PIERRO, CONNOR & STRAUSS, LLC
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2020 LONG-TERM CARE PLANNING GUIDE

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I. INTRODUCTION

Do you know someone who has spent time in a nursing home? Have you ever thought it could be you?

Most people answer the first question yes, and the second question no. Often we hear, "It would never happen to me." However, studies show that approximately 70% of people reaching age 65 will need some type of long-term care. More importantly, if you are someone who would prefer to stay at home, rather than enter a nursing home, proper long-term care planning is extremely important, especially over the lack of available services and the staggering price-tag.

What is Long-Term Care? Long-term care involves a variety of services that help to meet both the medical and non-medical needs of people with chronic illness, disability or advanced age who have difficulty caring for themselves. Long-term care can be assistance with normal daily tasks like dressing, bathing, meal preparation and using the bathroom, or medical care that requires the expertise of skilled practitioners to address the frequent and numerous chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. People of any age may need long-term care, although it is a common need for senior citizens.

In New York State, the 2020 annual cost of nursing home care ranges from approximately $135,000.00 to over $200,000.00 and is climbing every year. That is approximately $370.00 to $550.00, per day. If you choose to stay at home, where most of us would prefer to be, and hire home health aides, the cost of your care could be even more. Home health care costs vary widely, but agencies charge anywhere from $22 to $30 per hour for companions and personal care aides. In some cases, people pay over $200,000.00 per year for 24-hour a day home care. What many people fail to realize is their health insurance and Medicare **will not** cover the cost of long-term care, whether you are at home, in an assisted living or a nursing facility. Paying for long-term care is a personal responsibility that has become an overwhelming financial burden for all age groups across New York and the nation.

The causes of our long-term care crisis are many: increasing costs; a growing population of seniors (78 million Baby Boomers began turning 71 in 2018); inefficient government management; medical technology resulting in greater longevity, and the inability of families to care for our elderly at home. The result of the crisis is that we must all "rethink" the way we plan for retirement and take into consideration the very real possibility that long-term care and its astronomical costs may become a part of our lives.

This outline is designed to give you a better understanding of the components involved in long- term care planning: Medicare, Self-Insuring, Private Insurance, Medicaid, and other long-term care planning concerns, and explain how recent changes in the law, and future trends, will affect you if the need for long-term care arises.

II. MEDICARE

A. Medical Expenses, Hospital and Post-Hospital Skilled Care

Contrary to the belief of many seniors, one cannot rely on Medicare to pay for long-term care costs. Although Medicare is available to most individuals age 65 or older, coverage is limited to:

1. Qualified Medical Expenses (80% of an approved amount for doctors, surgical services, etc).
2. Hospitalization for 90 days per benefit period ("spell of illness") with a deductible of $1,408.00 for the first 60 days and a co-payment of $352.00 per day for the remaining 30 days. Beyond the 90 days of hospitalization per spell of illness, there is an additional one-time lifetime benefit of up to 60 days, with a co-payment of $704.00 per day.
3. Post-Hospital Skilled Nursing Home Care with payment in full for 20 days and a co-payment of $176.00 per day for the next 80 days, for a maximum of 100 days of care. The term "skilled care" is narrowly defined (see "Gaps in Coverage" below), and even though it is the only Medicare nursing home benefit, its availability is very limited.

B. Gaps in Coverage

Medicare only pays for nursing home care following a qualifying inpatient hospital stay of at least 3 days and 3 nights, and only if the care provided is considered "skilled care". Skilled care is provided under the supervision of a doctor, requiring skilled professionals such as therapists (physical, occupational or speech) and/or registered nurses. Medicare payment for skilled care ends when the individual is determined to have reached a "plateau", usually in 20-30 days, but can be provided for up to 100 days in a benefit period if you continue to meet the Medicare requirements. A recent federal lawsuit has led to changes in the Medicare program as to what was known as the "improvement standards". Skilled nursing care or therapy care may also now be provided if it is necessary to **maintain** your current condition or delay it from getting worse.

"Custodial care" or non-skilled care provides basic personal care and other maintenance level services such as assistance with walking, bathing or dressing. Home health care may be covered in limited amounts by Medicare, but only if "medically necessary", which is a very rigorous standard. For all Medicare benefits there are deductibles and co-payments, which can be substantial, and it appears that Medicare is in the process of becoming a "means tested" program as monthly Part B premiums are now higher for individuals at higher income levels. At present, there are excellent insurance policies available to fill these "gaps" in Medicare coverage, appropriately called "Medigap" insurance, which must be purchased privately.

Medicare does not cover hospital costs beyond 150 days, skilled nursing home costs beyond 100 days per benefit period and, most importantly, Medicare does not cover any custodial nursing home care or non- skilled home health care. It is difficult for a Medicare recipient to qualify even for the limited "skilled care" benefits. With the Medicare Trust Fund currently projected to run out of money within the next decade, the gaps in Medicare coverage are expected to widen rapidly, ultimately causing seniors more out of pocket expenses.

C. Medicare Part D (Prescription Drug Coverage)

Enrollment in Medicare drug plans is voluntary, with the exception of beneficiaries who are dually eligible for both Medicare and Medicaid and certain other low-income beneficiaries who are automatically enrolled if they do not choose a plan on their own. If you are offered prescription drug coverage through your employer as part of retiree benefits, you may choose to accept this coverage or to enroll in Medicare Part D.

The initial period for enrollment is the period that begins 3 months before and ends 3 months after your 65th birthday (or the month you begin receiving Medicare based on disability). Individuals may only change their plan once a year, from November 15 through December 31. There are many different plans to choose from, and the choice is often confusing. In New York, there are currently over 20 different Prescription Drug Plans, and numerous Medicare Advantage Plans that are offered by each county. Part D plans vary in benefit design, cost-sharing amounts, utilization management tools (prior authorization, quantity limits and step therapy), and drugs covered. The monthly premium for the Medicare Part D plan varies by company. The 2020 base beneficiary premium is $32.74 per month, but actual premiums can range from $12.20 to $76.40.

