other factors. These figures may also vary for Alaska, Hawaii and U.S. territories. In such cases local Medicare offices should be contacted for accurate information regarding qualification. www.socialsecurity.gov/pubs/10118.htm.

16 Other factors considered in addition to one's income level are: Support of other family members, known as dependents, who live in the same household. Have earnings from work. Live in Hawaii, Alaska, or a U.S. Territory.

17 A house and car are not counted as resources. Stocks, bonds, bank accounts, etc., are countable assets. These numbers may be increased by $1,500 dollars a person if the money is intended for burial expenses. https://secure.ssa.gov/apps6z/i1020/main.html.

18 Generic drugs are prescription drugs that have the same active ingredients as a brand-name drug, but usually cost less because they are a spin off of the more popularly known original. They are rated by the Food and Drug Administration as being just as safe and effective as their brand name counterparts.

19 Brand-name drugs are those medications which are sold under a trademarked brand name. They are usually well known and cost more than their generic counterparts.

20 *Medicare Interactive,* "What Happens to Medicaid Drug Coverage."

21 *Medicare Interactive,* "Medicare Part D and Nursing Homes."

22 Network is the group of doctors, hospitals, and pharmacies that have contracts with the insurance company with which you have purchased your Part D plan.

23 For example transferring from a hospital or assisted care facility into a nursing home.

24 *Medicare Interactive,* "Medicare Part D and Nursing Homes."

25 If your nursing home care is being covered by Medicare Skilled Nursing Facility benefits then your prescription drug coverage is being covered by Medicare Part A and not Part D.

26 *Your Guide to Medicare Prescription Drug Coverage.*

27 Francine Chuchanis, *Medicare Managed Care.*

28 *Id.*

29 Grievances may not be in regards to coverage or payment for a drug covered by the plan, they must be relating to other issues.

30 Center For Medicare and Medicaid Services, *How to File a Complaint, Coverage Determination or Appeal.*

31 *Id.*

32 The plan will either explain why things are as they are or they will pay you back for your extra expenditures on the drug and adjust it for future costs. An expedited request is for current or future costs or changes in prescriptive coverage.

33 A family member, doctor, or elder attorney may all be parties you may want to consider when choosing a representative to assist you. Your plan will inform you as to how to elect a representative.

34 For serious and life threatening issues it is important to request an expedited decision.

35 This statement is needed if you are requesting a drug that is not covered by your plan, on its formulary, or if you want a non-preferred drug covered at a preferred drug price.

36 When you join your Medicare Part D plan they will send you an information packet that will outline for you how the plan's appeal procedure process works. Center for Medicare and Medicaid Services, *Medicare Prescription Drug Coverage: How to file a Complaint, Coverage Determination or Appeal.*

37 Some plans may accept requests by phone, but it is important to keep accurate records and send a follow up letter recording the request and the date that it was made on for confirmation purposes. Center For Medicare and Medicaid Services, *How to File a Complaint, Coverage Determination or Appeal.*

38 For an expedited request on appeal the plan must either determine themselves that your life or health will be seriously jeopardized by waiting the standard decision time of one week, or they must be given a statement from a doctor in writing stating as much.

39 The IRE reconsideration decision will notify you of the specific entity to which your administrative appeal must be sent. The request must be in writing.

40 To receive an ALJ hearing there is a projected value of your denied coverage that must be met, i.e. a minimum dollar amount. Claims may be combined to meet such a minimum dollar amount. The IRE's decision will include in it this required dollar amount.

41 The MAC decision will direct you as to what court your request for review must be sent. The request must be in writing.

42 Do not give out your Social Security number or bank account information.

43 American Foreign Service Association, *Medicare D: Take Your Time Deciding and Beware of Scams.* 2005.

CHAPTER FIVE

Reverse Mortgages

Basic Information About a Potentially Helpful Financial Instrument

INTRODUCTION

Many elders are "house rich, but cash poor," meaning that their home is their most valuable asset and they do not have much, if any, income.[1] Lacking liquid assets, or cash, these elders may find it difficult to pay for health care bills, insurance premiums, energy costs, property taxes, home maintenance, or even subsistence needs.[2] One tool that elders aged 62 and above can use is a "Reverse (negative amortization)[3] Mortgage" loan. A reverse mortgage allows elderly homeowners to meet the above needs and also remain in their home by using their home equity to receive cash income. The loan works by enabling elderly homeowners to borrow against their home equity and receives loans that can be used for almost any expense. However, reverse mortgages are often misunderstood and they are not the answer for everyone, so elders should postpone entry into a reverse mortgage until after they have weighed their options and gained familiarity with the potentially serious consequences of these loans.

A. How does a reverse mortgage work?

A reverse mortgage works the opposite of a traditional loan because you do not pay monthly installments to the lender, rather the lender pays you monthly income. Meaning, the lender disburses the loan proceeds to you via monthly cash advance (check or direct deposit), in a lump sum, as a line of credit — or in some combination of all three. As you take these loans and interest accrues, it is added to the outstanding loan balance. A loan from a reverse mortgage does not have to be repaid at all until the borrower (you) transfers the home, ceases to occupy it as a principal residence for 12 consecutive months, or dies. Over time, the borrower's home equity decreases, while his debt increases.[4]

B. Types of reverse mortgages

Individuals in Massachusetts can choose between three types of reverse mortgages. One is through the U.S. Department of Housing and Urban Development (HUD) FHA-insured Home Equity Conversion Mortgage (HECM). The loan from HUD and HECM can be used for any purpose, and is generally offered by mortgage companies or banks.

Another type of reverse mortgage available is a proprietary one. This type can also be used for any purpose, but it is owned and backed by private companies. While HECM loans are typically lower in cost than proprietary mortgage products, their maximum loan size is typically smaller.

Lastly, elders should be aware of a third option: a single-purpose reverse mortgage, which is offered by some state and local government agencies and nonprofit organizations.[5] While there are limitations as to how the loan proceeds may be used, products such as the Senior Home Equity Line of Credit (SELOC) offered by Homeowner Options for Massachusetts Elders may offer elders a source of funds to cover unexpected property and life-related expenses that cannot be paid for with the reverse mortgage loan.[6]

NOTE: This is the 2009 version of the resource guide; some presented information may be out-of-date.

C. Repaying an outstanding reverse mortgage

Four circumstances trigger repayment of an outstanding reverse mortgage. The first occurs when the borrower sells the property or otherwise conveys title.[7] The second occurs if the borrower ceases to occupy the real estate as a principal residence (for example, by establishing a new principal residence, or by continuous confinement to a nursing home).[8] The third trigger is if the borrower defaults in the performance of his obligations under the loan, such as failure to maintain the property or to pay property taxes and homeowner's insurance premiums.[9] Finally, the loan becomes due when the last borrower dies.[10]

Because a reverse mortgage is a "non-recourse" loan, borrowers cannot owe more than their home's value at the time the loan is due, even if the reverse mortgage lender has lent more money than the value of the home. The lender does not have legal recourse to anything other than the value of the home when the loan is to be paid off. Generally, the loan is repaid by the selling of the home or its refinancing into a regular mortgage if an heir wishes to remain in the house. If the home happens to sell for more than is owed to the lender, the heirs receive the additional money. Lenders allow the estate one year from the last borrower's date of death to repay the reverse mortgage.[11]

D. Determining eligibility for a reverse mortgage

There are few requirements to be eligible for a reverse mortgage because income and job security are barely relevant since there are no monthly payments to be made by the elder. One prerequisite in Massachusetts is that the reverse mortgage borrower is 62 years of age or over. It is important to note that there is no minimum property value to be eligible.

While home ownership is ordinarily a prerequisite, life tenants and renters may also secure a reverse mortgage, subject to some restrictions. Single family residences are eligible for all reverse mortgage products, but lenders will also extend credit on multifamily dwellings (up to four families) and some condominiums. Lenders may be willing to lend to an elder whose home requires repair (exposed wires or termite damage, for example); a typical solution is for the lender to withhold a portion of the loan proceeds until specified repairs are complete.

The loan amount available under a reverse mortgage varies based upon a number of factors, but primarily upon the borrower's age and life expectancy, the value of the home, and the interest rate.[12] Therefore, older borrowers with more valuable homes can access greater loan amounts.[13]

E. Fees associated with obtaining a reverse mortgage

Lenders generally charge borrowers many up-front fees for reverse mortgages. Although elders need not pay these expenses out of pocket, they should be aware that if they finance the loan costs by adding them to their loan balance, they will still pay them back (plus interest) when the loan is over.[14] For this reason, reverse mortgages are likely inappropriate for elders who plan to change residences in the very foreseeable future as they are a relatively expensive method to access cash.

As of Jan. 1, 2009, a new law, the Housing and Economic Reform Act (HERA), will take effect in order to help make reverse mortgages more attractive.[15] HERA is an effort to restore homeowner's confidence in the home lending system and make reverse mortgages feasible and worthwhile for lower, middle and upper class elderly individuals. HERA increases the loan amounts, restricts fees and regulates insurance.[16]

Although fees vary based upon the particular reverse mortgage program, some common fees include those for credit and appraisal reports, processing fees, a land survey, title insurance, monthly servicing fees, closing attorney fees, and loan origination fees. Typical origination fees equal 2 percent of the principal loan amount, but be aware that this fee is often negotiable. Reverse mortgage

borrowers enrolled in HECM programs must pay for mortgage insurance regardless of their loan size (regular mortgage borrowers must purchase private mortgage insurance (PMI) only when their loan-to-value ratio (LTV) is 80 percent or greater).

F. Mandatory counseling prior to reverse mortgage

In an effort to protect elders from pressurized decisions involving their largest asset, their home, elders must go through a 45-minute counseling session with a HUD counselor. Massachusetts law mandates that lenders not make reverse mortgage loans "until the borrower has completed a home equity conversion counseling program which shall include instructions on reverse mortgage loans and which shall be approved by the Executive Office of Elder Affairs."[17] Be sure that your right to knowledge and unbiased counseling is upheld.

