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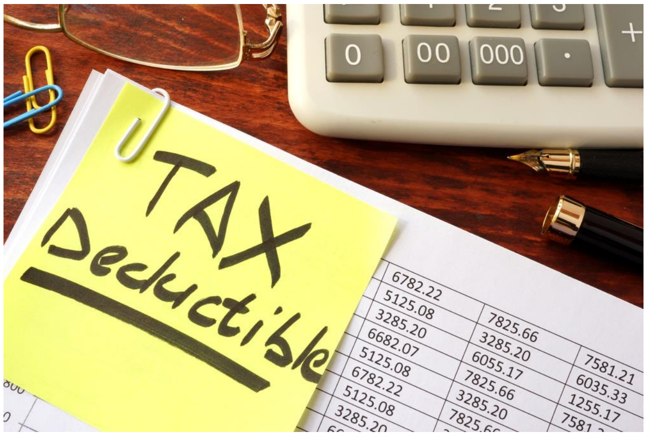
IRS ISSUES LONG-TERM CARE PREMIUM DEDUCTABILITY LIMITS FOR 2022, AND THEY LOOK PRETTY FAMILIAR



The Internal Revenue Service (IRS) has announced the amounts taxpayers of different ages can deduct from their 2022 income as a result of buying long-term care insurance, and the figures are almost the same as in 2021.

Many types of medical expenses are deductible from your taxes. To claim the deduction, your total unreimbursed medical expenses (which can include premiums for “qualified” long-term care insurance policies), have to be more than 7.5 percent of your adjusted gross income in 2022.

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As long as the long-term care insurance policy is “qualified” (see below), 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 tax-deductibility rules are a little different: You can take the amount of the premium as a deduction as long as you made a net profit; your medical expenses do not have to exceed a certain percentage of your income. The tax deduction is generally not available with so-called hybrid policies, such as life insurance and annuity policies with a long-term care benefit.

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 tax year 2022. They are the same as in 2021, with the exception that for those in the age 60 to 70 age range the IRS reduced the limit by $10, from $1,420 to $1,410. Any premium amounts for the year above these limits are not considered to be a medical expense.

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Attained age before the close of the taxable year	Maximum deduction for year
40 or less	$450
More than 40 but not more than 50	$850
More than 50 but not more than 60	$1,690
More than 60 but not more than 70	$4,510
More than 70	$5,640

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 $390 per day, whichever is greater.

For these and other inflation adjustments from the IRS, click here.