The Affordable Care Act made significant changes to the Medicare program, including for Medicare beneficiaries enrolled in a Part D plan. For 2020, the basic plan has an initial deductible of $435.00 and then the plan will cover 75% of prescription costs up to a limit of $4,020.00per year. However, many plans choose to charge a lower copayment (such as $3 or $10) instead of charging 25% of the prescription cost during this initial coverage payment stage.

After the initial coverage limit of $4,020 is met, plan beneficiaries pay 25% toward the cost of prescription drugs, whether brand name or generic, for costs up to $6,350.00. Once a plan member spends over $6,350 in out-of-pocket costs, he or she has reached the Part D spending limit and automatically gets "Catastrophic Coverage", which only requires a 5% copayment for covered drugs for the rest of the year.

Prior to 2020, there was a wider coverage gap (known as the "donut hole") and higher out-of-pocket charges for prescription costs between $4,020 and the Part D out-of-pocket spending limit. However, the ACA took measures to eliminate the gap in coverage.

The following chart shows 2020 basic plan deductible and co-payments for individuals in a standard Medicare Part D prescription drug plan (PDP) starting with the deductible at the top of the chart and ending with catastrophic coverage at the bottom of the chart.

COST	PRESCRIPTION	MEMBER PAYS	PLAN PAYS
$0-$435		100%	0%
$435-$4,020		25% (or plan co-payment)	75%
$4,020- $6,350	Generic	25%	75%
$4,020- $6,350	Brand Name	25%	5% the drug manufacturer pays 20% or provides an equivalent discount
Above $6350.00	Catastrophic	5%	95%

Certain individuals with limited income and resources may qualify for "extra help" from Medicare to pay the costs of Medicare prescription drug coverage, premiums, deductibles and co-payments. If you have full Medicaid coverage or get Supplemental Security Income (SSI) benefits, you may automatically qualify for extra help. You can reapply any time if your income and resources change.

There are a number of factors you should take into account in deciding whether to enroll in a Medicare Part D plan and which plan to choose. Differences in terms of deductibles, co-payments and coverage gaps are all important considerations. Please contact us for more detailed information on the Medicare prescription drug benefit, or to schedule an appointment for a consultation.

III. PAYING YOUR OWN LONG-TERM CARE EXPENSES

There are several ways in which a senior or an individual with a disability who have chronic care needs can pay for his or her own long-term care expenses. **The questions become: can you? Do you have to? Should you?**

A. Self-Insuring

"Self-insuring", or paying your own way, is one available option for those who have sufficient income, including income producing assets. You can expect to pay approximately $135,000.00 to $200,000.00 per year for nursing home care depending on where you live, and the cost is even greater for better facilities. In downstate NY areas, the cost of care rises dramatically. Home care can be even more expensive, with 24/7 care costing $120,000.00 to over $200,000.00 per year. If a person has sufficient fixed income and income generating assets, which

together produce total income of $130,000 or more, then self-insuring may be a viable option. However, you may also want to leave sufficient assets and income to ensure the future well-being of your spouse, your children and your younger family members, who may themselves need long-term care.

B. Financial and Tax Planning for Long-Term Care

Planning to "self-insure" for long-term care expenses requires a collaboration of financial, estate, and tax planning to ensure that sufficient income can be generated to prevent the depletion of assets. Use of our thorough fact-finding Long-Term Care Questionnaire is highly recommended to assemble all the necessary information regarding assets, income, expenses and other factors, such as where care will be provided and what support can be expected from informal family caregivers. This information provides a foundation for the planning required to maximize the value of Social Security income, fixed pensions, dividend and interest income and other income streams, along with maximizing deductions for costs such as medical expenses and other deductible items. Investment strategies to produce growth and income sufficient to fund projected expenses are a key ingredient for successful retirement and potential long-term care planning, and a qualified financial planner or investment advisor should be consulted. Once investment strategies are in place, and projections for income and expenses are done, the plan to "self-insure" can be implemented.

C. Wealth Replacement Using Life Insurance

Creative tax and financial planning can further maximize the value of existing assets and income, provide tax savings, and allow for legacy planning should long-term care become necessary. One example is the targeting of retirement funds (IRA's, 401(k)s and other retirement vehicles) to pay long- term care expenses. Qualified long-term care expenses are fully income tax deductible as a medical expense, subject to a floor of 10% of adjusted gross income. For example, if an individual has $50,000 of adjusted gross income, medical expenses above $5,000 are fully deductible.

If the need for long-term care should arise, accessing assets such as retirement funds, tax deferred annuities and U.S. savings bonds may provide an excellent opportunity to utilize the medical expense deduction to offset income tax consequences created by liquidation of those assets. Should you target a particular asset or assets to pay long-term care if necessary, the purchase of life insurance in an amount sufficient to replace the asset should they be depleted by long-term care costs provides a tax-free legacy to your heirs. In this way, an otherwise taxable asset can be used to pay long-term care expenses, while the life insurance policy is used to replace the value for your family with the pay out at death, free of income and estate taxes provided certain conditions are met. Should you never need long-term care, your family would

receive both the targeted asset, and the life insurance proceeds, doubling the legacy that you leave to your heirs.

IV. PRIVATE LONG-TERM CARE INSURANCE

Based upon the current cost of long-term care and the average net worth of an American household, most people will not be able to self-insure for long-term care. A study by the U.S. Department of Health and Human Services forecasts that four out of every ten people who reach age 65 will enter a nursing home at some point in their lives. Therefore, based upon the current costs of health care, the projected need for long-term care and the gaps, limits and uncertainty of what Medicare will cover in the future, if you are insurable and long-term care insurance premiums are affordable, private long-term care insurance should be integrated into your estate plan to provide protection without the need for liquidating or divesting assets.