You should be wary of situations in which you: 1) receive counseling only from the lender; 2) receive counseling only immediately before or during the closing, rather than in advance; or 3) insurance premiums and other costs are not explained clearly.[18] The following nonprofit agencies have been approved by the Department of Housing and Urban Development (800-245-2691) and the Executive Office of Elder Affairs to provide the above counseling service:

Homeowner Options for Massachusetts Elders (HOME)
www.home-ma.org
(617) 451-0680

Quincy Community Action Programs
1509 Hancock St., Quincy, MA 02169
www.qcap.org
(617) 479-8181

Plymouth Redevelopment Authority
Plymouth Town Hall
11 Lincoln St., Plymouth, MA 02360
www.plymouthredevelopment.org
(508) 747-1620

Consumer Credit Counseling Service of Southern New England
(800) 208-2227

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CHAPTER SIX

Long-Term Care Insurance

Background Information on an Increasingly Popular Estate Planning Tool

INTRODUCTION

While all elders would prefer to remain healthy and independent throughout their lives, inevitably some develop chronic illnesses or conditions that require care over a prolonged period. Some of these elders need only home health assistance, while others require more extensive care of the kind provided by assisted living facilities or nursing homes. Care in each of these settings can be expensive; according to AARP, the average costs in Massachusetts are $23 hourly for a home health aide, $53,112 yearly for an assisted living facility, and a staggering $122,275 yearly for a private room in a nursing facility.[1]

Unfortunately, ordinary health insurance generally does not cover long-term care expenses. Medicare covers medically necessary, short-term home health care, but generally does not cover prolonged nursing home care and custodial care to help elders with so-called activities of daily living (ADLs). Finally, while MassHealth covers some long-term care needs, many seniors must spend down their assets over time to qualify for coverage.[2] Thus, elders are increasingly relying upon private long-term care insurance (LTCI) to help pay for these important needs, preserve their hard-earned assets, and maintain their independence.[3] LTCI helps elders pay for skilled care as well as custodial care. Ideally, by helping to mitigate the expenses associated with these types of care, LTCI also allows elders greater choice as to what type of long-term care they receive, and where to receive it.[4]

However, because LTCI is expensive and the policies and the regulations surrounding it are constantly changing, it is vital that elders considering LTCI become educated consumers.

A. Why purchase long-term care insurance?

LTCI is not appropriate for every elder. Some elders have the financial wherewithal to pay for all of their long-term care needs out-of-pocket, while others either already qualify for MassHealth, or can quickly spend down their assets to qualify. LTCI makes the most sense for elders situated between these two extremes.

For these elders, LTCI serves three important purposes. First, it helps them by covering some of the costs of long-term care. Second, and correspondingly, it allows them to preserve their assets, which can be rapidly depleted by, for example, a prolonged nursing home stay. Finally, LTCI may yield psychological benefits by: 1) allowing elders to pay for their own care; and 2) allowing them to avoid reliance on family, friends, or the MassHealth program.

B. When to purchase long-term care insurance

As with any other type of insurance, it is important for elders to purchase LTCI before they need it, because once long-term care is required, premiums may be unaffordable.[5] The main advantage to purchasing LTCI earlier in life is price: policies purchased at 65 cost $1,800 per year for four years of comprehensive coverage, while the same policy purchased at age 79 costs $5,900 per year on average.[6] Further, some insurers deem older prospective purchasers medically ineligible to purchase LTCI due to preexisting conditions.

However, purchasing LTCI early — and the middle-aged population is, increasingly, the target

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market[7] — carries its own risks. First, LTCI is generally an unwise investment for those who cannot afford to pay the policy premiums for the remainder of their lives, since policyholders often pay premiums more than 20 years before needing services.[8] In addition, both long-term premiums can and do increase over time. Optional non-forfeiture and inflation provisions can protect against these risks, but may increase premiums significantly.[9]

C. Where to purchase long-term care insurance

Currently, 45 companies issue LTCI policies that meet the requirements of Massachusetts Long-Term Care Regulation (211 CMR 65.00)[10] and the minimum standards established by the DOI (www.mass.gov/doi, Phone: (617) 521-7794). These policies cover either nursing home care, or home health care, or some combination of the two. While state regulation somewhat simplifies the process of shopping for an LTCI policy, it is still necessary and wise to shop around.

First, it is important that elders buy LTCI from financially strong insurers, since they may be paying presently for coverage they may not need for 20 years or more.

Consumer Reports recommends consulting a recognized insurance-rating company and choosing only those policies offered by insurers with strong ratings.[11] Information may be available through an insurance agent or broker, local public libraries, or online:

1. A.M. Best Company, www.ambest.com, (908) 439-2200
2. Fitch IBCA, Duff & Phelps, www.fitchibca.com, (212) 908-0500
3. Moody's Investor Services, www.moodys.com, (212) 553-0300
4. Standard and Poor's Insurance Ratings Service, www.standardpoor.com, (212) 438-7280
5. TheStreet.com, www.weissinc.com, (800) 289-9222[12]

Elders should compare at least three policies, noting variations among benefits, eligibility for benefits, and premiums.

D. What to consider when comparing policies

1. Two ways to acquire policies

Elders may purchase two types of LTCI policies: individual, non-group policies, and group policies, which are typically purchased through employers using pre-tax dollars. The Division of Insurance (DOI) mandates that individual policies meet specified minimum standards, including a two year minimum benefit period (or a comparable dollar value), elimination periods (waiting period) of no more than one year, and the option to purchase additional inflation and non-forfeiture protection.

Because groups purchase policies collectively, they usually feature discounted premiums. While group policies may substantially resemble individual policies, they are subject to reduced DOI regulation. Elders contemplating purchasing group LTCI should request and review the policy's illustration form and outline of coverage, and compare the coverage available in the group with coverage available on the individual market.

2. Limits on benefits

LTCI policies generally feature both daily (expressed in dollars) and lifetime maximum benefits (expressed in days). Daily maximum benefits vary in terms of the amount of money the insurance company pays for each day or month an elder is covered by an LTCI policy. If the cost of

care is more than the elder's daily or monthly benefit, the elder will need to pay the balance out of his or her own pocket.

3. Length of benefit period

LTCI policies cover different benefit periods, which measure the length of time policy holders receive benefits from their policy. In Massachusetts, LTCI benefit periods may last as little as two years, or as long as a lifetime. While lifetime policies offer the greatest security, many elders cannot afford the premiums. For most elders, four years of coverage is more than sufficient; the average nursing home stay for elders aged 65 to 94 is two and a half years, while 90 percent of elders stay less than four years.[13]

4. Length of elimination period

LTCI elimination periods are analogous to health insurance deductibles. Just as health insurance beneficiaries usually pay for a portion of their treatment out-of-pocket before they are eligible for benefits, LTCI beneficiaries must pay their long-term care expenses out-of-pocket during the elimination period. Policies may have no elimination period at all, or may have an elimination policy lasting a full year; typically, the longer the elimination period, the lower the premium. Policies with long elimination periods are most suitable for elders with more assets, and those concerned primarily with catastrophic long-term care needs.

5. Eligibility to begin receiving benefits

While insurers determine whether an elder is eligible to begin receiving policy benefits in different ways, the most prevalent method centers around the elder's ability to perform various ADLs. Typical ADLs insurers consider are an elders' ability to eat, walk, move from a bed to a chair, dress him or herself, bathe, and use the bathroom. Ordinarily, a physician or licensed health care practitioner chosen by the insurer evaluates these skills, and an elder becomes eligible to begin receiving benefits when they cannot perform two or more ADLs.

When comparing LTCI policies, learning which ADLs a prospective insurer considers is important. Consumers are prudent to consider only those policies that mention bathing specifically, since most elders with long-term care needs require assistance with this task.[14]

E. Hybrid long-term care products

1. What are hybrid products?

Hybrid products are one option for people who cannot afford stand-alone LTCI policies. Hybrid products are an intersection of life insurance or annuities with long-term care insurance. Such products allow sellers of annuities and life insurance to package long-term care contracts with their products that pay tax-free benefits. These policies offer the benefits normally associated with an annuity or life insurance, as well as protection against long-term care expenses.

a. Long-term care annuities

The long-term care annuity product functions exactly like a fixed annuity, but has a long-term care multiplier built into the policy. There is no premium rider attached to this medically underwritten annuity policy. Instead, a portion of the internal return in the contract is used to pay for the long-term care benefit. Long-term care coverage is calculated based on the amount of coverage selected when the policy is purchased. The insurance company offers a payout of 200 percent or 300 percent of the aggregate policy value over two or three years after the annuity account value is depleted.[15]

Example 1:

A policyholder with a $100,000 annuity who had selected and aggregate benefit limit of 300 percent and a two-year benefit factor would have an additional $200,000 available for long-term care expenses after the initial $100,000 policy value was depleted. The policy owner would spend down the $100,000 annuity value over a two-year period and then receive the additional $200,000 over a four-year period or longer. In this example the contract pays $50,000 a year for a minimum of six years, but care will last longer if less benefit is needed. If long-term care is never needed the annuity value would be paid out lump sum to any named beneficiary.[16]

Another example of annuity hybrid policies links long term care benefits to a single premium deferred annuity. This product begins as an annuity with either a lump sum deposit or structured deposits made over time. If no care is needed, the annuity gains interest functioning like any other fixed annuity. But if the owner needs care in a nursing home or elsewhere, a formula will be used to determine the amount of the monthly benefit available to the client.[17]

Example 2:

A healthy 65-year-old woman who deposited $150,000 into a lump sum annuity would have the advantages of tax-deferred, safe growth in the annuity and approximately $4,700 a month of long term care benefits for 36 months. At an additional cost, a benefit rider added to this policy would provide the $4,700 monthly benefit for her lifetime. On these types of policies, the additional benefit rider is usually a wise purchase in order to obtain maximum guarantees.[18]

Example 3:

A 60-year-old woman buys a deferred annuity with $100,000. At age 80, she needs 25 months of long-term care. Without a long-term care "rider," her annuity value by age 80 would stand at $265,000. With a long-term care "rider" that pays up to 150 percent of asset value and costs her 50 basis points of asset value per year, the annuity would have grown to just $240,000 by age 80. But the contract would pay $360,000 in long-term care benefits — potentially tax-free under product designs that comply with tax law requirements.[19]

b. LTCI/life insurance policy

At the essence of the hybrid product is the fact that buyers will eventually receive some benefit. In life insurance/LTCI combos, insureds can accelerate access to the death benefit if they need long-term care. Beneficiaries receive either the full death benefit or what remains if the policy has been tapped for long-term care. Some contracts offer amounts greater than the death benefit to pay for long-term care, and even if the death benefit is exhausted by LTC expenses, some products offer a residual death benefit payable to beneficiaries.[20] However in most cases, with an accelerated death benefit, one cannot expect substantial insurance payouts for both an expensive long-term care episode and death. The consumer must continue to pay the life insurance premiums while receiving the accelerated benefit.[21]

