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December 1st, 2018

BRENNAN & ROGERS PLLC

Informed and compassionate legal care

Elder law focus

ANNUAL CLIENT RELATIONSHIP SERVICE NEWSLETTER

QUESTIONS? CALL (207) 361-4680

Office Developments

- **Additional office space in York:** We have taken over the larger office space previously occupied by the Bean Realty Group and have continued to retain Smilie's office which adjoins the new office space. Our offices in York (279 York Street) are now under one roof.

- **New faces:** We have hired two (2) new employees, Emilee Wooldridge and Council Rogers.

    - Emilee is our new administrative assistant. Emilee is a recent graduate of the University of Connecticut and is a native of Wells.

    - Council is our new receptionist, paralegal and administrative assistant. Council is a graduate of Plymouth State and served in the US Army before returning to civilian life. Council is also Smilie's brother.

- **New office in Kennebunk:** We have opened a local office in the Lafayette Center in Kennebunk, 2 Storer Street, Suite 111.

- **New meeting place in Portsmouth:** We have leased a meeting space in Portsmouth with Regus. Smilie, who is licensed in New Hampshire, can now conveniently meet with clients in Portsmouth.

- **Refer a Friend Postcards:** Help us promote our new office locations, and our practice generally, by using the ready to go "refer a friend" postcards enclosed with this newsletter. Use of the postcard will entitle your friends to a $100 discount off our initial consultation fee!

- **New child:** Smilie and Mary Kathryn are proud to announce the birth of their third child, Ann Covington Rogers ("Annie") in early August. Both mother and child are healthy and doing well.

Mary Kathryn Brennan, Esq. Licensed in Maine
Smilie G. Rogers, Esq. Licensed in Maine, New Hampshire and Massachusetts

Planning and Long-Term Care Issues

- **Look Back Period:** For Medicaid planning purposes, the look back period for gratuitous transfers continues to be 60 months (5 years).

- **IRS Issues Long-Term Care Premium Deductibility Limits for 2019:** The Internal Revenue Service (IRS) is increasing the amount taxpayers can deduct from their 2019 income as a result of buying long-term care insurance. Premiums for "qualified" long-term care insurance policies (see explanation below) are tax-deductible to the extent that they, along with other unreimbursed medical expenses (including Medicare premiums), exceed 7.5 percent of the insured's adjusted gross income. (The 7.5 percent threshold is for the 2017 and 2018 tax years. It is scheduled to revert to 10 percent in 2019.) These premiums -- what the policyholder pays the insurance company to keep the policy in force -- are deductible for the taxpayer, his or her spouse and other dependents. (If you are self-employed, the rules are a little different.) However, there is a limit on how large a premium can be deducted, depending on the age of the taxpayer at the end of the year. Following are the deductibility limits for 2019. Any premium amounts for the year above these limits are not considered to be a medical expense.

Attained age before the close of the taxable year	Maximum deduction for year
40 or less	$420
More than 40 but not more than 50	$790
More than 50 but not more than 60	$1,580
More than 60 but not more than 70	$4,220
More than 70	$5,270

Another change announced by the IRS involves benefits from per diem or indemnity policies, which pay a predetermined amount each day. These benefits are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $370 per day, whichever is greater.

What Is a "Qualified" Policy?

To be "qualified," policies issued on or after January 1st, 1997, must adhere to certain requirements, among them that the policy must offer the consumer the options of "inflation" and "nonforfeiture" protection, although the consumer can choose not to purchase these features. Policies purchased before January 1, 1997, will be grandfathered and treated as "qualified" as long as they have been approved by the insurance commissioner of the state in which they are sold.

- **Is Not Signing up for Medicare Supplemental Coverage a Mistake?** You are turning 65 and enrolling in Medicare, but as a healthy senior do you really need to also sign up for Medicare's supplemental coverage? Not signing up initially can be very costly down the road. Medicare pays for only about half of all medical costs. To augment Medicare's coverage, you can purchase a supplemental or "Medigap" insurance policy from a private insurer. There are 10 Medigap plans that each offer a different combination of benefits, allowing purchasers to choose the combination that is right for them. In addition, Medicare offers a federally subsidized prescription drug program, in which private health insurers provide limited insurance coverage of prescription drugs to elderly and disabled Medicare recipients. Purchasing the supplemental coverage means paying more premiums. If you don't go to the doctor very often or have any regular prescriptions, you may not want to sign up for the additional coverage. However, if you get sick,

what Medicare doesn't cover can be a lot more costly than the extra premiums. Moreover, buying coverage after you get sick can be difficult and expensive.