A. Policy Benefits

Benefits to look for in a long-term care ("LTC") insurance policy include but are not limited to:

- Nursing home and home care coverage (will you get care where you want it)
- A sufficient daily payout ($300.00/day is a good start, but income and assets must be factored
- The elimination period for nursing home care as well as for home care (the number of days you must be in need of long-term care before benefits begin, typically 0 to 100 days)
- Duration of benefits (3 years to 5 years)
- Renewability (make sure it is "guaranteed renewable")
- Waiver of premiums (allows you to stop paying premiums during the time you are receiving benefits)
- Inflation protection (5% compound, 5% simple, 3.5%, CPI, etc.)

B. Tax Deductibility

Individuals may deduct the cost of long-term care insurance premiums paid as a medical expense, subject to two limitations. First, medical expenses must exceed 10% of the individual's adjusted gross income for the calendar year 2020. Second, an individual may deduct the lesser of the premium paid or the amount in the following chart:

Age at End of Taxable Year	Premium Limit - 2020 Amount
40 or less	$430
Over 40-but not over 50	$810

Over 50- but not over 60	$1,630
Over 60- but not over 70	$4,350
Over 70 and older	$5,430

Unless your adjusted gross income is low, or you have significant other medical expenses, the federal tax deduction may be of little value. Business Owners, such as sole proprietors, partners and shareholders, however, may deduct LTC insurance premiums without having to itemize their deductions or meet the floor of 10% of adjusted gross income. This provides planning opportunities. For New York State residents there is a substantial benefit in the form of a 20% tax credit for the payment of LTC insurance premiums. This credit produces a dollar for dollar savings off of your New York State income tax bill, in effect providing a 20% discount on LTC insurance.

C. The New York State Partnership

New York State has adopted a unique program which integrates Long-Term Care insurance with Medicaid Extended Coverage. Insurance companies may offer policies which bear the logo of the New York State Public/Private Partnership for Long-Term Care, provided they meet certain minimum policy requirements. The Partnership polices allow New Yorkers to protect some or all of their assets (depending on whether a "Total Asset" Protection plan or a "Dollar for Dollar" Asset Protection plan is selected) and helps avoid the traditional Medicaid "spend down" should the insurance benefits be exhausted.

In 2020, participating insurers are able to offer five different Partnership policies. Total Asset Protection policies are unique to New York, and allow policyholders to protect all of their assets when they apply for Medicaid Extended Coverage. Dollar for Dollar Asset Protection policies will protect assets up to the amount of maximum benefits paid from the policy. The comparison table below shows the five basic plans.

Plan	Minimum Policy Duration	Maximum Policy Duration	Daily Benefit Allowances (2020)	Max. Elimination Period
Total Asset 50 3/6/50*	3 years Nursing Home Care 6 years Home Care 6 year Residential Care	Unlimited	Nursing Home = $337 Home Care = $168	100 days
Total Asset 50 2/4/50*	2 years Nursing Home Care 4 years Home Care 4 years Residential Care	Unlimited	Nursing Home = $337 Home Care = $168	100 days

Total Asset 100 4/4/100**	4 years Nursing Home Care 4 years- Home Care 4 years Residential Care	Unlimited	Nursing Home = $337 Home Care = $337	100 days
Dollar for Dollar 50 1.5/3/50*	1.5 years Nursing Home Care 3 years Home Care 3 years Residential Care	2.5 years Nursing Home 5 years Home Care N/A Residential Care	Nursing Home = $337 Home Care = $168	60 days
Dollar for Dollar 100 2/2/100**	2 years Nursing Home Care 2 years Home Care 2 years Residential Care	3 years Nursing Home 3 years Home Care 3 years Residential	Nursing Home = $337 Home Care = $337	60 days

*Pays 50% of daily benefit for home care. **Pays 100% of daily benefit for home care.

Benefits of all New York Partnership Policy Plans include:

- Nursing home care
- Home care
- Personal care
- Assisted living care
- Inflation protection equal to 3.5% compounded annually
- Guaranteed renewable
- Adult day care
- Respite care (14 nursing home equivalent days per year)
- Care management (minimum of 2 days per calendar year of long-term care planning services by a professional)
- Nursing home bed reservation (20 days per year)
- Hospice care
- Portability – coverage under the private insurance may be used outside New York State

Optional Plan benefits include:

- Waiver of premium
- Combined home care benefit
- Independent provider benefit
- Non-licensed/non-certified provider benefit
- Inflation protection equal to 5% compounded annually

Like traditional LTC insurance, the cost of policy premiums for a Partnership policy depends largely on the purchaser's age, health and the coverage. We encourage you to consult with your insurance professional to compare companies, prices and policy coverage based on your needs, the cost of care in your area, and what you can afford.

Once an individual is in need of care, he or she will use the LTC insurance proceeds to pay for the number of years and type of care as dictated by the policy. This private care can be used in New York or anywhere in the country. At the expiration of the applicable term, the individual will become qualified for Medicaid in New York State*. The individual's assets will not count towards the traditional NY Medicaid resource limits, although income continues to be available, and must

be “spent- down” to pay for the individual’s care. It should be noted that the Partnership program allows policy holders to keep more income during periods of home care than traditional Medicaid applicants. For community-based care, a non-married Partnership policyholder can keep $1,680 per month (compared to $875 for a non-Partnership Medicaid applicant). A married Partnership policyholder can keep $3,216.00 per month (compared to $1,284.00 for a non-Partnership Medicaid applicant).