2. What are the benefits of hybrids?

The Pension Protection Act of 2006 changed the tax rules involving the long-term care hybrid product, so that funds withdrawn wither from an annuity or from the cash-value portion of a

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life insurance policy to pay for long-term care coverage will no longer be taxable as income. The changes, which take effect Jan. 1, 2010, already are prompting insurers to design and sell more hybrid products.[22]

Many consumers will not make claims against their long-term care insurance until decades after their initial purchase, if at all. Some consumers may feel they have lost or wasted all of their premium payments, even though they may not develop a similar sentiment towards they home or car insurance. Hybrids may overcome such barriers for these consumers, by incorporating another insurance product that is perceived to have value.[23]

Earlier purchase of long-term care insurance protects against the increasing possibility that with age one might not be eligible due to chronic conditions. Life insurance products are typically purchased earlier in life than long-term care insurance. If hybrids of long-term care insurance were marketed to persons when life insurance is normally marketed, such hybrids could encourage earlier purchase of long-term care insurance than is generally the case today. Still, some hybrids of life and long-term care insurance are marketed to older persons who have accumulated sufficient savings to be able to afford to purchase policies with a sizable single premium payment.[24] State Life Insurance Co. for example, has increased their maximum age requirement for such products from 72 to 80, and declines of submitted applications have fallen from the 30 to 35 percent range to less than 10 percent today.[25] Despite State Life's success with the hybrid product, product approvals can take six to nine months in the less regulated 25 states and 18 to 24 months in the closely-regulated states.

3. Consumer precautions

Generally, stand-alone LTC policies provide a wider range of benefit options than a combination policy. For example, most stand-alone LTC policies carry inflation protection riders that ensure the policy will still adequately cover long-term care expenses 20 years from now. Combination policies may not have inflation protection, which would significantly erode the purchasing power of the benefits in the future.[26]

LIMRA recently conducted 10 focus group studies concentrating on consumer perspectives on hybrid long term care insurance products. All participants were over 40 years old, had incomes of at least $50,000, and either owned or had recently looked into buying one of the hybrid policies. In general, they found that the participants were open to these products, with just fewer than half expressing interest. The combination life insurance/LTCI product was the most attractive for consumers. The study found that consumers concerns and questions increased with these products due to the added complexity that comes with combining two already complex products. Thus, agents need to thoroughly understand the product and be able to explain them in simple manner to the consumer. Agents must also be able to do a cost comparison of the combination product vs. buying each type of coverage as a standalone product to put consumers' minds at rest about the policy pricing.[27]

Annuities present several potential issues for the consumers, in their cost, suitability for specific savings objectives, the attractiveness of their rates of return compared to alternative investments, and their safety. In recent years, variable annuities have received particular attention. Even with fixed annuities, consumers should carefully consider the following factors before purchasing: their life expectancy, the desire to leave assets after death, and desire to retain flexibility to access savings in response to significant life events.[28]

Hybrids are complicated products that require significant consumer education before one makes a decision to purchase.

4. What population is best suited for the hybrid?

According to a recent LIMRA Study, "Consumer Views on Combination Products," the potential markets for LTCI hybrid products include:[29]

- Older, affluent customers who have looked into LTCI but decided against it;
- Upper-middle-income and mass-affluent pre-retirees who have not looked into LTCI but do have a primary need for life insurance;
- Single individuals who might need long-term care and don't have family to look after them; and
- Adult children who would be buying the product for their parents, where the children would benefit one way or the other.

Hybrid long-term care insurance products have been available for about five years. Currently 15 companies offer long-term care benefits with individual life insurance products, and six more offer them with annuities.[30]

F. Conclusion

Currently, LTCI plays only a small part in the overall long-term care financing scheme, covering only about 10 percent of all long-term care costs.[31] However, as elders live longer lives, the prevalence of LTCI as an estate-planning tool is likely to grow. To decide whether LTCI is right for them, elders should gather information and begin discussing their long-term care needs and preferences with family members and trusted advisers well in advance.

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Chapter Seven

Elder Abuse, Neglect and Financial Exploitation

INTRODUCTION

Elder abuse encompasses classic physical and emotional abuse, as well as neglect, and financial exploitation. Numerous studies have found that elder abuse is far under-reported, roughly one in five incidents, and this is due partly to the common familial or close relationship between the victim and perpetrator.[1] Although the vast majority of nursing homes do not have staff to adequately care for residents, roughly 90 percent of elders are abused by family members, two-thirds of the abuse is by adult children and spouses.[2] To stop the abuse and serve victims, elder abuse, neglect and exploitation must be on the forefront of educational efforts and in your thoughts.

A. What is elder abuse?

Elder abuse has a broad definition because there are many ways that elders are vulnerable and often victims of abuse. In Massachusetts, elder abuse includes actions by a caregiver[3], conservator[4], or guardian[5] causing: (1) **physical, sexual, or emotional injury**, or; (2) **financial exploitation**, or; (3) life necessities essential for physical and emotional well-being to be denied (**neglect**). Elder abuse also includes an elderly person's own failure to care for them self. Some often overlooked warnings signs of neglect are bedsores, poor hygiene, malnutrition and mood change.[6]

B. What should I know about financial exploitation of elders?

1. Definition

Financial exploitation is an act or omission which causes a substantial monetary or property loss to an elderly person, or causes a substantial monetary or property gain to the other person, which gain would otherwise benefit the elderly person but for the act or omission of such other person.[7] If the elderly consented to the harmful act or omission this consent is not valid if it was the consequence of misrepresentation, undue influence, coercion or threat of force.[8]

Some common examples of financial abuse include: misuse of durable powers of attorney and bank accounts, misuse or neglect of authority by a guardian or conservator, failure to provide reasonable consideration for the transfer of real estate, excessive charges for goods or services, use of fraud or undue influence to gain control of or obtain money or property — and some consider predatory lending, telemarketing fraud, sweepstakes fraud and other scams that are targeted toward the elderly to also be financial exploitation.[9] For the more traditional forms of financial abuse by persons that the elder trusts it can be hard to identify the abuse because it happens overtime, often the elder do not know it is happening, the elder depends on the abuser, and commonly this financial abuse is accompanied by physical or emotional abuse which silences the elder.[10]

2. Warning signs

There are some warning signs that can help you identify whether financial abuse may be occurring, such as: large sums of money missing from a bank account, signatures on checks look suspicious, bank statements are no longer being sent to the older person's home, the elder cannot pay

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necessary bills, the elder's will is unexpectedly changed, elder's home is suddenly sold, valuables are missing from an older person's home, or the elder is asked to sign legal papers (such as a power of attorney, a will or a joint deed to a house) without being informed.[11]

3. Role of banks

Financial exploitation can be devastating to an elder and an evolving first line of defense is bank tellers. Often financial exploitation can be hard to detect because the person exploiting the elder has been trusted with the elder's money but a bank may be able to notice sudden changes in accounts and other suspicious activity. To address financial exploitation Massachusetts has implemented a program, "The Massachusetts Bank Reporting Project: An Edge Against Elder Financial Exploitation" that provides training to bank personnel in how to identify and report financial exploitation.[12] The project has been successfully replicated in numerous communities.[13] If you would like more information on the Bank Reporting Project call (617) 727-7750, ext. 222.[14]

4. Power of attorney

Give a trusted individual the power to make decisions about the elder's property. These can be easily misused to exploit the elderly.[15] Therefore, the grant of power should be carefully and thoughtfully drafted and the actions of the attorney-in-fact should be monitored.

Classic Examples:

a. Clara, 86, lives in her own home in a very expensive neighborhood. Clara has a niece, Polly, who has visited her regularly for over 30 years. Polly has reported to Protective Services that Clara's son, Uriah, showed up "out of the blue" last year. Polly reports that she heard Uriah "screaming" at his mother. Polly brought in Clara's mail and noticed four different bills that appeared to be related to bank credit cards, all addressed to Uriah, and Clara has complained to Polly that Uriah will not show her her own bank account records. Also, Uriah is insisting that Clara transfer title to her residence to him "in case anything happens" to her. In addition, Polly was in the bank, and a teller took her aside and expressed concern about Uriah depleting Clara's accounts.[16]

b. An elderly man went to his bank and asked the teller questions about why his checks were not clearing. The bank teller could see that the elder's ATM card had been used numerous times even though the elder denied using it at all since he had been housebound.[17] The bank contacted Protective Services who helped the elder with the repercussions of this financial exploitation.

C. I am worried about an elder who cannot care for him or herself. Is help available?

Elder abuse encompasses "self-abuse" meaning when an elder is no longer provide for his or her own essential life needs, nor make informed decisions understanding the consequences of his or her actions, and his or her mental and physical condition declines without it being addressed.[18] One of the reasons that the law includes this self-neglect is so that these individuals can receive services from the Protective Services. The Protective Services must always use the least restrictive measures and try to keep a self-neglecting elder in the community safely.[19] Even in cases of self-neglect, a competent

elder has the right to refuse services and only in emergency situations or if the elder is incompetent can the court be petitioned for Temporary Guardianship.