- **Medicare plan open enrollment ends December 7th:** Do you have the right Medicare plan? It is Fall, which means it is time to think about whether your current plan is still giving you the best coverage or whether a new plan could save you money or offer better coverage. Medicare's Open Enrollment Period, during which you can freely enroll in or switch plans, runs from October 15th to December 7th.

- **Shop Around for Your Medigap policy:** Medigap premiums can vary widely depending on the insurance company, according to a new study, so be sure to shop around before choosing a policy.

- **For First Time, Median Cost of Private Nursing Home Room Hits Six Figures in Annual Survey:** The median cost of a private nursing home room in the United States increased to $100,375 a year in 2018, up 3 percent from 2017, according to Genworth's annual Cost of Care survey.

- **Be Careful About Putting Only One Spouse's Name on a Reverse Mortgage:** Despite federal regulations designed to protect a nonborrowing spouse, many spouses are still facing foreclosure and eviction after the death of the spouse whose name is on the reverse mortgage. When purchasing a reverse mortgage, it is always safer to put both spouse's names on the mortgage. If one spouse is underage when the mortgage is originally taken out, that spouse can be added to the mortgage when he or she reaches age 62.

- **Can Your Children Become Liable for Your Nursing Home Bill?** Although a nursing home cannot require a child to be personally liable for their parent's nursing home bill, there are circumstances in which children can end up having to pay. This is a major reason why it is important to read any admission agreements carefully before signing. Federal regulations prevent a nursing home from requiring a third party to be personally liable as a condition of admission. However, children of nursing home residents often sign the nursing home admission agreement as the "responsible party." This is a confusing term and it isn't always clear from the contract what it means. Typically, the responsible party is agreeing to do everything in his or her power to make sure that the resident pays the nursing home from the resident's funds. If the resident runs out of funds, the responsible party may be required to apply for Medicaid on the resident's behalf. If the responsible party doesn't follow through on applying for Medicaid or provide the state with all the information needed to determine Medicaid eligibility, the nursing home may sue the responsible party for breach of contract. In addition, if a responsible party misuses a resident's funds instead of paying the resident's bill, the nursing home may also sue the responsible party. In both these circumstances, the responsible party may end up having to pay the nursing home out of his or her own funds. Although it is against the law to require a child to sign an admission agreement as the person who guarantees payment, it is important to read the contract carefully because some nursing homes still have language in their contracts that violates the regulations. If possible, consult with your attorney before signing an admission agreement. Another way children may be liable for a nursing home bill is through filial responsibility laws. These laws obligate adult children to provide necessities like food, clothing, housing, and medical attention for their indigent parents. Filial responsibility laws have been rarely enforced, but as it has become more difficult to qualify for Medicaid, states are more likely to use them. Pennsylvania is one state that has used filial responsibility laws aggressively.

- **It's Now Harder for Veterans to Qualify for Long-Term Care Benefits:** The Department of Veterans Affairs (VA) has finalized new rules that make it more difficult to qualify for long-term care benefits. The rules establish an asset limit, a look-back period, and asset transfer penalties for claimants applying for VA pension benefits that require a showing of financial need. The principal such benefit for those needing long-term care is Aid and Attendance. The VA offers Aid and Attendance to low-income veterans (or their spouses) who are in nursing homes or who need help at home with everyday tasks like dressing or bathing. Aid and Attendance provides money to those who need assistance. To be eligible for Aid and