**New York now has a reciprocity agreement with other Partnership states, but Medicaid eligibility and services are determined on a state-by-state basis. Assets may be protected in a reciprocal state under the terms of a Dollar for Dollar policy. A state can opt out of reciprocity at any time and only those who are currently receiving Medicaid services will be exempt from new regulations. If you have plans to retire to another state and never return to New York, you should check with that state’s Medicaid program or consider a different form of insurance product to cover long-term care needs. For many people, the asset protection feature provided by automatic Medicaid qualification is a valuable benefit.*

D. Reimbursement vs. Indemnity Benefits

A cash or indemnity policy can allow you to receive a monthly payment, tax free, and to use the money any way you choose. With a reimbursement contract, you must hire approved providers, pay for all services out of your own pocket, and then seek reimbursement from the policy carrier. It is important to analyze your individual situation to determine the proper fit for a partnership policy, as all current contracts are reimbursement. Decisions on policy type and coverages are complex, and should be fully understood prior to buying a policy.

E. Innovative Products - Hybrid Policies

There has been a great deal of change in the traditional long-term care insurance marketplace in recent years. The prolonged low interest rate environment, along with higher than anticipated persistency rates (percentages of policyholders keeping their traditional long-term care policies for an extended period of time) has had a negative impact on carriers. The low interest rates have significantly diminished their expected returns, and the higher than expected persistency rates have resulted in higher than anticipated claims. The combination of those two factors has resulted in, among other things, premium volatility, both in the form of significantly higher rates for newer policies being issued today, and rate increases (in some instances, significant) on existing policy blocks. A recent study by the society of actuaries found that policies currently being sold have sound underwriting, and they estimate that only 1 in 10 will require a premium increase, and even then, only in the amount of 10%.

Nonetheless, the marketplace has seen a proliferation of "hybrid" (a.k.a. "linked benefit" or "blended" or "combination") policies. Those policies, in New York State, combine a base life insurance policy with a rider to pay for long-term care, or sometimes referred to as "chronic illness" expenses. Note that it is important to distinguish between long-term care benefits and chronic illness benefits, as the manner in which benefits are paid, and the potential tax benefits offered, may vary between them. (Long-term care riders are classified under IRC Section 7702B(b); Chronic Illness benefits fall under IRC Section 101(g)).

These policies typically allow for a life insurance death benefit to be paid, and may also allow for benefits to be paid for long-term care or chronic illness. Their long-term care (or chronic illness) benefit structure may be in the form of:

- An "acceleration" of the death benefit to pay for long-term care or chronic illness benefits.
- A base of life insurance coverage and an additional benefit pool to pay for long-term care or chronic illness expenses.

The former most often carries a modal (e.g. annual) premium payment structure over the life of the policy, while the latter is typically funded with a single premium, or a limited number of years of premium payments.

For example, in the former acceleration-type plan, a 60-year-old female client may purchase a $250,000 face amount life insurance policy for an annual premium of $4,500 per year, and the amount payable as a life insurance death benefit OR a long-term care or chronic illness benefit may also be $250,000 (e.g. A policyholder cannot get a $250,000 long-term care benefit AND still have a remaining $250,000 life insurance death benefit).

In the latter type of plan, that same 60-year-old female client may have, for example, $200,000 set aside in a conservative, "rainy day" fund earmarked to offset long-term care costs later in life. By reallocating $75,000 from that account into a single premium linked benefit policy, that same 60-year old female may be able to obtain a death benefit of $130,000, and a long-term care benefit pool of $375,000. Certain of these types of policies may also offer a "return of premium" guarantee, whereby the policy holder can cancel the policy, and obtain all or a portion of her premium back.

Some additional points ~~for~~ to consider when evaluating hybrid or linked benefit policies include:

- The manner in which benefits are paid.
- Most (but not all) long-term care benefit policies pay their benefits in the form of expense reimbursement (e.g. a policyholder must pay for care first, then be reimbursed up to the

cost of covered care, and up to the limits of the rider), pursuant to their long-term care rider.

- Some long-term care benefit riders – and all chronic illness rider benefits currently on the market – are payable in the form of indemnity (sometimes referred to as cash) benefits. While some riders will require a substantiation that some level of "formal" (e.g. paid) care has been received, the amount of benefits paid is not limited to the cost of that care; rather, the limits on benefits are those placed by the rider and/or tax limitations.
- Entire death benefit available for acceleration vs. "discounting" formula.
- Some chronic illness riders charge an extra premium for the benefit and typically preserve the entire face amount of the policy for acceleration. However, other policies do NOT charge an extra premium; rather, they discount the amount available (a percentage of the death benefit) for acceleration at the time of benefit access. While, everything else being equal, the resulting premium for a no-premium charge rider may be less, it is important for clients to consider that, in the event they do exercise benefits under the rider, the total amount available for payment at claim time will be less as well.
- Ownership flexibility.
- Because indemnity or cash payment riders may allow for benefits to be paid to a third party (e.g. an irrevocable trust), those types of riders may be preferable if multiple planning goals are desired by the client. With reimbursement benefits, benefits must be paid to the insured/policy owner. Thus, even if a reimbursement-based rider were allowed to be owned by a third party (e.g. an irrevocable trust), there may be inclusion of the death proceeds in the estate, which may not be desired.
- Tax treatment of benefits. Both long-term care and chronic illness benefits are usually received income tax free by the insured or policyholder. One main exception to that is with indemnity or cash-based benefits. Such benefits may be income taxable to the policy owner to the extent those benefits exceed the IRS "per diem" amount, and there are no eligible long-term care expenses to offset that excess.
- Tax incentives for premium payments. While traditional long-term care insurance policies (tax qualified under IRC Section 7702B) clearly fall under the tax incentives outlined in IRC Section 2013(d), it remains unclear whether premiums paid for long-term care riders (under IRC Section 7702B) are also eligible for similar incentives. The scope of that discussion goes beyond this text.
- There is consensus that premiums paid for riders that fall under the definition of chronic illness (and IRC Section (101(g)) are not eligible for similar tax treatment. While traditional long-term care insurance policies offer the highest ratio of benefit per premium dollar for clients (as well as the aforementioned Partnership asset protection and potential tax benefits), clients may find hybrid policies especially attractive if they have concerns such as:

- Lack of premium guarantees in traditional long-term care policies. Note: the November 2019 Society of Actuaries LTCI Pricing Study may offer insights into premium stability today vs. for past policies.
- The lack of any benefit back to one's estate in the event traditional long-term care benefits are not paid from the policy (and the policy has no "return of premium" benefit). It is worth noting that this lack of return of premium is a large part of the reason why traditional long-term benefits carry the highest of the benefit-per-premium-dollar ratios we described.