D. What should I know about abuse in a nursing home?

Abuse in a long-term care facility (LTCF) is separately defined as "the willful infliction of injury, unreasonable confinement, intimidation, including verbal or mental abuse, or punishment with resulting physical harm, pain or mental anguish or assault and battery … [20] Regulations require that reports of abuse be made to the Department of Public Health rather than Protective Services.[21] There are reports about neglect at nursing homes due to understaffing as well as mis-medicating but it seems that most of the offenses by nursing homes are by a small minority of nursing homes.[22] In addition, it has been found that there are far fewer complaints of abuse at non-profit nursing homes than at for-profit ones.[23] (*Note that Protective Services are discussed later in this section and the Rights of a Nursing Home Resident are fully discussed in Chapter 7.)*

E. Who can report elder abuse, neglect or financial exploitation?

Reporting elder abuse is powerful act that anyone can do but it should not be done without the reporter having some level of certainty that the abuse did occur or is about to occur. Every day of the year, the Massachusetts Elder Abuse Hotline can be reached at (800) 922-2275. Most members of society are not required to report suspected elder abuse, but others such as doctors, police, and elder outreach workers, are mandated reporters. Mandated reporters who have reasonable cause to believe abuse has occurred but fail to report may be subject to a $1,000 fine.[24]

F. Is there a statewide agency that helps elderly victims?

Yes. The Executive Office of Elder Affairs by law maintains 22 Protective Services agencies throughout Massachusetts.[25] All Protective Services are 100 percent free. The role of Protective Services is to investigate cases, and where appropriate offer services, make referrals, and connect elders to community resources. To find the Protective Services agency nearest you, call the above hotline, or visit www.mass.gov—click on the "For Residents" tab and scroll down to the section for elders.

Currently, Massachusetts is addressing the need for attention to be paid to the often overlooked problem of elder abuse. In September of 2008, the House of Representatives passed the "Elder Abuse Victims Act of 2008," which is still pending approval by the Senate.[26] This act orders the Attorney General to research the sufficiency of the current laws dealing with elder abuse, neglect and exploitation, as well as fund prosecutorial programs and give grants in order to develop ways to deal with these issues.[27] Massachusetts takes all forms of elder abuse, exploitation and neglect very seriously and works to keep victims safe and prevent improper allegations.

G. What happens when abuse is reported?

If an allegation of abuse is made, be it physical, financial, etc, then a caseworker from the Protective Services will investigate the allegation. The investigation can be intrusive into the elder's home, elder's family, and into the life of the alleged abuser—this is why reporting abuse should be carefully thought through. If one or more types of abuse are found then the social worker from the Protective Services will try to intervene to protect the elder's safety. Often this means that a "care plan" will be drafted with the elder, if he or she is competent. The "care plan" may include counseling, legal aid, home health care, transportation, housing aid or safety planning. If the abuse is very serious, Protective Services will report it to the prosecuting authority who may choose to criminally charge the

abuser. In addition to criminal charges, in some cases there may also be civil lawsuits due to abuse, neglect or exploitation.

It is very important to note that elders who are victims and competent can chose whether or not to take advantage of any of the services offered.[28] If the elder is not competent and Protective Services believes they should be involved with an elder, they can petition the court for a Temporary Guardianship.[29] In a petition, Protective Services must prove a preponderance of the evidence that the elder is being abused, in need of services and lacks the capacity to consent.[30] If a guardian is appointed, the services must be the least restrictive and least intrusive means of offering help.[31]

H. Will an elder lose his or her rights once protective services are involved?

An elder should not lose rights once Protective Services has been contacted because, as noted above, Protective Services cannot provide services unless the elder consents or a guardian consents. Due to the "Doctrine of Self-Determination," a competent elder has the right to refuse services.

In addition, the Protective Services shall not act as a conservator, therefore for example, they may not make financial or property decisions for the abused elderly.[32] Conservatorships strip elders of their rights so they are used sparingly, though there are certainly instances where they are useful and appropriate. Additionally, the Protective Services agencies may not act as guardians, meaning they may not make personal or medical decisions for the elder.[33]

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1 U.S. Department of Health and Human Services Administration on Aging, *The National Elder Abuse Incidence Study*. (1998), www.apa.org/pi/aging/eldabuse.html, www.aoa.dhhs.gov/abuse/report/default.htm).

2 *Id.*

3 Caregiver is a person responsible for the care of an elderly person, which responsibility may arise as the result of a family relationship, or by a voluntary or contractual duty undertaken on behalf of an elderly person, or may arise by a fiduciary duty imposed by law, Mass. G.L. ch. 19A, §14.

4 Conservator is a person who is appointed to manage the estate of a person pursuant to chapter two hundred and one. *Id.*

5 Guardian is a person who has qualified as a guardian of an elderly person pursuant to chapter two hundred and one, but shall not include a guardian *ad litem*. *Id.*

6 *A Guide for Elders: Planning That Protects You and Your Assets*, Ch. 10. www.geront.umb.edu/inst/Planning%20guide/Guide%20for%20Elders,%20Ch_%2010%20What%20If%20I%20Am,%20or%20Know,%20a%20Victim%20of%20Elder%20Abuse.htm.

7 Mass. G.L. ch. 19A § 14.

8 *Id.*

9 Lori A. Stiegel, "Financial Abuse of the Elderly: Risk Factors, Screening Techniques and Remedies." www.abanet.org/elderly/financial_abuse_of_the_elderly.doc.

10 Lori A. Stiegel, "Financial Abuse of the Elderly: Risk Factors, Screening Techniques and Remedies." www.abanet.org/elderly/financial_abuse_of_the_elderly.doc.

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11 www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/agefinancialab_e.html.

12 www.preventelderabuse.org/communities/best.html.

13 *Id.*

14 *Id.*

15 www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/agefinancialab_e.html.

16 “A Guide for Elders: Planning that Protects You and Your Assets” (based on example from), www.geront.umb.edu/inst/Planning%20guide/Guide%20for%20Elders,%20Ch_%2010%20What%20If%20I%20Am,%20or%20Know,%20a%20Victim%20of%20Elder%20Abuse.htm.

17 *American Bar Association*, “Can Bank Tellers Tell?” (based on an example from), www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/publication/bank_reporting_long_final_52703.pdf.

18 Mass. G.L. 19A, 14.

19 651 C.M.R., § 5.02 Code of Massachusetts Regulation, Title 651: Department of Elder Affairs, Ch. 5, “Elder Abuse Reporting and Protective Services Program,” Current through Nov. 28, 2008, Register #1118.

20 Mass. G.L. ch. 111, § 72F.

21 Mass. G.L. ch. 111, § 72F.

22 “Patients’ Deaths Are Scrutinized,” *Detroit News,* Jan. 30, 2005 and “Much Ado About Nothing,” *California Advocates for Nursing Home Reform (CANHR)*, 2003, www.canhr.org/pdfs/CANHR_Litigation_Report.pdf.

23 Charlene Harrington, *et al*, “Does Investor Ownership of Nursing Homes Compromise the Quality of Care?,” *American Journal of Public Health*, Sept. 2001.

24 www.mass.gov/?pageID=eldersterminal&&L=2&L0=Home&L1=Service+Organizations+and+Advocates&sid=Eelders&b=terminalcontent&f=protective_services&csid=Eelders.

25 *Id*.

26 www.govtrack.us/congress/bill.xpd?bill=h110-5352&tab=summary.

27 *Id*.

28 www.mass.gov/?pageID=eldersterminal&&L=2&L0=Home&L1=Service+Organizations+and+Advocates&sid=Eelders&b=terminalcontent&f=protective_services&csid=Eelders.

29 www.massresources.org/pages.cfm?contentID=67&pageID=27&Subpages=yes.

30 Continuing Legal Education Inc., *2003 Estate Planning for the Aging or Incapacitated Client in Massachusetts*, Mark I. Zarrow, Esq., 2005, *Protecting Legal Rights, Preserving Resources and Providing Health Care Options, Volume I* and “Part III: Living in the Community, Protecting Elders From Abuse and Neglect,” Ch. 12.

31 *Id.*

32 651 C.M.R., § 5.02 Code of Massachusetts Regulation, Title 651: Department of Elder Affairs, Ch. 5, “Elder Abuse Reporting and Protective Services Program,” Current through Nov. 28, 2008, Register #1118.

33 *Id.*

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CHAPTER EIGHT

The Rights of a Nursing Home Resident*

INTRODUCTION

A nursing home resident has even greater rights than he or she had while living in the community. A nursing home resident has rights as a medical patient, a tenant or resident, a consumer and as a citizen. A nursing home is not a prison, and residents do not check their rights at the door. Experienced nursing home staff understands and respects these rights. A major responsibility of a resident's guardian is to ensure that these rights are upheld. Every nursing home is visited regularly by a representative of the long-term care Ombudsman Program *(see below)*.

1. Does a resident have the right to choose his or her doctor and medical treatment?

Yes, a nursing home resident has the right to hire and fire the treating physician.[1] Practically speaking, however, there are some limitations to that right. A resident may not be able to keep the doctor who treated him or her in the community because that doctor may not have credentials to practice medicine in that particular nursing home. Or, a doctor may not be available because of the resident's insurance or medical coverage.

Control over one's medical care is a basic civil right for everyone, including nursing home residents, so residents have the right to be given information about their medical condition and proposed treatment, to participate in the treatment plan, and to accept or decline medical treatment.[2] A basic rule in the practice of medicine is that a patient must give informed consent prior to receiving any medical treatment. Therefore before a medical provider renders services he must obtain the informed consent of the patient, his or her health care proxy agent or court-appointed guardian. Moreover, a patient (and resident) retains the authority to refuse medical care even when the medical authorities feel strongly that the care should be furnished.

Every nursing home resident has a patient care plan[3] in his or her records, and the plan should be developed with input from the resident and any person designated by the resident to participate in the process. Under federal law, the goal of the plan is to provide for the highest level of functioning that the resident can achieve. Therefore, the resident has the right to see the treating physician, ask for changes in the treatment plan, and to ask for accommodation of any special needs. Of course, a guardian has the right, indeed the duty, to assert the rights of the resident.

2. Does a nursing home resident have a right of privacy?

Yes, the right of privacy is also a basic right and extends to the resident personally and to his or her records maintained at the nursing home.[4] Recent changes in the federal law have put additional requirements on medical providers to protect medical and health-related information by prohibiting the release of such information without consent of the patient. Privacy rights must received heightened attention in crowded group living setting such as a nursing home.

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The right of privacy includes:

- The right to have medical examinations performed in complete privacy; [940 C.M.R. § 4.06(1)];
- The right to participate or to decline to participate in activities; [940 C.M.R. § 4.06(19)];
- The right to have a conversation with a visitor or on the telephone without being overheard; [940 C.M.R. § 4.06(14)];
- The right to confidentiality with respect to all records, which can be disclosed only with the consent of the resident; [105 C.M.R. § 150.013]; and
- The right to gain access to personal or medical records within 24 hours of the request. [940 C.M.R. § 4.08(5)].