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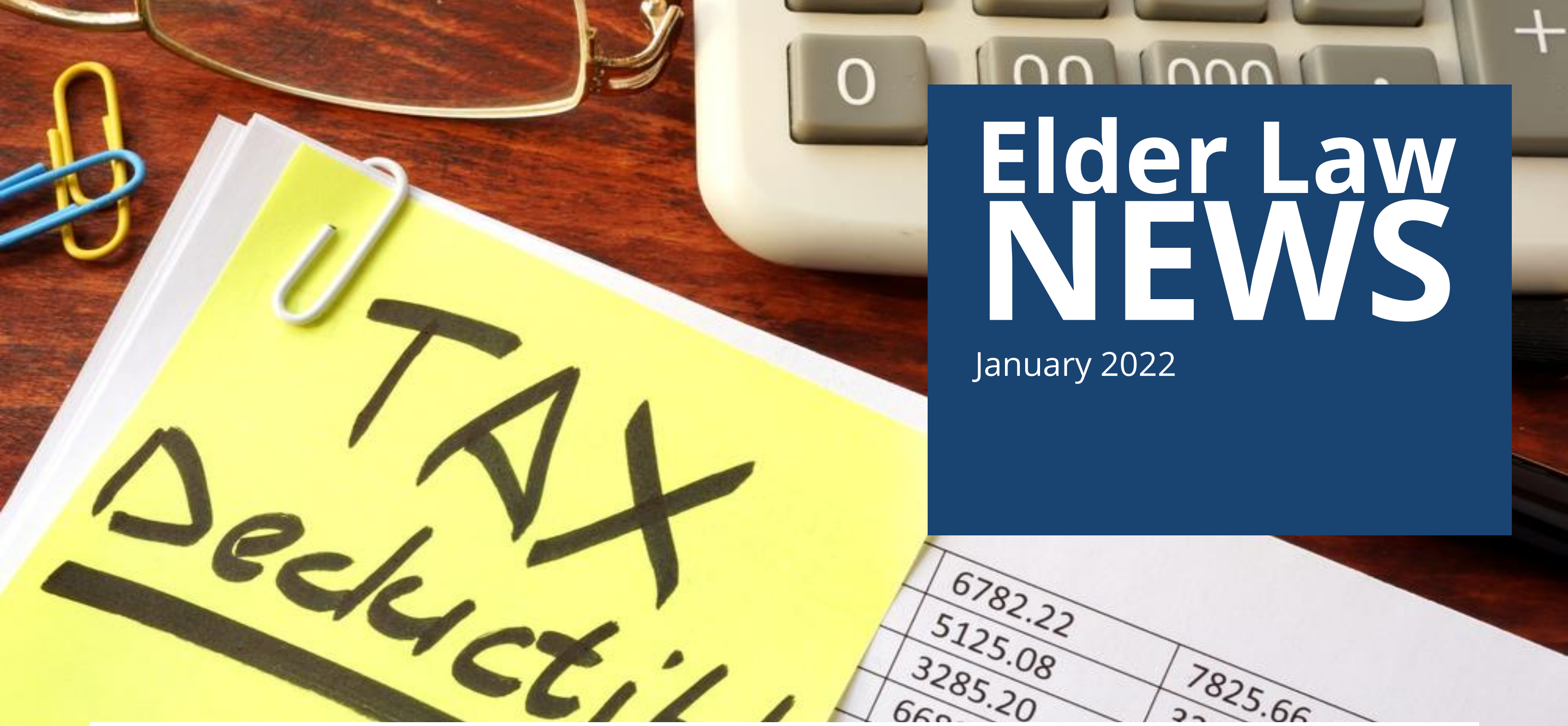

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What Is a “Qualified” Policy?

To be “qualified,” policies issued on or after January 1, 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.

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ADVOCATES SOUND ALARM ABOUT PILOT PROGRAM THEY SAY COULD PRIVATIZE ALL OF MEDICARE

The Biden administration is moving forward with a Trump-era pilot program that would hand over the care of millions of Medicare beneficiaries to private, mostly for-profit, groups.

Health care advocates warn that that the little-known plan will limit patients' choice of providers and effectively privatize Medicare for beneficiaries who specifically chose traditional, public Medicare because they wanted to be able to select their own doctors.

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The program was created without congressional oversight and can expand without Congress's approval.

"It could potentially complete the privatization of our public precious good called Medicare," says Ed Weisbart, MD, who chairs the Missouri chapter of Physicians for a National Health Program (PNHP). "It violates the spirit of a public health program, which Medicare is, by driving larger corporate profits as a priority over improving our health, which Medicare is remarkably successful at."

Already, some 42 percent of Medicare beneficiaries are in private Medicare Advantage plans, to which the federal government gives a fixed monthly fee for each Medicare beneficiary under the plan's care. The less money the plans spend on patient care, the more money they and their investors make.

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The new pilot program, called Direct Contracting, would extend key aspects of this model to other Medicare beneficiaries in 38 states, Washington, D.C., and Puerto Rico, potentially covering 30 million of the 36 million beneficiaries in traditional Medicare. Fifty-three Direct Contracting Entities (DCEs), most of which are investor-owned with ties to Medicare Advantage commercial insurers, have already signed contracts to be fiscal intermediaries between patients and their providers.