- Finally, clients should consider underwriting as part of their decision-making process as well. Traditional long-term care policies are underwritten for "morbidity" (the likelihood of an applicant becoming chronically ill earlier and/or to a greater degree than expected), whereas the hybrid policies are typically (with a few exceptions) underwritten for both morbidity and mortality (the likelihood of dying sooner than expected).

Counseling clients on the use of Long-Term Care insurance has become a sub-specialty of Elder Law and an integral part of comprehensive estate planning. Choosing a solid company, the right policy (partnership or traditional), daily benefit amounts, etc. call for independent advice from a qualified professional or attorney, a service which we are pleased to provide. If you or a loved one is considering long-term care insurance or would like to know more, please contact Pierro, Connor & Strauss to schedule an appointment for a consultation.

V. MEDICAID

If an individual has insufficient income to private pay for care and does not have or cannot obtain a long-term care insurance policy, the only option available is Medicaid. Unlike Medicare, Medicaid is a government program which pays both medical costs and long-term care costs. However, Medicaid is designed as a payor of last resort and to qualify you must meet strict financial and other eligibility requirements. The rules governing Medicaid are complex and frequently change, requiring great care in the planning and application for benefits.

If you or a loved one is in need of Medicaid, please contact our office to schedule a consultation. As described below there are excellent planning options available for long-term care, but under the new Medicaid eligibility rules, waiting to plan is NOT one of those options.

A. Medicaid Income & Resource Limits

An individual applying for Medicaid in a nursing home can have only $15,750 in total assets, plus an irrevocable burial fund of any reasonable amount and certain exempt assets (a car, IRA in payout status, clothing, etc.). Income must also be contributed toward the cost of care, and the individual is entitled to keep only a $50.00 per month allowance. If the individual owns a home that is occupied by a spouse, his or her child who is under the age of 21, or certified blind

or disabled, the home is not included in the total asset calculation and is not subject to the assets limits or a Medicaid lien. If the individual owns a home that is not occupied by one of those protected people, the value of the house is counted towards the total amount of available assets.

If the Medicaid applicant is married and enters a nursing home while the other spouse remains in the community, the "community spouse" may keep $74,820 (or one-half of a couple' s resources up to a maximum of $128,640) in assets, in addition to the home, while the institutionalized spouse may keep up to $15,750. Furthermore, the spouse in the nursing home is entitled to keep only a $50.00 per month income allowance while the "community spouse" is allowed a minimum income allowance of $3,216.00 per month, with adjustments for certain items. Without proper planning, all assets and income above these levels must be spent on care ("spent down") or on exempt items before Medicaid will become available.

B. Home Care Rules

Individuals seeking to obtain long-term care services outside of a nursing home must navigate a different set of Medicaid eligibility rules, depending on the type of services required. One of the primary goals expressed by our clients is to remain in their own homes or at least in the most independent and appropriate setting possible. Navigating the maze of community care requires an in-depth knowledge of the services available. We work closely with our clients to coordinate care in the proper setting.

Community-based Medicaid services are currently available through several programs, including the Personal Care Aide ("PCA") program, the Consumer Directed Personal Assistance Program ("CDPAP"), the Nursing Home Transition and Diversion Waiver ("NHTD"), and traditional home care. Generally, however, Medicaid does not pay for adult home or assisted living care (with limited exceptions), which under existing rules must be paid for privately.

The 2014 changes to the Medicaid home care program in New York State resulted in the requirement for the Medicaid recipient to enroll in a Managed Long-Term Care Program (MLTC). An MLTC company is a private insurance company that receives a fee from Medicaid to approve and provide home care services. The key change is that the MLTC takes over the role of the local Medicaid/Department of Social Services ("DSS") office in conducting the home care assessment and determining how many hours of care you need. The MLTC then arranges with home care providers it has contracted with to provide the care to you in your home. These MLTC rules are complex, and require careful planning as well as strong and experienced legal advocacy to ensure you get the services you require.

In order to access community-based care, an individual is allowed to keep the same $15,750 in total assets, but he/she may also retain the home in which they live[1] along with the

[1] Note: Medicaid has imposed a home equity limit of up to $893,000, subject to a few exceptions. If the equity in the home exceeds that limit, planning for the home must be undertaken.

other exempt assets listed above. Recipients of Medicaid home care are allotted an income allowance of $875 per month. Income over the $875 limit is technically available, however, an alternative is to contribute the excess income to a "Pooled Trust", through which the excess income can then be used to pay other expenses necessary for the Medicaid recipient to live in the community. The Pooled Trust is an excellent tool allowing all income to be used to support the Medicaid recipient at home.