3. Does a nursing home resident have the right to choose what to eat and what to do?

Yes, and nursing homes are obliged to offer alternative selections at each meal and snack, all in keeping with the resident's care plan relative to dietary considerations as well as personal choice.[5] Additionally, residents cannot be forced to engage in any activities that they do not like. Residents are encouraged to suggest activities that they or others may enjoy as nursing home staff are very likely to welcome ideas.

4. Does a nursing home resident have the right to leave the nursing home temporarily?

Yes, a resident may leave the facility either on staff-supervised outings or on visits with family or friends. Such visits may include overnight stays, called leaves of absence (LOAs). Unfortunately, the most common overnight stays for nursing home residents are hospitalizations because of acute illness, for examinations, or tests that cannot be conducted at the nursing home. These are called medical leaves of absence (MLOAs).

An important issue is whether or not a resident's bed will be held for his or her return, which raises questions about who, if anyone, will pay the costs of holding the nursing home bed open. That answer depends on how the costs of care are being paid for in the first place. Currently, Medicaid pays for 10 days per 12-month period for non-medical leaves of absence of nursing home residents. Medicaid requires the nursing home to hold a Medicaid-eligible resident's bed for up to 10 days during a medical leave of absence (hospitalizations); Medicaid pays for this medical leave of absence as often as needed. If the resident does not return to the nursing home during the bed-hold period, the facility must offer the next available bed to that resident, who, by that time, may be either in the hospital or another long-term care facility.

In addition, a resident has the right to attend outside religious services and social gatherings, though he or she may have to arrange for transportation.

5. Does a resident have a right to be spoken to in his or her native language?

Yes.[6] Every effort must be made to communicate with the resident in a language the resident understands. Residents with dementia often revert to the language they spoke as children, which is a challenge for the nursing home staff. Conversely, staffers whose primary language is not English must not converse in their native language while providing care to a resident who does not understand that language.

6. Does a nursing home resident have a right to information on how to apply for financial assistance to cover the costs of the resident's care?

Yes and the nursing home administrator has a legal duty to inform the resident, or his or her representative(s), of the right to apply for such assistance, although there is not a requirement that the nursing home actually file applications. It is reasonable to expect a nursing home to prepare medical insurance claim forms and will at least identify resources like the long-term care Ombudsman Program, the SHINE (Serving the Health Information Needs of Elders) Program, or local public interest legal services programs to provide assistance with filing applications or securing coverage.

7. Does a nursing home resident have rights concerning roommates?

Yes, although in group living there is no guarantee of compatibility, roommates who can coexist is a priority. A resident has the right to ask to be moved to another room and has the right, absent an emergency, to be given 48 hours advance notice of a change of roommates.[7]

In addition, generally a resident can voluntarily move from one room to another in the facility. If the proposed transfer is between beds with different certifications (for example, a transfer from a Medicare-certified bed to a Medicaid-certified bed), the resident may file a Medicaid appeal. When the beds are of the same certification, the Attorney General regulations at 940 C.M.R. § 4.09(4) outline the circumstances under which a move can be made involuntarily. To challenge such a proposed move, the resident or guardian must send a demand letter pursuant to the Consumer Protection laws, Mass. G.L. Ch. 93A. An elder law attorney should be consulted.

8. Does a nursing home resident have the right to be free of restraints?

Yes, as a general rule, a nursing home may not use restraints, whether physical or chemical, to restrict a resident's movement.[8] This issue is often complicated by concerns for safety, especially where the resident has some dementia and is at risk of falling, eloping (running away), or endangering him or herself or others. Staff should be skilled at methods of dealing with such behaviors, including electronic warning systems and personal interventions to redirect the resident exhibiting such behaviors. However, restraints are permitted when they are required to treat a resident's medical symptoms.[9]

9. Must a nursing home resident have a third-party guarantee payment of the resident's bill?

No, federal and state laws prohibit nursing homes from requiring that a third-party guarantee payment of the nursing home bill.[10] Facilities often require a responsible party to sign admission documents, but the liability of the responsible party is limited to the income and assets of the resident. A responsible party cannot be held liable for the resident's expenses but should be willing to explore the appropriate sources of payment for the nursing home bills, whether that source is health insurance, Medicaid, veterans services, or another source. A guardian has the legal duty to determine whether the resident is eligible for such programs and to secure such coverage.

10. Must a nursing home resident provide a security deposit before being admitted?

In the case of a private-pay resident, a nursing home may demand a security deposit of no more than one month private-pay costs, according to the consumer protection regulations that the Attorney General's office has promulgated under the consumer protection laws of the commonwealth.[11]

11. Does a facility have the right to discharge or transfer a resident against his or her will?

If a nursing home administrator wants to discharge a resident permanently, or temporarily transfer a resident to another medical facility, the administrator must give a written notice to the resident or his or her guardian/healthcare proxy agent. The notice must explain the reason(s) for the proposed action. Except for an emergency medical transfer, the notice must be provided to the resident and his or her representative 30 days in advance of any such action. The notice must state:

- The action to be taken by the facility; and
- The specific reason for the discharge or transfer, which can only be for one of the following reasons:
    1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; or
    2. The proposed action is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility; or
    3. The safety of individuals in the facility is endangered; or
    4. The health of individuals in the facility is endangered; or
    5. The resident has failed, after reasonable and appropriate notice, to pay for (or failed to have Medicaid or Medicare pay for) a stay at the facility; or
    6. The nursing home ceases to operate.
- The effective date of the transfer; and
- The location to which the resident is to be discharged or transferred; and
- A statement of the resident's right to request an appellate hearing before the DMA Board of Hearings (whether or not the resident is Medicaid-eligible), how and where to apply, within what time period the appeal must be filed, and the effect of the request (that the resident cannot be moved pending the appeal); and
- A statement of how to find the local long-term care ombudsman and any free legal assistance available.

In summary, the law provides that the nursing home may discharge or transfer a resident only for one of the reasons permitted by law and after the requisite notice.[12]

12. Does a facility have an absolute right to discharge a resident and send them home?

No, the appeal process described in the answer to Question 11 usually ensures a discharge plan to which both the resident and the nursing home agree. It also calls for a visiting nurse or other supports to ensure that the resident will be able to remain safely at home. If the resident is not satisfied with the discharge plan, filing an appeal will result in either an acceptable plan or a DMA hearing, where the facility must carry the burden of proving to a hearing officer that the discharge plan is appropriate for the resident's needs.

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13. May a facility treat a private and medicaid paying resident differently?

No, the care must be the same, even though the nursing home will receive less money from Medicaid than from a private-pay resident. Any difference in treatment or care is unlawful discrimination and should be reported to the ombudsman, the Attorney General's office of the Department of Public Health.[13] A nursing home may not discriminate against a Medicaid-eligible person in any fashion or at any time.[14]

14. What is the long-term care Ombudsman Program?

The long-term care Ombudsman Program is authorized to place visiting ombudsman in nursing homes in order to ensure quality of care by ensuring that any problems are either resolved or referred to appropriate authorities. The long-term care ombudsman is the best resource in circumstances where the resident is complaining about nursing home conditions or personnel.

Visiting ombudsmen are trained volunteers who are supervised by professional program directors, usually located in the local Aging Services Access Point (ASAP), the elder services programs of the Commonwealth. The State Nursing Home Ombudsman at the Executive Office of Elder Affairs (EOEA) heads the program. Ombudsmen assist residents with all types of problems or complaints and are trained mediators who receive training in all aspects of the nursing home system. If they cannot resolve a problem immediately, they will make referrals to appropriate resources. Ombudsmen are key resources for residents and their advocates and are always available to assist residents. *To learn how to contact an ombudsman, call 1-800-AGE-INFO, (800) 243-4636 or (617) 727-7750.*

15. Does a facility have the right to demand that the resident waive or limit liability for loss of personal property or injury suffered at the nursing home?

No.[15]

16. How will a resident know his or her rights and responsibilities?

A resident should be informed of these upon his or her admission. In addition, residents' rights are required to be posted conspicuously in the nursing home.[16] And a resident or his or her representative may request a copy at any time.

17. Who can help with nursing home placement?

Few nursing home placements are easy, but the family or guardian can get help from hospital discharge planners, long-term care Ombudsman Program directors or geriatric care managers. An applicant for nursing home placement may ask about vacancies or vacancy rates, but as a practical matter, such inquiries should be directed to the local Ombudsman Program director who maintains or can obtain current lists of available beds in all nursing homes in his or her catchment area.

18. If a resident requires anti-psychotic medication but is unable to give consent, may the doctor proceed?

No. A doctor must obtain the informed consent of a resident for any treatment, and especially treatment with anti-psychotic medications.[17] If the resident has appointed a health care proxy agent, that person may have authority to approve such treatment, but only where there is no evidence of the resident's refusal to accept such medications. For example, when a resident is spitting out the medication, such behavior is considered a revocation of the authority granted to the health care proxy agent and a "Rogers guardian" must be appointed by the probate court.

19. Does an applicant have the right to have an admissions contract and related documents in an easy-to-read and understandable format?

Yes.[19]

20. Does a resident have the right to assistance in placement at another facility if his or her nursing home goes out of business?

When a nursing home is going out of business, it must give advance notice and obtain the permission of the Department of Public Health (DPH), which licenses and de-licenses long-term care facilities. The DPH and the local Ombudsman Program monitor such closings to ensure quality of care during the closing process and the orderly transfer of residents to other appropriate facilities.

21. May a resident manage his or her personal funds (personal needs account)?

Yes, a resident should manage his or her own personal needs account at the nursing home or should designate a person to have such responsibility. The facility can manage a resident's funds with the approval of the resident or the resident's guardian.

22. Does a resident have the right to reserve a room for special family occasions?

Yes, the resident has the right to make any reasonable request, including the right to request a room for a family function, provided that the facility has such a room. Remember, the nursing home is the resident's home.

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1 940 C.M.R., § 4.08(1).

2 940 C.M.R., § 4.08(2) and (3).

