PIERRO, CONNOR & STRAUSS, LLC

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2023 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 2023 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 $300.00 to $490.00, 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 $250,000.00 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 (21.45% of the American population); 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. 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

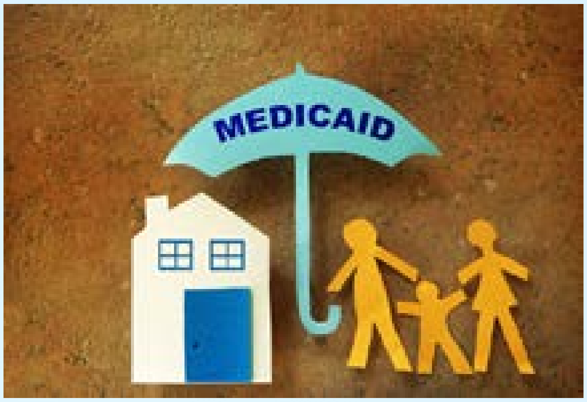
Planning to “self-insure” for long-term care expenses requires a collaboration of financial, estate, and tax planning to ensure that sufficient income can be generated to prevent the depletion of assets. Use of our thorough fact-finding Long-Term Care Questionnaire is highly recommended to assemble all 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. Use of Trusts

A Trust is a legal entity which is created by an agreement, under which three roles are created. First, you, as Grantor, Settlor or Creator of the Trust, dictate the terms of the Trust and decide what to put in it. Second, an individual you select, known as the Trustee, holds and manages property under the terms of the agreement. Third, you name the beneficiaries of the trust, which could include yourself, family members, charities or anyone else you want to benefit.

Thus, a Trust is a legal arrangement through which you give property to your Trustee to manage and use for the benefit of whomever you name.

1. MAPT (Medicaid Asset Protection Trust)



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 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 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.

How a MAPT Works

2. Revocable Living Trust
A Revocable Living Trust is a complete Will substitute. It can control all of your assets both during your life and after your death. When you set up your Revocable Trust, you transfer the title of all your assets (stocks, bonds, real estate, etc.) from your name to the name of the trust. You then name yourself as the trustee and beneficiary. This gives you, and you alone, total and complete control of all your assets. You can buy, sell, trade, and do whatever you want - just like you do now.

When you die, there will be no assets left in your name, and therefore, no probate for your family to endure. Whomever you name as your successor trustee will immediately gain control of your assets to distribute them according to your exact instructions. With a Revocable Trust your assets will go directly to your beneficiaries after your death. There will be no probate or court costs, and greatly reduced attorney's fees. There will also be no delay in distributing your assets, and all your estate planning wishes will be completely private. Furthermore, the trustee will be able to ensure continuity of asset management during your lifetime for any period in which you are unable to manage your trust due to incapacity.

Having your assets owned by a revocable living trust can substantially reduce the risk that a guardianship proceeding will become necessary if you become disabled. You can establish detailed instructions for how your successor trustee is to handle and manage your assets upon your disability. By avoiding guardianship, you will save on the associated fees and preserve continuity of the management of your assets that would be lost with a guardianship proceeding.

Revocable Trusts can insure that your wishes are carried out and are not easily subject to attack. Because Revocable Trusts are difficult to challenge, disgruntled heirs will have a much harder time contesting your estate plan.

Alternatives to Trust Planning

III. 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. 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

C. 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.

IV. MEDICAID

If an individual has insufficient income to private pay for care and does not have or cannot get 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. That does not have to happen, however, and we have helped hundreds of clients navigate the “minefield” of the Medicaid planning and filing process. 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 $30,182 in total assets, plus an irrevocable burial fund of any reasonable amount and certain exempt assets (a car, IRA, 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 a Medicaid lien. If the individual owns a home that is not occupied by one of those protected people, the home may be subject to a Medicaid lien. It may also be subject to an estate recovery action by the State if it is included in the Medicaid recipient's probate estate at the time of death.