C. Transfer of Asset Rules

What if an individual gives assets away in order to qualify for Medicaid? As you might expect, there are rules governing such transfers. When one gives money or property away, that individual and their spouse will be ineligible for "institutional" Medicaid for a certain number of months, known as the "penalty period". This only applies to a nursing home until October 1, 2020. Exceptions are made for transfers to a spouse or a disabled child and for certain transfers of the home to siblings or caretaker children. **The transfer of asset rules do not currently apply to Community Based Medicaid**, but only until October 1. New rules within the 2020-2021 State Budget impose a 30-month lookback on all financial assets of the Medicaid applicant in order to be eligible for Community Medicaid. (For skilled nursing Medicaid, the look back will remain five years). However, if the individual later needs institutional or home care Medicaid after October 1, the prior transfers may result in a penalty period for such Medicaid services, so thought and care must be given to how a transfer is made. In some circumstances, an applicant for Medicaid may argue that a transfer was made for purposes other than to qualify for Medicaid, but that is very difficult to establish and successfully prove. In either case, careful planning is required

How far back does Medicaid look to find asset transfers, or what is the "lookback" period? When applying for "nursing home" Medicaid, the Department of Social Services will ask for **all** financial records, such as bank statements, tax returns, etc. for the past 60 months (5 years). From there, the agency may question certain transactions within that time frame. A thorough analysis of all transactions within the look-back period must be undertaken prior to filing for Medicaid, and a comprehensive "paper trail" provided to DSS. Remember, there is NO LOOKBACK for home care benefits only up until October 1. Thereafter, the same documentation including financial records that is submitted for a nursing home application must be submitted for a home care application for 30 months before the eligibility date. (see above paragraph).

How is the penalty period calculated? The penalty period for non-exempt transfers is calculated by dividing the total value of all assets transferred by the average monthly cost of nursing home care in your area, called the "Monthly Regional Rate". The State determines this "average" each year for different regions across New York State. See Appendix A for a list of 2020 NY Regional Rates.

Example 1: Mrs. Jones, a widow who lives in the Capital District, transferred her non-exempt home worth $259,785 to her only child in January, 2016. Mrs. Jones enters a nursing

home in October of 2018, spends down to the $15,750 asset limit and in a skilled nursing setting, applies for Medicaid in January 2020. The resulting penalty is 23 months, calculated as follows

$259,785 (value of transfer made within the look-back period) divided by
$11,295 (2020 Northeastern Regional Rate) = 23-month penalty period.

Mrs. Jones would not be eligible for Medicaid until January, 2022 - who pays the 23 months?

Mrs. Jones transferred her home in January 2016. Assuming a 23-month penalty period, under the old rules the penalty period would have started February 1, 2016 and run through December 31, 2017. However, under the current rules, the penalty period would not start running until February 1, 2020, the first day of the month after the date when Mrs. Jones applies for Medicaid. Now Ms. Jones will not start receiving institutional Medicaid benefits until after the 23-month penalty period expires on January 1, 2022.

Who pays for Mrs. Jones' care for that time period? Remember, she has already spent her life savings and only has a mere $15,750 left. There are solutions available, even in this crisis situation, but the Medicaid rules pose complex problems for the elderly, individuals with disabilities, and their families. The laws were enacted not to solve the long-term care crisis, but to lay a trap for the unwary and merely cut the Medicaid budget. Without proper planning, anyone could fall into these "Medicaid Trap" situations.

Example 2: Mr. Smith, who is single and lives in New York City, transferred a bank account and savings bonds worth $449,540 to his 2 nephews in 2012 to help pay for their college tuition. Mr. Smith enters a nursing home, and once reaching the $15,750 asset limit applies for Medicaid in May, 2020. There is NO resulting penalty period.

Why? The transfer of his assets was completed 7 years ago and is now outside the look back period. Had Mr. Smith waited until 2016 to transfer his assets, the resulting penalty period would be 35 months.

$449,540 (value of transfer made within look-back period)
divided by $12,844 (2020 NYC Regional Rate) = 34-month penalty period.

The penalty period does not begin to run until the applicant meets 3 conditions:

- He or she enters skilled nursing care;
- He or she has $15,750.00 or less of countable assets; and
- He or she actually applies for Medicaid.

Pierro, Connor & Strauss regularly advises clients on Medicaid eligibility, preparation and filing of the Medicaid application, asset protection, advocacy and litigation to challenge Medicaid denials, spousal claims and estate recoveries. In addition to proactive planning, our attorneys

routinely assist clients in crisis or last-minute situations where families want to protect assets but need to access care immediately.

D. Other Medicaid Rules

How Does Medicaid Treat Jointly Held Assets? If assets are held in an account by a Medicaid applicant and another individual as "joint" owners, and funds are withdrawn by either individual, it may count in full as a transfer against the Medicaid applicant. For example, withdrawal of funds from a "joint" bank account by the child of a Medicaid applicant will be treated as though the Medicaid applicant parent had transferred all the funds to the child. In addition, funds held in a joint account in a bank or similar financial institution will be presumed by the Department of Social Services to be owned entirely by the applicant. However, if both signatures are required to withdraw funds (i.e., brokerage accounts require all named owners to sign), only ½ of the value will be counted as belonging to the Medicaid applicant. Each asset must be evaluated to determine ownership and ownership rights prior to filing a Medicaid application.

How Does Medicaid Treat Trusts? If assets are held in a revocable trust, they are considered fully available for Medicaid purposes. An individual who establishes an irrevocable trust (sometimes known as a "Medicaid Asset Protection Trust" or MAPT), will protect the assets held by the trust after the expiration of the applicable penalty period imposed as a result of the transfer of property into the trust. Income generated by assets held in an irrevocable trust will usually be available to the Grantor (the Medicaid Applicant or his or her spouse), and considered available to pay for the cost of long-term care. Decisions regarding the use of a trust as part of a Medicaid plan require careful review of an individual's circumstances, as discussed below.

What are the Rules for Home Care Benefits? Remember, under current law, transfers of assets do not count against an applicant who is seeking only Medicaid benefits under New York's homecare and waiver programs. Unlike nursing home care, assets can be protected and home care can be available the very next month. This will change drastically as of October 1, 2020 when a 30-month lookback period will be applied to homecare.