Beneficiaries Automatically Enrolled

Under the program, these DCEs will form their own networks of providers, which beneficiaries will be strongly encouraged, although not required, to use. Traditional Medicare beneficiaries will be enrolled in these networks, often without their knowledge or consent. The DCEs will be paid a set amount per patient, called a capitation payment, which will vary depending on a patient's "risk score." If the patient care costs less than the

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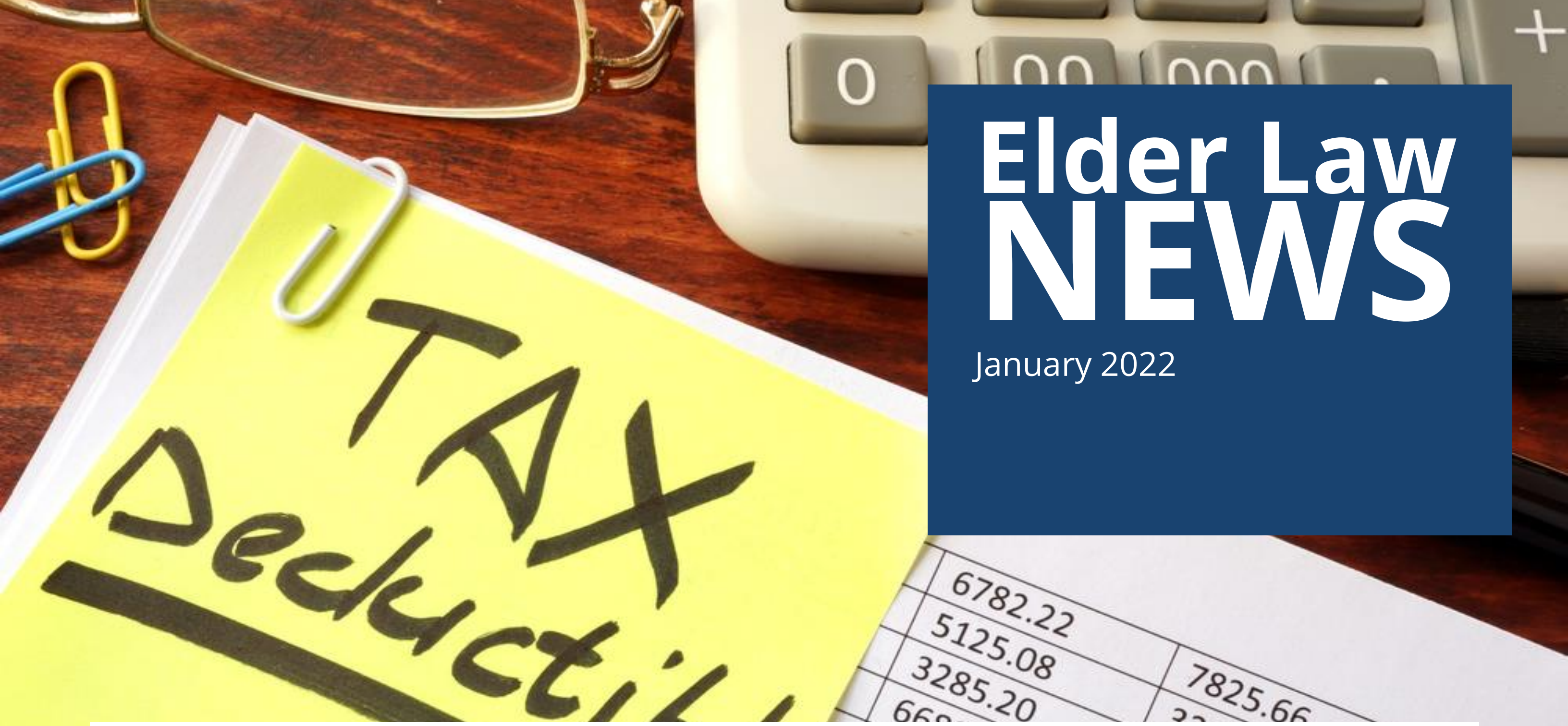


per-patient amount, the DCE keeps some or all of the difference. If it costs more, the DCE loses money.

Beneficiaries will not be able to opt out of being "aligned" with a DCE. Medicare will assist the DCEs by searching the claims history of beneficiaries – again without patients' knowledge or consent — to see if they have visited a participating DCE provider with which they could be aligned.

All this will likely be confusing for Medicare beneficiaries, many of whom will have three different entities processing their claims: the DCE, Medicare, and the beneficiary's Medicare supplemental insurance (Medigap) plan.