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 in assets, in addition to the home, while the institutionalized spouse keeps $30,182. The spouse in the nursing home is entitled to keep only a $50.00 per month allowance while the "community spouse" is allowed a minimum income of $3,715.50 per month, with adjustments for certain items. Without proper planning, all assets and income above these levels must be spent on care 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 in the home, and in adult homes and assisted living facilities. We work closely with our clients to coordinate care in the proper setting, and to manage income and resources to maximize their value, while utilizing Medicaid services wherever available to supplement the care provided by the individual's family.

Community-based Medicaid services are 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.

Medicaid recipients are required 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 MLTC takes over the role of the local Medicaid/ DSS office in completion of the home care assessment and the determination of 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. The new MLTC rules are complex, and you should work with an experienced Elder Law Attorney to help navigate the system.

In order to access community-based care, an individual is allowed to keep the same $30,182 in total assets, but he/she may also retain the home in which they live along with the other exempt assets listed above. Recipients of Medicaid home care are allotted an income allowance of $1,697 per month, $2288 for a couple living at home. Income over the allowance is technically available to Medicaid, but rather than spending it down, an alternative is to contribute the excess income to a "Pooled Trust." The Pooled Trust can then be used to pay other expenses necessary to live in the community. The Pooled Trust is an excellent planning tool, allowing all income to be used to support the Medicaid recipient at home. Detailed information on the various home care programs, and the planning available to access community-based Medicaid, is available upon request.

C. Transfer of Asset Rules

What if an individual gives asset 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 Medicaid for a certain number of months, known as the "penalty period."

Exceptions are made for transfers to a spouse or a disabled child and for certain transfers of the home to siblings or caretaker children.

How far back does Medicaid look to find asset transfers, or what is the "look-back" period? When applying for "nursing home" Medicaid, the Department of Social Services will ask for financial records, bank statements, tax returns, etc. for the past 60 months (5 Years) and will examine all transactions within that time frame. For in-home benefits, new rules are expected to take effect in 2024 that will phase in a first-time lookback period that will eventually total 30 months. All transactions for homecare applications will be scrutinized, just like nursing home applications.

Additional changes to eligibility requirements for home care, also known as Community Medicaid, now include:

• Independent Assessor (Maximus) to replace counties and Managed Long-Term Care programs (MLTC) to determine your Medicaid eligibility, i.e. Do you get care benefits? And if you do, how many hours?

• No role for your physician. State will create an 'Independent Physician Panel' that will review applications.
• Additional Medicaid review to be conducted by "Independent Review Panel" if elder or disabled person needs more than 12 hours/day of home care

A thorough analysis of all transactions within either look-back period must be undertaken prior to filing for Medicaid, and a "paper trail" provided to DSS.

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 2023 NY Regional Rates.

Example 1

Jerry and Patty are a couple ages 70 and 66 who want to create an estate plan and protect their assets in the event they need long-term care in the future. Recently retired, they also want to create a legacy for their two adult children and one grandchild. At their consultation they present their assets and income:

Home: $325,000
Savings & Checking: $75,000
Jerry: Roth IRA at $325,000 and Stock $225,000
Patty: 401(k) at $250,000, Non-Qualified Annuity $150,000 and CDs $100,000

Step 1: the estate planning team at Pierro, Connor & Strauss creates advance directives for Jerry and Patty that include wills, powers of attorney, health care proxies and disposition of remains planning.

Step 2: Jerry and Patty become the grantors in a customized "Medicaid Asset Protection Trust,"
transferring their home, $50K from cash accounts, Jerry's stock portfolio, and Patty's annuity and CDs into the trust. They keep Patty's 401(k) and Jerry's Roth IRA outside the trust because those assets are exempt from Medicaid. They also leave 50K outside the trust for various expenses.

Jerry and Patty name their two adult children as co-trustees to manage assets, as make their children and grandchild the beneficiaries upon death. They can change trustees or beneficiaries at any time and will have income and rights to use their real and personal property for life. They retain power to revoke the trust with the consent of the beneficiaries as well.

Outcomes:
Now that Jerry and Patty's plan is completed, their long-term care costs will be covered by Medicaid, their home and assets are protected during lifetime, and their wishes upon death will be followed. Their children – co-trustees – will not need to probate the estate of their parents, and a legacy for children and future generations has been established. Jerry and Patty now have peace of mind!