Can Medicaid Recover from a Beneficiary's Estate? Under Federal Law, states are required to seek recovery of benefits paid to a Medicaid recipient from his or her estate. It has been left to each individual state to determine what assets will be included in the "Medicaid estate," which could conceivably include assets which are exempt during life and other partial transfers, such as deeds with retained life estates.

New York State has traditionally defined "estate" as the "probate" estate only, or those assets passing by passing by will or by intestacy (without a will). In 2011 the New York State

Legislature amended the law to expand estate recoveries to include assets which pass outside of the probate estate, but which the Medicaid recipient had an interest in at the time of death, including jointly held assets, deeds with retained life estates and interests in revocable trusts as assets subject to estate recovery. However, on March 27, 2012, Governor Cuomo and the State Legislature agreed upon the NY State Health Budget Bill for 2012-13, which repealed the expanded definition of a Medicaid recipient's "estate" and rejected the elimination of spousal refusal. Thus, only Probate assets and intestate assets are recoverable and not those that are jointly held or pass by a beneficiary designation or Transfer on Death or other designation outside of a Court proceeding. Although it has been repealed, the issue of estate recovery may be proposed again in the future. If you or a loved one have a deed with retained life estate, please contact us for planning options.

Can Medicaid Recover from a Community Spouse's Estate? If assets are held by a community spouse, the state may have rights to recover for Medicaid paid on behalf of the applicant spouse from amounts that exceed the Resource Allowance. These rules are evolving, and must be analyzed in each case.

Are There any Exceptions to the Medicaid Eligibility Rules, or what does Medicaid Consider an "Undue Hardship"? New York State is required to establish procedures to determine whether the denial of Medicaid eligibility would pose an undue hardship on an applicant. If an individual makes transfers "innocently," which disqualify him or her from receiving Medicaid, the state may not impose a transfer penalty.

- The applicant meets the other eligibility requirements;
- The applicant or his or her spouse is unable to get the transferred assets back, despite his or her best efforts; and
- The applicant cannot get appropriate medical care and it would endanger his or her health or life if Medicaid did not pay for nursing home care or the penalty period would deprive the applicant of food, clothes, shelter or other necessities of life.

As a practical matter, these hardship exceptions are difficult to prove and not often granted.

VI. PLANNING FOR LONG-TERM CARE

What can be done to plan for long-term care, ensure that a health crisis or chronic illness will not erode an individual's security and dignity, and provide for family and loved ones? As you may have already gathered, the answer is not simple. A careful analysis of each individual's personal and financial situation must be undertaken to formulate the proper plan. Factors such as income from social security, pensions and investments; the nature and value of assets; age and

health of applicant; family situation; and other considerations must be evaluated in order to make the right choices.

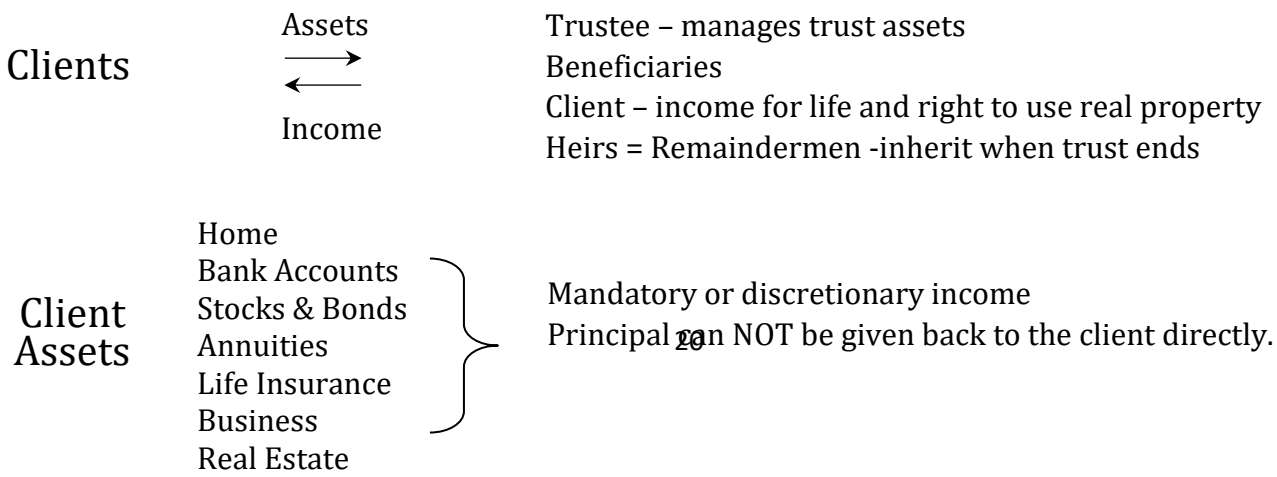
Use of Trusts

If long-term care insurance is not an option, and personal income and resources are not sufficient to pay the future costs of Long-Term Care, the most popular planning technique is to transfer assets into a **Medicaid Asset Protection Trust (MAPT)**, retaining the income for the "Grantor", and preserving the principal of the assets (the assets held by the "Trustee") for a spouse, children or other beneficiaries. When properly drafted, the trust will provide asset protection along with significant tax benefits, including avoidance of gift taxes, elimination of capital gains taxes, and maintenance of real property tax exemptions (NY STAR). In addition, using a trust can avoid the need for a family to go through probate which can be costly and time consuming.

The MAPT does allow the Trustee to access the principal of the trust during the Grantor's lifetime for the benefit of the Grantor's children or other beneficiaries, although the Trustee cannot give the principal directly to the Grantor. The remaining principal will go to the beneficiaries upon death of the Grantor. Most Grantors also choose to maintain the right (called a Special Power of Appointment) to change the ultimate beneficiaries of the trust, by "reappointing" the assets to different family members at a later date. This power retains control for the Grantor, and prevents transfers to the trust from being treated as taxable gifts.