3 As part of an individual service plan as required by DPH regulations, 105 C.M.R. §150.004(D).

4 105 C.M.R., §150.013.

5 105 C.M.R., §150.009.

6 *See,* for examples, 940 C.M.R., § 4.02(4) and 4.08(7).

7 940 C.M.R., § 4.06(11).

8 940 C.M.R., § 4.08(15).

9 42 C.F.R., § 483.13(a).

10 940 C.M.R., § 4.04(1).

11 940 C.M.R., § 4.05(10). The consumer protection statute is Mass. G.L. ch. 93A.

12 *See* 130 C.M.R., 610.028.

13 940 C.M.R., § 4.03.

14 940 C.M.R., § 4.03, G.L. ch. 151B.

15 940 C.M.R., § 4.04(3).

16 940 C.M.R., § 4.02.

17 940 C.M.R., § 4.08(19).

18 940 C.M.R., § 4.02(2).

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CHAPTER NINE

Long-Term Care

Regulations and Resident Rights

NURSING HOME CARE

A. Who is nursing home care suited for?

Nursing home care is suited for elders who require 24 hours of skilled sub-acute nursing care. Nursing homes provide adequate medical care and assistance with daily living activities.[1]

B. Department of Public Health regulations

The Massachusetts Department of Public Health monitors and licenses nursing home facilities throughout the state.[2] To determine whether the applicant is responsible and suitable for licensing, the department will look to the potential licensee's criminal history, if any, financial capacity to operate a long term care facility, and history and experience in providing long term care.[3] The department sets out rules and regulations governing medical and nursing care, the maintenance of medical records, the handling of patient funds, the prevention of loss or damage to patients' personal possessions, and the standards of facility sanitation.[4] The department and its agents have the right to visit and inspect any nursing home institution at any time to monitor compliance with regulations.[5] The inspections are unannounced, and occur at least twice per year.[6] If violations are found, the nursing home facility may be subjected to a monetary fine, and will be expected to submit a plan of correction to the department within a certain time period; at the expiration of such time period, the violation will be made public if no correction plan has been submitted.[7]

C. Medicaid regulations

To be certified for participation in Medicaid and Medicare programs, a nursing home facility must also follow regulations set out by the Division of Medical Assistance.[8] Otherwise, the nursing home will not be reimbursed for any services the nursing home provides to Medicaid or Medicare eligible residents.[9]

D. Attorney General's regulations

Nursing home facilities must also follow regulations set out by the Attorney General's Office in order to prevent being liable upon a private right of action by residents.[10] It will be considered an "unfair and deceptive" act, in violation of Mass. G.L. ch. 93A, for a nursing home to fail to comply with a statute protective of resident rights and for a nursing home to fail to disclose the policies of the facility to a resident or prospective resident.[11] Further, a nursing home will be in violation of 93A if it discriminates against a Medicaid eligible resident on the basis of how that resident will be paying for nursing home services.[12] The attorney general's regulations also prohibit nursing homes from requiring residents to have a third-party guarantor or requiring residents to waive the facility's liability for loss of personal property.[13] Nursing homes may not limit a resident's choice of physician or, for that matter, his choice of pharmacy.[14] Nursing home facilities cannot require residents to pay a nonrefundable deposit.[15] Additionally, it will be considered a violation of 93A if a nursing home

facility refuses to permit a resident to have privacy during medical treatment or other daily living activities, or refuses to allow a resident to live in the same unit with his or her spouse if both consent.[16] While this is hardly an exhaustive list of the regulations as set out by the Attorney General's Office, it provides an overview of standards by which nursing homes must follow to prevent liability.

E. Nursing home resident rights

Nursing home residents are entitled to certain rights with regard to quality of care, treatment and safety.[17] Nursing home residents have the right:

- To obtain, upon admittance to the facility, written notice of their rights as residents;[18]
- To freedom of choice of a physician, facility and health care mode;[19]
- To obtain, upon request, an itemized bill for nursing home services;[20]
- To have all medical records and communications kept confidential to the extent provided by law;[21]
- To have all reasonable requests responded to promptly within the capacity of the facility;[22]
- To access all of their medical records upon request;[23]
- To refuse to be examined, observed, or treated without jeopardizing access to other medical care;[24]
- To have privacy during medical exams or treatment;[25] and
- To informed consent to the extent provided by law.[26]

A nursing home resident is also entitled to certain rights relating directly to his or her personal freedoms. A nursing home resident is entitled:

- To communicate with persons of one's choice, privately and without restriction;[27]
- To make a complaint or express a grievance free from reprisal, restraint, coercion or discrimination;[28]
- To be free from any requirement to perform any service for the facility not in his or her individual care plan, unless one volunteer or pays for such service;[29]
- To participate in social, religious, and community groups;[30]
- To manage one's own financial affairs;[31]
- To keep and use personal possessions and clothing as space permits and to have personal possessions reasonably safeguarded and secured;[32]
- To be permitted to share a room with his or her spouse;[33] and
- To receive at least 48 hours notice of a roommate change, barring any emergency.[34]

ASSISTED LIVING

A. What is assisted living and who is it suited for?

Assisted living is a residential arrangement providing room and board for eligible elders as an alternative to nursing home care.[35] It suits elders who require some aid, support or supervision with daily activities such as meal preparation, medication regimen, housekeeping, clothes laundering, dressing

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or bathing, grocery shopping and transportation needs.[36] However, elders in assisted leaving do not require 24 hours of skilled nursing home care.[37] Assisted living provides the security of having assistance available 24-hours-a-day as needed, but encourages the maintenance of elders' autonomy and privacy.[38]

B. Assisted living regulations

The Executive Office of Elder Affairs certifies all assisted living residences in Massachusetts.[39] An assisted living residence must provide only single or double living units with lockable doors and a kitchenette within the unit or access to cooking residences.[40] Any newly constructed assisted living residence must provide a full bathroom for each unit, while existing assisted living residences must provide at minimum a private half bathroom.[41] After evaluation of eligibility and assessment of appropriateness of assisted living services for an elder, the elder should receive an individualized service plan which sets out the services provided, who will provide them, how often and for how long the services will be provided, the payment terms and reimbursement source for such services, the way the residence will provide for the presence of 24-hour on-site staff capability, and information regarding self-administered medication management.[42] In addition to a service plan, each resident and sponsor of the assisted living residence must execute a written agreement setting out the responsibilities and rights of the resident and sponsor with regard to the charges for services, a grievance procedure and termination conditions.[43]

C. Assisted living resident rights

Massachusetts law specifies that a resident of an assisted living facility has the right:

- To live in a decent, safe and habitable environment;[44]
- To be treated with consideration and respect;[45]
- To have your personal dignity and privacy observed;[46]
- To retain and use personal property in one's unit;[47]
- To communicate privately and without restriction;[48]
- To contract or engage with health care professionals in one's unit as needed;[49]
- To engage in community services and activities as he or she chooses;[50]
- To manage one's own financial affairs;[51]
- To present grievances and recommendations without reprisal;[52]
- To have all one's records kept confidential;[53]
- To have privacy during medical treatment or other services;[54] and
- To have reasonable requests responded to promptly and adequately.[55]

D. Ombudsman Program

A resident, family member of a resident, or representative of a resident may contact a statewide EOEA-trained ombudsman in the case of a complaint or violation. The ombudsman will enter the assisted living residence to review and examine the situation.[56] In order to maintain certification, each assisted living facility must comply with the Ombudsman Program and facilitate the ombudsman's right to enter and investigate the residence.[57]

CONTINUING CARE RETIREMENT COMMUNITIES

A. What is a continuing care retirement community?

A continuing care retirement community (CCRC) is a housing option which offers single and married elders a continuum of housing, services and nursing care which allows them to age in place as their services are adjusted and altered depending upon their needs.[58] It is a comprehensive and individualized plan offering such services as nursing and health care, housekeeping, transportation, meals and special diets, recreational activities, and emergency help.[59] Residents enter into one of three different contracts with the community to secure long term care depending on the particular needs of the resident.[60]

B. Continuing care retirement community regulations

The Executive Office of Elder Affairs registers and regulates CCRC's in Massachusetts pursuant to Mass. G.L. ch. 93, § 76, which sets out disclosure requirements regarding the contractual rights of the parties.

OTHER IMPORTANT ELDER PROGRAMS[61]

A. Statewide nutrition programs

The Elderly Nutrition Program, administered by the Executive Office of Elder Affairs, allows local elderly agencies to provide nutritious meals to senior citizens. Meals are provided at congregate meal sites and through home-delivered meals to senior citizens (aged 60 or older) and handicapped or disabled people under age 60 who live in housing facilities occupied primarily by the elderly where congregate meals are served.

Each meal contains at least one-third of the current daily Recommended Dietary Allowance of nutrients and considers the special dietary needs of the elderly. In addition to providing meals, the Elderly Nutrition Program also provides access to social and rehabilitative services.

The Congregate Meals Program provides at least one meal per day at senior centers, churches, schools, and other locations. The congregate setting provides opportunities for socialization and companionship. It also offers programs related to nutrition education, exercise activities, health promotion and disease prevention. Some programs also offer meals on weekends. Transportation is often available for those who have trouble getting around on their own.

To apply for one of the elderly nutrition programs, you can contact EOEA at (800) 882-2003 to find the elderly nutrition agency nearest to you.

B. Prescription Advantage

Prescription Advantage is a prescription drug insurance plan available to all Massachusetts residents aged 65 and older, as well as younger individuals with disabilities who meet income and employment guidelines. An elder is eligible for the program if they are not receiving prescription drug benefits under Medicaid. Individuals with Medicare may be eligible for assistance with paying for prescription drug costs, also known as "Extra Help", from Social Security. In order to receive this assistance, an application must be submitted to Social Security.

Individuals with Medicare may be eligible for assistance with paying for prescription drug costs, also known as "Extra Help," from Social Security. In order to receive this assistance, an application must be submitted to Social Security.

Significant budgetary restrictions will be imposed upon the Prescription Advantage Program in 2009. *See the Executive Office of Elder Affairs for more information.*

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C. Pharmacy Outreach Program

The purpose of the Pharmacy Outreach Program is to work closely with local and statewide health care resources, physicians and elders to help relieve the burden of medication expenses. The Pharmacy Outreach Program is a public service to the people of the commonwealth. Any Massachusetts resident may utilize the MassMedLine toll-free telephone number, (866) 633-1617, and Web site, www.massmedline.com, to inquire about prescription drug medication support programs that are available at low cost or free of charge. Clients can ask any questions regarding their medications and general health.