Example 2
Mrs. Jones, a widow who lives in the Capital District, transferred her non- exempt home worth $263,760 to her only child in January 2018. Mrs. Jones enters a nursing home in October of 2019, spends down to the $30,182 asset limit and in a skilled nursing setting, applies for Medicaid in March 2022. The resulting penalty is 21 months, calculated as follows:

$263,760 (value of transfer made within the look-back period) divided by $12,744 (2023 Northeastern Regional Rate) = 21-month penalty period.

Mrs. Jones would not be eligible for Medicaid until January 1, 2024

Mrs. Jones transferred her home in January 2018. Assuming a 21-month penalty period, under the old rules the penalty period would have started February 1, 2018 and run through October 31, 2019. However, under the current rules, the penalty period would not start running until April 1, 2022, 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 21-month penalty period expires on January 1, 2024. **Who pays for Mrs. Jones' care for that time period?** Remember, she has already spent her life savings and only has a mere $30,182 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.

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 ap-

plicant. 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. If both signatures are required to withdraw funds (i.e., brokerage accounts require all named owners to sign), however, only ½ of the value will be counted as belonging to the 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, 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.

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). Thus, only Probate assets are recoverable 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 waive the eligibility requirements if:

i. The applicant meets the other eligibility requirements
ii. The applicant or his or her spouse is unable to get the transferred assets back, despite his or her best efforts; and
iii. The applicant cannot get appropriate medical care that 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. **Refer to Medicaid 2023 Guide***

V. PLANNING FOR LONG-TERM CARE

A. Crisis Planning for Nursing Home or Home Care
Even if someone needs long term care imminently, 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 situation is encountered by the family. 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.

B. Creative Planning for Home Care
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 harsher Medicaid transfer rules - 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.

C. Life Care Management
In the past, families facing a senior crisis could count on help from a variety of sources, including hospital social workers, discharge planning nurses or home care assistants. These positions have been virtually eliminated, however, due to cost-cutting measures in the health care system. Comprehensive planning assistance for families and follow-through services for newly discharged older persons have all but disappeared from the hospital scene.

This is where a Life Care Coordinator ("LCC") becomes a vital cog in the planning wheel. The professional LCC conducts a comprehensive clinical assessment of the long-term care needs. This includes consideration of all financial and other resources available to sustain the individual at the highest possible level of independence. After a thorough assessment, a plan is developed and care management is then coordinated by the LCC, with the legal and financial plan coordinated by Pierro, Connor & Strauss.

We have found that our clients benefit from the LCC's varied contacts and vast knowledge of the local health care system, and we have integrated LCC services into Long-Term Care Planning so the LCC and attorney work as a team to develop and follow through on a long-term care plan to ensure success.

VI. 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, such as nursing home and home health care. The Government faces continuing pressure to limit expenditures on existing programs, including Medicare and Medicaid.

Reforms of Medicare, Social Security and Medicaid have risen to the top of the government's agenda in Washington, DC, 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 impossible to discuss all of the planning opportunities in this outline.

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 for a consultation or visit us on the web at www.pierrolaw.com.

VII. 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 $1,600 for each benefit period. The first 60 days has a $0.00 coinsurance per day. Days 61-90 has a co-payment of $400 per day. 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 $800 per day.
3. Post-Hospital Skilled Nursing Home Care with payment in full for 20 days and a co-payment of $200 per day for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period. 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.

Appendix A: 2023 NYS Medicaid Regional Rates

REGION	COUNTIES	2023	2022	2021
New York City	Bronx, Kings (Brooklyn), NY (Manhattan), Queens, Richmond (Staten Island)	**$14,142**	**$13,415**	**$13,037**
Long Island	Nassau, Suffolk	**$14,012**	**$14,012**	**$13,834**
Northern Metropolitan	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	**$13,906**	**$13,389**	**$13,206**
Western (Buffalo)	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**$12,130**	**$11,884**	**$11,054**
Northeastern (Albany)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**$12,744**	**$12,560**	**$11,689**
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	**$13,421**	**$13,376**	**$13,020**
Central (Syracuse/ Utica)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	**$11,726**	**$11,328**	**$10,857**

LOCATIONS

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