A properly drafted MAPT is an "income-only" trust, which provides a valuable long-term care planning tool to preserve and protect assets, provide income, ensure favorable tax treatment and allow the creator of the MAPT to maintain control of the trustee and beneficiaries. Therefore, a senior doing estate planning may keep the income from an irrevocable "income only" trust for himself or herself, with the remainder distributable to specific beneficiaries, and qualify for Medicaid (once the applicable "penalty period" for nursing home benefits or home care benefits, if applicable, has expired) without the assets in the trust being considered by the Department of Social Services as available to pay for the cost of long-term care.

A. How a MAPT Works



KEEP OUT	Security Features
Cash, Bank Accounts, IRA, 401K	Choose initial Trustee, and change at any time. Choose initial beneficiaries, and change at any time With the consent of all beneficiaries, in some jurisdictions the trust can be "amended or revoked"

B. Crisis Planning for Nursing Home Care

Even if skilled nursing care is imminent, planning opportunities still exist to protect a substantial portion of the applicant's assets (generally approximating half of non-exempt assets). Proper use of the Medicaid transfer rules allows individuals to provide security for themselves and a legacy to their families, while ensuring that they will receive quality long-term care. Pierro, Connor & Strauss can advise families on the use of creative planning, such as Promissory Notes and Private Annuities, as vehicles which permit gifts and transfers when an unplanned nursing home admission is encountered by the family, as well as for Medicaid home care applications upon the implementation of the new home care rules on October 1, 2020. Proactive planning is always a better solution, but we understand that families do not always realize the need to plan until a crisis presents itself.

C. Crisis Planning for Home Care

One very important fact to remember is that if an individual can live at home with the assistance of home health care, it is possible to transfer assets and qualify for Medicaid immediately to cover home care costs up until the new law takes effect. Medicaid benefits for home care are a well-kept secret, and Pierro, Connor & Strauss prides itself on being proactive advocates for our clients who wish to stay in their own home. Caution must be exercised, however, because while home health care may be appropriate initially, the individual's condition may deteriorate to the point where he or she cannot be safely maintained at home and skilled nursing facility placement may be required. If this higher level of care is needed, a new application is required, and the Medicaid transfer rules - including the 5-year lookback - will be imposed. Thus, when planning for home care, the possible need for institutional services must be evaluated before transfers are made.

Moving in with a relative or family member may also be an option for a senior. There are several programs available through Medicaid to help pay for personal care aides and home health aides to replace and/or supplement care provided by family. In addition, a senior can put in place

a Caregiver Agreement and/or Personal Service Contract to make a transfer to a family member as compensation for their agreement to provide home care services.

D. Geriatric Care Management: EverHome Care Advisors

EverHome Care Advisors is a New York-based company that offers individualized care plans, beginning with in-home assessments by independent professional care managers. Implementation of the care plan is carried out by best-in-class local providers using an innovative technology platform operated by VivaLynx. Ongoing care coordination and monitoring through VivaLynx offer a suite of products and services designed to keep people at home throughout the aging process, improve quality of care, reduce costs and allow families to manage the care.

Families who live far apart can stay connected and informed through a unique app that integrates all aspects of the plan into a single dashboard, which also reduces caregiver burn-out. One of those services is eCaring, a unique care coordination system that integrates behavioral, clinical, and medication adherence data to provide a real-time home healthcare management and monitoring system for seniors, post-acute patients and people with chronic conditions.

eCaring's Cloud-based platform allows payers, providers, hospitals and health plan care managers to receive alerts enabling timely interventions that keep small problems in the home from becoming big ones leading to hospital stays as well as improving outcomes and lowering costs. Annually, 31 billion dollars is wasted on preventable hospital readmissions and 45 billion dollars is wasted on lack of care coordination.

VII. WHAT THE FUTURE HOLDS

The crisis in health care and long-term care will shape public policy for years to come. It has become clear that individuals need to make their own plans for long-term care, which is not covered by Medicare or Private Health Insurance, especially if they wish to live independently and use home health care. The government faces continuing pressure to limit expenditures on existing programs, including Medicare and Medicaid. Within the past year, reform of Medicare, Social Security and Medicaid has risen to the top of the government's agenda in Washington, Albany and every county in the state. It is thus imperative that seniors, those approaching retirement age, and the families of those needing long-term care take advantage of the planning opportunities that exist today. Everyone's situation is unique, and although this outline provides valuable information, it is only possible to discuss all of the planning opportunities on a one-on-one basis.

As with any planning, a good way to begin is to seek competent advice from a qualified professional. At, Pierro, Connor & Strauss we are dedicated to helping you find solutions to your

long-term care concerns. Please call us at 518-459-2100 (Capital District), 212-661-2480 (NYC), or toll-free at 1-866-951-PLAN for a consultation, or visit us on the web at www.pierrolaw.com.

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Appendix A: 2020 NYS Medicaid Regional Rates

REGION	COUNTIES	2020	2019	2018
New York City	Bronx, Kings (Brooklyn), NY (Manhattan), Queens, Richmond (Staten Island)	**$12,844**	$12,419	$12,319
Long Island	Nassau, Suffolk	**$13,407**	$13,407	$13,053
Northern Metropolitan	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	**$12,805**	$12,636	$12,428
Western (Buffalo)	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**$10,720**	$10,556	$10,239
Northeastern (Albany)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**$11,295**	$11,280	$10,719
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	**$12,460**	$12,342	$11,692
Central (Syracuse/Utica)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	**$10,451**	$10,068	$9,722

Use the region in which the individual resides or in which the facility is located. For out of state facilities, use the region closest to the location of the facility.