Legal Matters®

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Estate planning essential for unmarried couples

While estate planning is important for married couples, it is arguably even more critical for couples who live together but aren't married. Without an estate plan, unmarried couples won't be able to make end-of-life decisions or inherit from each other.

Estate planning serves two main functions: determining who can make decisions for you if you become incapacitated and who gets your assets when you die.

For couples who have failed to plan, there are laws in place that govern the distribution of property in the event of death and protect spouses. If you do not have a will, property will pass to your spouse and children, or to your parents if you die without a spouse or children.

But there are no laws in place to protect unmarried partners. Without a solid estate plan, your partner may be shut out of the decision making and the inheritance. The following are the essential estate planning steps that can help unmarried couples:

Joint ownership. One way to make sure property passes to an unmarried partner is to own the property jointly, with a right of survivorship. If one joint tenant dies, his or her interest immediately ceases to exist and the remaining joint tenants own the entire property. This is also a good way to avoid probate.

Beneficiary designations. Make sure to review beneficiary designations on bank accounts, retirement funds, and life insurance to make sure your partner is named as the beneficiary (if that is what you want). Your partner will not have access to any of those accounts without a specific beneficiary designation.

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Durable power of attorney. This appoints one or more people to act

Continued on page 3

Medicare's different treatment of post-hospital care options


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Hospital patients who need additional care after being discharged are usually sent to either an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF). Although these facilities may look similar from the outside, Medicare offers very different coverage for each. While you may not have a complete say in where you go after a hospital stay, understanding the difference between the two facilities can help you advocate for what you need and know what to expect with regard to Medicare coverage.

An IRF can be either part of a hospital or a stand-alone facility that offers intensive physical and occupational therapy under the supervision of a doctor and nurses. IRFs offer a minimum of three hours a day of rehabilitation therapy. An SNF, on the other hand, provides full-time nursing care. Patients also receive physical and occupational therapy, but the care is generally less intensive and specialized than in an IRF.

IRFs and Medicare

Medicare Part A covers a stay in an IRF in the same way it covers hospital stays. Medicare pays for 90 days of hospital care per "spell of illness," plus an additional lifetime reserve of 60 days. A single "spell of illness" begins when the patient is admitted to a hospital or other covered facility, and ends when the patient has gone 60 days without being readmitted to a hospital or other facility. There is no limit on the number of spells of illness. However, the patient must satisfy a deductible before Medicare begins paying for treatment. This deductible, which changes annually, is $1,408 in 2020.

After the deductible is satisfied, Medicare will pay for virtually all hospital charges during the first 60 days of a recipient's hospital stay. If the hospital stay extends beyond 60 days, the Medicare beneficiary begins shouldering more of the cost of his or her care. From day 61 through day 90, the patient pays a coinsurance of $352 a day in 2020. Beyond the 90th day, the patient begins to tap into his or her 60-day lifetime reserve. During hospital stays covered by these reserve days, beneficiaries must pay a coinsurance of $704 per day in 2020.

To qualify for care in an IRF, you must need 24-hour access to a doctor and a nurse with experience in rehabilitation. You must also be able to handle three hours of therapy a day (although there can be exceptions).

SNFs and Medicare

Medicare's coverage of skilled nursing care is more limited. Medicare Part A covers up to 100 days of "skilled nursing" care per spell of illness. Beginning on day 21 of the nursing home stay, there is a copayment equal to one-eighth of the initial hospital deductible ($176 a day in 2020). However, the conditions for obtaining Medicare coverage of a nursing home stay are quite stringent. Here are the main requirements:

- The Medicare recipient must enter the nursing home no more than 30 days after a hospital stay (meaning admission as an inpatient; "observation status" does not count) that itself lasted for at least three days (not counting the day of discharge).
- The care provided in the nursing home must be for the same condition that caused the hospitalization (or a condition medically related to it).
- The patient must receive a "skilled" level of care in the nursing facility that cannot be provided at home or on an outpatient basis. In order to be considered "skilled," nursing care must be ordered by a physician and delivered by, or under the supervision of, a professional such as a physical therapist, registered nurse or licensed practical nurse. Moreover, such care must be delivered on a daily basis. (Few nursing home residents receive this level of care.)
- A new "spell of illness" can begin if the patient has not received skilled care, either in an SNF or in a hospital, for a period of 60 consecutive days. The patient can remain in the SNF and still qualify as long as he or she does not receive a skilled level of care during that 60 days.

Keep in mind that some or all of Medicare's deductibles and co-payments for both IRF and SNF care may be covered by Medicare supplemental insurance, also called Medigap coverage.