"Rather than allowing patients to go to providers directly under traditional Medicare, DCEs invite insurers and investors to step in and interfere with the care that Americans get," said Rep. Katie Porter (D-CA) at [a recent PHNP webinar] on Direct Contracting. The DCEs,

Porter charged, will “drive up costs for patients in order to maximize profits . . . Wall Street wins, patients and taxpayers lose.”

Lowering Costs Is the Stated Aim . . .

The idea behind the pilot is that these care networks will lower costs and spur innovation by managing care. The model, according to the federal Centers for Medicare and Medicaid Services (CMS), “is expected to increase beneficiaries’ access to innovative, affordable care while maintaining all original Medicare benefits.”

Not all medical providers oppose Direct Contracting, particularly those already affiliated with provider groups.

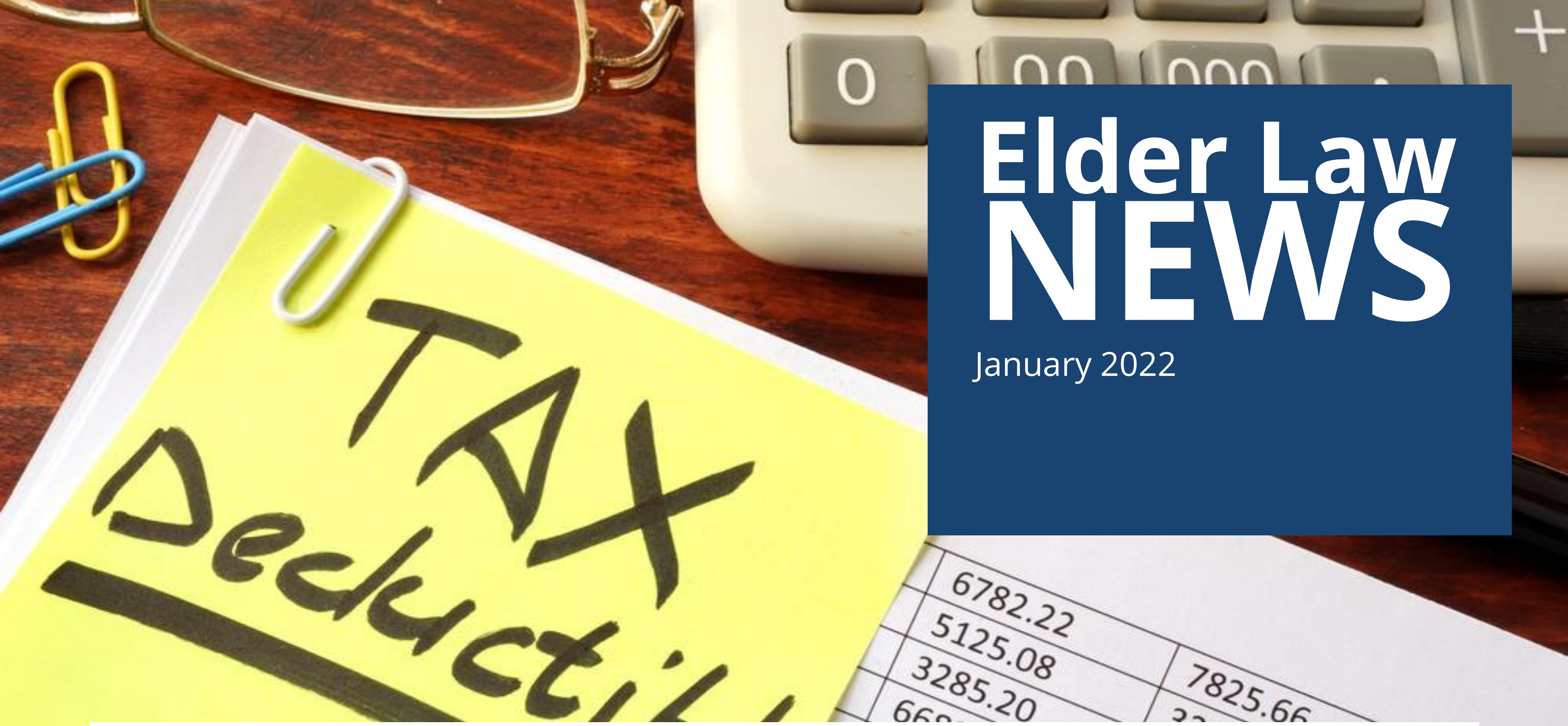
“Models of care that are focused on systems of reimbursement such as capitation and holding physicians accountable for cost, coordination, and quality are integral to moving