D. SHINE (Serving the Health Information Needs of Elders program)

The SHINE (Serving the Health Information Needs of Elders) Program provides health insurance counseling services to elderly and disabled adults. SHINE counselors are trained to handle complex questions about Medicare, Medicare supplements, Medicare Health Maintenance Organizations, public benefits with health care components, Medicaid, free hospital care, prescription drug assistance programs, drug discount cards and long-term health insurance.

SHINE counselors help elders and Medicare beneficiaries understand their rights and benefits under Medicare and other health insurance coverage. Counselors can identify and compare current options and protect clients from paying too much on their medical care. SHINE Counselors also help clients learn how to fill out insurance claims forms and public benefits applications.

SHINE counselors are available at most councils on aging, senior centers and Aging Services Access Points, hospitals and libraries. Counselors are also available for homebound clients. To locate a SHINE counselor in your community, contact your regional SHINE Program at www.medicare-outreach.org.

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1 "Estate Planning for the Incapacitated Client," § 26.1.

2 Mass. G.L. ch. 111, § 71 (2007).

3 *Id.*

4 Mass. G.L. ch. 111, § 72 (2007).

5 *Id.*

6 *Id.*

7 *Id.*

8 130 C.M.R., § 456.406 (2007).

9 *Id.*

10 940 C.M.R., § 4.02 (2007).

11 *Id.*

12 940 C.M.R., § 4.03 (2007).

13 940 C.M.R., § 4.04 (2007).

14 *Id.*

15 *Id.*

16 940 C.M.R., § 4.06 (2007).

17 Mass. G.L. ch. 11, § 70E (2007).

18 *Id.*

19 *Id.*

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 940 C.M.R., § 4.06 (2007).

28 *Id.*

29 *Id.*

30 *Id.*

31 940 C.M.R., § 4.07 (2007).

32 *Id.*

33 940 C.M.R., § 4.06 (2007).

34 *Id.*

35 Mass. G.L. ch. 19D, § 1 (2007).

36 *Id.*

37 651 C.M.R., § 12.01 (2007).

38 *Id.*

39 651 C.M.R., § 12.03 (2007).

40 651 C.M.R., § 12.04 (2007).

41 *Id.*

42 *Id.*

43 651 C.M.R.,§ 12.08(2) (2007).

44 651 C.M.R., § 12.08 (2007).

45 *Id.*

46 *Id.*

47 *Id.*

48 *Id.*

49 *Id.*

50 *Id.*

51 *Id.*

52 *Id.*

53 *Id.*

54 *Id.*

55 *Id.*

56 651 C.M.R., § 13.00 (2007).

57 651 C.M.R., § 12.04(7) (2007).

58 Mass. G.L. ch. 93, § 76 (2007).

59 *Id.*

60 *Id.*

61 Mass. Executive Office of Elder Affairs, www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders, site last visited on Dec. 1, 2008.

CHAPTER TEN

Real Estate Tax Exemptions and Deferrals

INTRODUCTION

If you are a homeowner and a legal resident of Massachusetts, there are programs available in your city or town which may provide either an exemption or a deferral of real estate taxes. An exemption releases an individual who owns and occupies property from the obligation of paying all or a fraction of the taxes assessed on that property. A deferral allows an elder homeowner to delay payment (with interest) on property taxes up to a maximum amount of 50 percent of the homeowner's interest in the property valuation.

In Massachusetts there are several real estate tax exemptions available to a homeowner who is:

- Elderly;
- A veteran of the armed forces;
- Blind;
- A widow or widower; or
- A minor child of deceased parents.

Each exemption has eligibility requirements that may include age, asset or income limitations. Eligibility requirements for each clause must be satisfied by July 1 of the year the exemption is sought, unless another date is specified. For a complete list of specific eligibility requirements, each exemption should be read carefully. However, the following are standard eligibility requirements for all of the above exemptions:

- The applicant must own the property solely or jointly;
- The applicant must be a legal resident of Massachusetts; and
- The applicant must occupy the property for not less than five years. (Veterans applying for the veteran exemption must either have been domiciled in Massachusetts for at least six months prior to entering the service, or must have resided in Massachusetts for five consecutive years.)

HOW EXEMPTIONS AND DEFERRALS WORK

Homeowners who believe that they meet the eligibility requirements for an exemption or deferral must file an application for that exemption or deferral at their local Board of Assessors office on or before December 15 (or three months after the tax bill is mailed). Applicants should not delay payment of their tax bill while their application is pending approval.

Generally, an individual can only qualify for one exemption each year, so review all exemptions annually and select the one that will result in the greatest reduction amount. A person who receives an exemption under Mass. G.L. ch. 59, § 5, cls. 17, 17C, 17D, 22, 22A, 22B, 22C, 22D, 22E, 37, 37A, 41, 41B, 41C, 42 or 43 shall not receive an exemption on the same property under any other provision of G.L. c. 59, § 5, except clauses 18 or 45 (which offer exemptions for hardship and for solar or wind-powered energy systems, respectively). Approved applications will result in a reduced real estate tax bill to the taxpayer/applicant. Exemption amounts vary based on the exemption, the applicant's ownership

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interest in the property and alternative exemptions adopted by an individual city or town.

Joint owners of property who are married may qualify for more than one exemption, so long as each spouse meets his or her respective exemption eligibility requirements.

Example:

Mary and John are married and own their home jointly. Mary is over 70 years old and John was honorably discharged from the army with a disability. If Mary meets the qualifications for the elderly person's exemption and John meets the qualifications for the veteran exemption, they will receive a reduction in their real estate tax bill for both exemption amounts.

An applicant who owns property jointly with someone other than his or her spouse may receive an exemption amount proportionate to the applicant's ownership interest, so long as he or she meets the minimum ownership interest and any other eligibility requirements stated by the exemption. However, some exemptions allow for only one exemption per year on the same parcel of property. For instance, if two elders (married or unmarried) own property jointly and both qualify for the elderly persons exemption, Mass. G.L. ch. 59, § 5, cls. 41, 41B or 41C, the first elder to apply for the exemption and meet the eligibility requirements will receive the tax reduction.

All exemptions allow holders of life estates in the property to satisfy the ownership requirement, as long as other eligibility requirements stated by the exemption are met.

THE EXEMPTIONS

A. Elderly persons

The elderly persons exemption is available to individuals who are 70 years of age or older, or to individuals who jointly own property with a spouse who is 70 years of age or older.

The elderly applicant must own the property, either solely or jointly. Applicants who jointly own the property must possess at least $4,000 worth of ownership interest in the property in order to satisfy the ownership requirement of this exemption. The applicant must also occupy the property as his or her primary residence. Clauses 41B and 41C of G.L. c. 59, § 5 require that the applicant must have been domiciled in Massachusetts for ten years preceding the application. A holder of a life estate in the property satisfies the ownership requirement, as well as a trustee or co-trustee of a trust under which the property is held, so long as the trustee or co-trustee also has a sufficient beneficial interest in the property, most often met by living in the property.

An elderly applicant must also meet income and estate (asset) limitations to be eligible for this exemption. The income limitations do not include Social Security benefits, and the asset restrictions vary depending on the clause adopted by each city or town. Refer to the following chart to determine if an elderly applicant meets the income and asset eligibility requirements under this exemption:

Elderly Persons Clause	Single			Married		
	Income	Estate Value (excluding home)	Estate Value (including home)	Income	Estate Value (excluding home)	Estate Value (including home)
41	$6,000	$17,000	$40,000	$7,000	$20,000	$45,000
41B	$10,000	$20,000	N/A	$12,000	$23,000	N/A
41C	$13,000	$28,000	N/A	$15,000	$30,000	N/A

Note that clauses 41B and 41C are only available in cities or towns that adopted these alternative clauses.

If the property is greater than a single family home, the estate value determination does not include any portion of the property which produces income, nor any portion which exceeds three dwelling units.

The exemption amount granted under this exemption is $500. Applicants who do not qualify for this exemption because they exceed the income restriction should apply for the Older Citizens exemption (G.L. c. 59, § 5, cl. 17) because there is no income restriction for that exemption. *See § 24.3.4, below.*

Practice note: *An individual can only apply for one exemption, so you should select the exemption that will result in the greatest reduction amount. Also, the elderly person's exemption is only granted to one person for the same parcel of property. If two elderly individuals own the property jointly, the exemption amount will only be granted to one owner.*

B. Veterans

The veteran exemption is available to veterans who were honorably discharged from the Armed Forces, their spouses and surviving spouses (if they remain unmarried) and parents of such veterans. The following individuals may be eligible for this exemption:

- Veterans who received at least a 10 percent disability rating from wartime service, as determined by the Veterans Administration;
- Veterans who were awarded the Purple Heart;
- Parents of Gold Stars;
- Spouses and surviving spouses of veterans entitled to this exemption; and
- Surviving spouses of World War I veterans (the total worth of surviving spouses of World War I veterans must not exceed $20,000, excluding the mortgage on the property).

Exemption amounts granted under this exemption vary depending upon the disability or disease contracted in wartime service in the line of duty or the decoration the veteran received from the armed forces. Exemption amounts range from $400 to $2,500. Paraplegic veterans, or their surviving spouses who do not remarry, are eligible for a total real estate tax exemption.

Example 1:

Mary is a veteran of the Army who permanently lost use of her hand as a result of wartime service in the line of duty. Because of the seriousness of her injury, Mary is eligible for an annual real estate tax reduction of $425.

While there are no income or asset restrictions, the applicant must own the property solely or jointly and occupy the property as his or her primary residence. Applicants who jointly own the property must possess at least $2,000 worth of ownership interest in the property in order to satisfy the ownership requirement of this exemption. A holder of a life estate in the property satisfies the ownership requirement, as well as a trustee or co-trustee of a trust under which the property is held, so long as the trustee or co-trustee also meets the sufficient beneficial interest in the property.

If the property is greater than a single family home, the exemption amount is calculated and prorated based on the value of the property that is occupied by the applicant.