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Continued from page 1

for you on financial and legal matters in the event of your incapacity. Without it, if you become disabled or even unable to manage your affairs for a period of time, your finances could become disordered and your bills may go unpaid, which would place a great burden on your partner. Your partner might have to go to court to seek the appointment of a conservator, which takes time and money. That can be avoided through a simple document.

Health care proxy. Similar to a durable power of attorney, a health care proxy appoints an agent to make health care decisions for you when you can't do so for yourself, whether permanently or temporarily. Again, without this document in place your partner might be shut out by other family members or forced to go to court to be appointed as guardian. If it is important for all of your family members to be able to communicate with health care providers, a broad HIPAA release — named for the Health Insurance Portability and Accountability Act of 1996 — will permit medical personnel to share information with anyone and everyone you name.

Will. Your will says who will get your property after your death. Wills are increasingly irrelevant for this purpose as most property passes outside of probate through joint ownership, beneficiary designations and trusts. But your will is still important for two other reasons. First, if you have minor children it permits you to name their guardian in the event you are not there to continue your parental role. Second, it allows you to pick your personal representative (also called an executor or executrix) to take care of everything having to do with your estate, including distributing your possessions, paying your final bills, filing your final tax return and closing out your accounts. It's best that you choose who serves in this role.

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Revocable trust. A revocable trust can be especially important for unmarried couples. It permits the person or people you name to manage your financial affairs for you as well as to avoid probate. You can name one or more people to serve as co-trustee with you so that you can work together on your finances. This allows them to seamlessly take over in the event of your incapacity.

Your attorney can help you determine the estate plan that is right for you and your partner.

Will Medicare cover a coronavirus vaccine?

With the coronavirus pandemic responsible for nearly 200,000 deaths and disrupting life across the United States, likely the only way for the country to return to normal is an effective vaccine. When a vaccine is available, Medicare will cover the cost.

Medicare covers vaccines in a variety of ways, depending on the vaccine. It may be through Medicare Part B, Medicare Part D, or a Medicare Advantage plan if you are enrolled in one. Part B covers vaccines only for certain illnesses: flu, pneumonia, and Hepatitis B (if you are at medium or high risk). Medicare covers 100 percent of the cost of these vaccines if you go to an approved provider; you do not have to pay a deductible or coinsurance.

Part B also covers vaccines if you are exposed to a dangerous virus or disease, such as rabies or tetanus. In those cases, you will have to pay a deductible and a 20 percent coinsurance.

Part D covers all other doctor-recommended vaccines, such as the shingles vaccine and the Tdap (tetanus, diphtheria, pertussis) vaccine. How much the vaccine costs will depend on whether you go to a provider who is in-network for your Part D plan. If you get the vaccine in-network, you will have to pay the co-pay amount. If you get the vaccine out-of-network, you may have to pay for the entire vaccine and bill Medicare. Medicare will only pay for the approved cost, which may be less than what you paid.

If you have a Medicare Advantage plan that covers prescription drugs, it may cover these vaccines. The cost to you will vary, depending on the plan.

With regard to COVID-19, the CARES Act — the coronavirus relief bill Congress passed in March — provides that if a vaccine becomes available, Medicare is required to cover it under Part B with no cost sharing. Medicare Advantage plans are required to include the basic coverage offered by Medicare Parts A and B, so this coverage also applies to beneficiaries in Medicare Advantage plans.

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How the pandemic may affect long-term care insurance

If you have a long-term care insurance policy, you may wonder how it is affected by the pandemic. If you don't have a policy, you may wonder if the pandemic will make it more difficult to get one. There are lots of uncertainties regarding COVID-19's impact on long-term care insurance, but here is some of what we know:

Qualifying for insurance. It is already more difficult to qualify for long-term care insurance as you get older. Because older individuals are at a higher risk for coronavirus, this can also affect your application. Some insurers have been putting limits on applicants' ages or imposing additional restrictions on applicants who have been in contact with the virus. If you had a positive COVID-19 test, you may have to wait for three to six months before qualifying for insurance. These policies vary by company.

Premiums. Insurers can't raise rates for customers due to individual circumstances. To raise rates, insurers must obtain approval from the state and raise them for the entire group. However, if you are considered high risk due to exposure to the coronavirus, you may not qualify for the best rates when you first apply for long-term care insurance.

Moving out of a nursing home. If you have a policy and want to move out of a nursing home, you will need to check what your policy will pay for. Some policies pay for long-term care in a variety of settings, including home care, while others are more restrictive. On the plus side, you may be able to use your policy to reserve your bed, allowing you to keep your nursing home spot.

Home care. If you have a policy that was paying for home care, there may be issues. For one, some home care workers are charging more for work during the pandemic, which could exceed your policy's coverage. For another, because of the pandemic you may want to switch receiving care from a family member, rather than an outside home health care worker. Unfortunately, most long-term care policies don't pay for family members to provide care.