away from the fee-for-service model and toward more transformative models of care that reward value," said Don Crane, president and CEO, of America's Physician Groups said in December 2020.

. . . But Financial Incentives Worry Critics

Critics of the program have raised a number of concerns. They note that many beneficiaries will be unaware that they can opt out of a DCE's provider network, and say that DCEs will seek to contain costs by discouraging or denying needed care. (It is unclear how CMS will monitor beneficiaries' access to care.)

Advocates also note that, as with Medicare Advantage, DCEs will have a strong financial incentive to "upcode" patients – that is, to tell the government that patients in their care are sicker than they really are so the DCE can receive a higher reimbursement. Finally, critics are convinced that DCEs affiliated with Medicare Advantage plans will use the



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opportunity to steer beneficiaries away from traditional Medicare and into these highly lucrative plans.

No one knows whether the DCEs will actually be profitable, but Wall Street is betting that they will be.

“Wall Street considers Direct Contracting Entities to be eight times more valuable per patient than Medicare Advantage firms,” wrote Chris Tomlinson, a business columnist for the Houston Chronicle.

Even if DCEs don’t make money initially, patient advocates say that many investors are betting on selling the DCE for a profit down the road, a favored model of private equity investment. “The real strategy is to make rapid growth and then leave and go on to the next investment,” said PNHP’s Weisbart.

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Two nationally known physicians who once led CMS are warning against the pilot program. Writing in the blog of the journal *Health Affairs*, Dr. Donald M. Berwick, a former CMS Administrator, and Dr. Richard Gilfillan, a former director of CMS's Center for Medicare and Medicaid Innovation, call Direct Contracting a new addition to the "Medicare Money Machine" and characterize its name as "Orwellian." "'Indirect Contracting' would have been a far more accurate name," they write, "since the cornerstone of the program was CMS's opening the door to non-provider-controlled [DCEs] to become the fiscal intermediaries between patients and providers."