Example 2:

Mary (discussed in the example above) lives in a two-family home. Mary occupies the first floor and her son occupies the second floor. Because Mary occupies 50 percent of the property, if she otherwise qualifies for a tax exemption of $750, her tax reduction would be $212.50 (50 percent of $425).

In addition, applicants seeking this exemption must satisfy a residency requirement:

- The veteran must have been a Massachusetts resident for at least six months prior to entering the service; or
- The applicant must have lived in Massachusetts for at least five years prior to filing for this exemption. (A city or town may have adopted an alternative residency requirement of one year prior to filing for the exemption.)

Practice Note: *Remember that an individual can only apply for one exemption, so you should select the exemption which will result in the greatest reduction amount.*

C. Blind

An applicant applying for the exemption for the blind must present a certificate showing that he or she is registered as legally blind with the Massachusetts Commission for the Blind or provide a physician's letter stating that he or she is legally blind. A letter from the applicant's physician is only sufficient for the first year the exemption is sought. For each subsequent year, a certificate from the Massachusetts Commission for the Blind is required. A city or town may elect to provide for an increased exemption amount under Clause 37A.

While there are no income or asset restrictions, the blind applicant must own the property solely or jointly and occupy the property as his or her primary residence. Applicants who own the property jointly must have at least $5,000 worth of ownership interest in the property in order to satisfy the ownership requirement of this exemption. Unlike other exemptions, this exemption does not apportion the exemption amount granted based on the blind applicant's ownership interest in the property. A blind applicant who owns the property jointly will receive the full exemption amount. A holder of a life estate in the property satisfies the ownership requirement, as well as a trustee or co-trustee of a trust under which the property is held, so long as the trustee or co-trustee also meets the sufficient beneficial interest in the property.

The amount available under this exemption is $437.50 (cities and towns that have voted to adopt the Clause 37A alternative exemption provide for an exemption amount of $500) or $5,000 of the taxable valuation of the property.

Practice Note: *This exemption is only granted to one person per parcel of property. If two blind individuals own the property jointly, the exemption amount will only be granted to one owner.*

Example 3:

Mary and her sister are both legally blind, registered with the Massachusetts Commission for the Blind and are joint owners of the property. Even though both women qualify for the exemption, the first person to apply for the exemption will receive the abatement because only one exemption is granted on the same parcel of land.

Applications for this exemption must be filed annually. However, if an exemption under this clause was granted in the preceding year, the applicant may simply file a renewal application.

Practice note: *Remember that an individual can only apply for one exemption, so you should select the exemption which will result in the greatest reduction amount.*

D. Older citizens, surviving spouses and minors

This exemption is available to individuals who are at least 70 years old, surviving spouses (e.g., widow, widower) of any age, or minors who have a deceased parent. Due to increases in property valuations, many individuals have been unable to qualify for this exemption. As a result, several cities and towns have adopted updated alternative exemptions, which allow for less stringent eligibility requirements. Mass. G.L. ch. 59, § 5, cls. 17C, 17C½, 17D.

An older citizen who is single or married and whose spouse is not an owner in the property must be 70 years old or older to qualify. If the property is owned jointly with a spouse, at least one spouse must be 70 years or older. Because there are no income limitations, this exemption is a good alternative to elders who do not qualify under the more advantageous elderly persons exemption discussed in § 24.3.1 above.

Older citizens applying for this exemption must have owned and occupied the property as their primary residence for at least 10 years. Mass. G.L. ch. 59, § 5, cls. 17, 17C and 17C½. The occupancy requirement is five years for clause 17D. Individuals applying for this exemption as a surviving spouse or a minor child must have owned and occupied the property on July 1.

While there are no income limitations, there are asset limitations which range from $20,000 to $40,000, depending upon the alternative exemption adopted by the city or town. An applicant's personal belongings, household furniture, car and prepaid funeral expenses are not counted in determining the applicant's maximum total worth amount. Mass. G.L. ch. 59, § 5, cls. 12, 20 and 21.

Example 4:

Mary has a CD in the bank valued at $10,000, $3,500 in her checking account, and she has prepaid her funeral expenses. Mary would satisfy the asset limit for this exemption.

Applicants meeting the eligibility requirements for this exemption will receive an exemption amount equal to $175.

Example 5:

Mary is 70 years old and has lived in her home for the past 10 years. In addition to $13,000 in the bank, Mary owns a car worth $15,000 and has household furniture valued at $20,000. Mary would qualify for this exemption and receive a reduction of taxes on her home of $175.

Practice note: *Remember that an individual can only apply for one exemption, so you should select the exemption which will result in the greatest reduction amount.*

E. Hardship

Individuals who do not qualify for any of the above exemptions may apply for a hardship exemption. A hardship exemption can be claimed even by individuals who also apply for one of the above exemptions, as noted above. This exemption grants relief to a homeowner in his or her tax bill due to medical hardship, financial hardship or extenuating circumstances and expenses. There are no

expressed restrictions, and eligibility is determined based on an individual's situation. This exemption is available to individuals who are unable to fulfill their tax obligation because of:

- Age;
- Infirmity and poverty; or
- Financial hardship resulting from a change to active military status, not including initial enlistment.

THE DEFERRAL

The elderly tax deferral allows an elder homeowner to defer payment on his or her property taxes. Unlike an exemption, deferred taxes must eventually be paid. Under the deferral, all or part of the property taxes due on the property are deferred until the deferred tax amount reaches 50 percent of the then-assessed property value. During the deferral period, the deferred tax amount incurs 8 percent interest annually (the interest rate is doubled to 16 percent if the property is sold or transferred prior to paying the deferred taxes or prior the death of the elder homeowner) and must be repaid within six months after the death of the elder homeowner or sale of the property. If the property is sold or the elder homeowner is deceased and the taxes are not repaid, the tax deferral becomes a lien on the property.

An elder homeowner who is single (or if married, whose spouse is not an owner) must be at least 65 years old to be eligible for the deferral. For elders owning property jointly with a spouse, at least spouse must be 65 years or older.

The elder applicant must have owned and occupied any real property in Massachusetts (including the current property) for five years and must have been a resident of Massachusetts for the previous 10 years. While there are no asset limitations, the elder's income may not exceed $20,000. Cities and towns may adopt higher income limitations, but no city or town may adopt a higher income limitation than $40,000.

The deferral can be used in conjunction with one of the available real estate tax exemptions, so long as the applicants meet eligibility requirements for both.

Example 6:

Mary has a yearly real estate tax bill of $1,200 on her home. She is 73 years old and receives a $500 reduction in her real estate tax under the elderly person's exemption. Mary's remaining tax amount due of $700 can be deferred.

ADDITIONAL RESOURCES AND CONCLUSION

Additional information and applications for exemptions can be obtained at the Assessor's Office in each city or town. Several assessors' offices have Web sites which provide local exemption information, downloadable applications, and links to other Web sites. The following are additional resources that may be useful:

- **Commonwealth of Massachusetts Citizen Information Service**
  www.state.ma.us/sec/cis
  (617) 727-7030
- **Massachusetts Association of Assessing Officers**
  33 Boston Post Rd., Suite 220 #4, Marlborough, MA 01752
  (774) 249-8624

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- **Department of Revenue, Division of Local Services, Property Tax Bureau**
  51 Sleeper St., Boston, MA 02210
  (617) 626-2300

This chapter should provide the reader with information needed to determine whether or not an individual may be eligible for a real estate tax exemption or deferral. Because several cities and towns have adopted alternatives for many exemptions, individuals should contact their local Assessor's Office for specific eligibility requirements and exemption amounts.

Chapter 11

RESOURCE DIRECTORY

General Information

Alzheimer's Association
www.alz.org
(800) 272-3900, (617) 868-6718

End-of-life decision-making organizations
www.dcmsonline.org
www.caregiver.org

Executive Office of Elder Affairs in Massachusetts
(617) 727-7750

National Council for Aging
www.ncoa.org
(202) 479-1200

National Multiple Sclerosis Society
www.nationalmssociety.org
(781) 890-4990

Legal Information

Legal Assistance—Massachusetts Bar Association Lawyer Referral Service
617) 654-0400
Toll-free (866) 627-7577

Massachusetts Bar Association Dial-A-Lawyer (held on the first Wednesday of each month, 5:30 to 7:30 p.m.)
(617) 338-0610

Massachusetts Chapter of Elder Law Attorneys
www.manaela.org
(617) 566-5640

National Academy of Elder Law Attorneys
www.naela.org

National Senior Citizens Law Center
www.nsclc.org

Elder Abuse Prevention and Reporting Information

Elder Abuse and Protective Services
(800) 882-2003

Long-Term Care Ombudsman
(617) 727-7750

Massachusetts Elder Abuse Hotline
(800) 922-2275

Massachusetts Bank Reporting Project
(617) 727-7750

Social Security Information:

Martin on Social Security
www.law.cornell.edu/socsec/martin

Social Security Advisory Service
www.ssas.com

Social Security Prescription Help
www.socialsecurity.gov/prescriptionhelp

U.S. Social Security Administration
www.ssa.gov
(800) 772-1213

Medical Insurance Information:

MassHealth

Customer Service Center
(800) 841-2900

24-hour hotline
(888) 665-9993

Massachusetts Health Care for All
www.hcfama.org

Health Care Resources
Consumer Health Helpline
(800) 272-4232

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Medicare and Medicaid Services

Centers for Medicare and Medicaid Services
www.cms.hhs.gov
(877) 267-2323

Prescription Drug Coverage— General Information
www.cms.hhs.gov/PrescriptionDrugCovGenIn

Medicare HelpLine — Official U.S. Government Site for People with Medicare
(800) 633-4227
www.medicare.gov

MassMedLine Pharmacy Outreach Program
(866) 633-1617
www.massmedline.com

Medicare Rights Center — Prescription Drug Plan
www.medicarerights.org/drughelp.html
Hotline: (800) 333-4114

SHINE (Serving Health Information Needs of Elders Program)
www.medicareoutreach.org
(978) 683-7747

Veterans Information

City of Boston Veterans' Services
(617) 635-3037

Massachusetts Department of Veterans' Services
www.mass.gov/veterans
(617) 210-5480

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