Attendance a veteran (or the veteran's surviving spouse) must meet certain income and asset limits. Until recently the asset limits weren't specified, but $80,000 was the amount usually used. However, unlike with the Medicaid program, there historically have been no penalties if an applicant divests him- or herself of assets before applying. That is, before now you could transfer assets over the VA's limit before applying for benefits and the transfers would not affect eligibility. This is not so anymore. The new regulations set a net worth limit of $123,600, which is the current maximum amount of assets (in 2018) that a Medicaid applicant's spouse is allowed to retain. In the case of the VA, however, this number will include both the applicant's assets and income. It will be indexed to inflation in the same way that Social Security increases. An applicant's house (up to a two-acre lot) will not count as an asset even if the applicant is currently living in a nursing home. Applicants will also be able to deduct medical expenses -- now including payments to assisted living facilities, as a result of the new rules -- from their income. The regulations also establish a three-year look-back provision. Previously there had not been a look back. These changes are examples of how proactive planning is becoming more and more critical to protecting your assets.

- **Scams**: Please be careful if anyone contacts you claiming that they are from the IRS or with a deal that seems too good to true. Be careful about opening emails or attachments from people you don't know. If you think you might be a victim of a scam, seek out help quickly – don't worry about appearing foolish.

- **Hospitals Now Must Provide Notice About Observation Status:** All hospitals must now give Medicare recipients notice when they are in the hospital under observation status. The notice requirement is part of a law enacted in 2015 but that just took effect. Signed by President Obama in August 2015, the law was intended to prevent surprises after a Medicare beneficiary spends days in a hospital under "observation" and is then admitted to a nursing home. This is important because Medicare covers nursing home stays entirely for the first 20 days, but only if the patient was first admitted to a hospital as an inpatient for at least three days. Many beneficiaries are being transferred to nursing homes only to find that because they were hospital outpatients all along, they must pick up the tab for the subsequent nursing home stay -- Medicare will pay none of it. The law, the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, did not eliminate the practice of placing patients under "observation" for extended periods, but it did require hospitals to notify patients who are under observation for more than 24 hours of their outpatient status within 36 hours, or upon discharge if that occurs sooner. The Act required hospitals to begin giving patients this notice as of March 8th, 2017. Some states, including California and New York, already require such notice. The law does not make hospital observation stays count towards Medicare's three-day requirement.

- **Poor Doctor Communication Can Negate End-of-Life Planning:** When seriously ill patients are nearing the end of life, they and their families sometimes find it difficult to decide whether to continue medical treatment and, if so, how much treatment is wanted and for how long. In these instances, patients rely on their physicians or other trusted health professionals for guidance. In the best of circumstances, the patient's wishes regarding treatment have been set down in an advance medical directive known as a living will. Research by the Agency for Healthcare Research and Quality (AHRQ) indicates that most patients have not participated in advance care planning. ***Moreover, AHRQ research found that even the existence of a medical directive is no guarantee that the patient's wishes will be followed. Between 65 and 76 percent of physicians whose patients had a medical directive were not aware that it existed***. It's no surprise, therefore, that research shows that care at the end of life sometimes appears to be inconsistent with the patients' preferences to forgo life-sustaining treatment, and patients may receive care they do not want. According to the AHRQ, lack of communication between patients and physicians and other health care providers is a chief culprit. AHRQ-funded studies have shown that discussing advance care planning and directives with their doctor increased patient satisfaction among patients age 65 years and over.

Taxes

The new tax law makes a number of changes. This newsletter only scratches the surface. If you are concerned about the change in the tax law, please call.

The New Estate Tax Law Means It's Time Review Older Estate Plans.

While the new tax law doubles the federal estate tax exemption to $11,180,000 million per decedent (meaning the vast majority of estates will not have to pay any federal estate tax) it doesn't mean you should ignore its impact on your estate plan.

Maine, which did not conform its estate tax to the new federal exemption, remains, after being adjusted for inflation, at $5,490,000. While most estates won't have to worry about either estate tax, some estate plans may still need to be reviewed.

Top Changes Likely to Impact Seniors

1. New lower tax rates.
2. Reduction in medical expense floor and an increase in the maximum long-term care premium that can be deducted.
3. Increase in standard deduction to $12,000 per taxpayer. Many may no longer need to itemize but for those close to the tipping point, bunching charitable gifts, rather than spreading them out over time, may become the new norm.
4. Elimination of the personal exemption.
5. Suspension and limitation on itemized deductions.

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Monthly E-Newsletter

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Happy Holidays!