Blanket Authority to Experiment

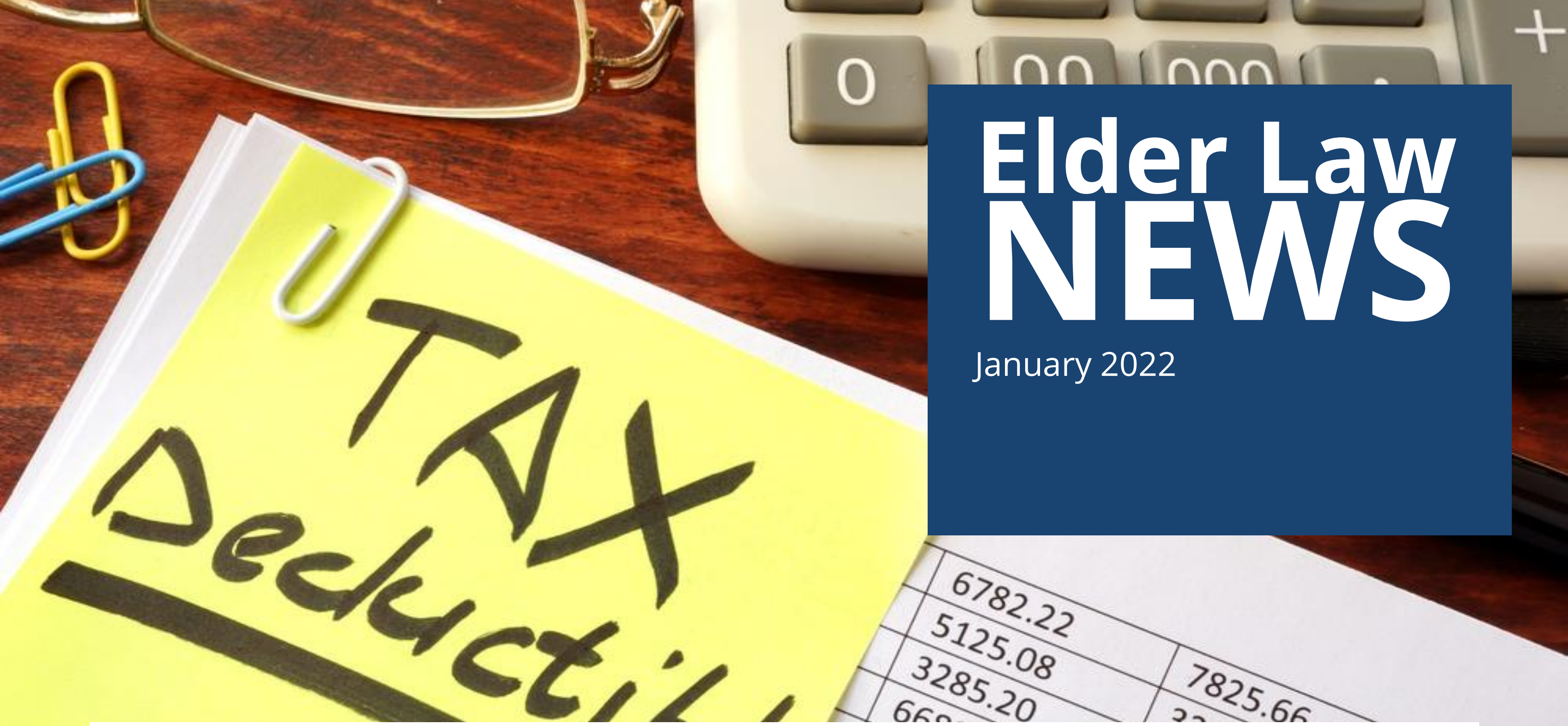
Experimental health delivery models like Direct Contracting were made possible by the Affordable Care Act. The landmark 2008 law established the Center for Medicare and Medicaid Innovation and gave it almost blanket authority to test ways to improve health

care quality and reduce costs without congressional approval or oversight. The Trump administration seized on this authority to craft the Direct Contracting model.

Its most extreme version is called Geographic Direct Contracting, which would auto-assign every traditional Medicare beneficiary living in a number of large geographic regions into a Medicare Advantage-like “Geo DCE” without the right to opt out. Advocates persuaded the Biden administration to pause this program in March, although it is still “under review” and could resurface.

But the Biden administration has continued the rollout of a less extreme version, the Global and Professional Direct Contracting (GPDC), which CMS calls a “voluntary risk-sharing payment model.”

Rep. Porter is among lawmakers who are calling on the administration to immediately freeze this version as well, contending that while it is intended to make Medicare more



efficient, it actually will do the opposite, noting that between 2008 and 2020 the federal government has overpaid Medicare Advantage plans — which were designed to contain costs in similar ways – by $143 billion.

In late November a group of physicians from around the nation traveled to Washington, D.C., to educate lawmakers about the Direct Contracting threat, call for a congressional hearing and present U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra a petition signed by more than 13,000 people, including 1,500 physicians. The petition warns that moving the DCE program forward threatens "the future of Medicare as we know it."

"[Direct Contracting] is very complex and it is extremely hard to explain," said PNHP board member Dr. Judy Albert at the HHS press event. "There has been very little coverage in

the mainstream media, allowing the program to fly under the radar. . . . Together, we will continue to raise the alarm until we stop this threat to Medicare."

YOU CAN 'CURE' A MEDICAID PENALTY PERIOD BY RETURNING A GIFT

Anyone who gifted assets within five years of applying for Medicaid may be subject to a penalty period, but that penalty can be reduced or eliminated if the assets are returned.

In order to be eligible for Medicaid, you cannot have recently transferred assets.

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Congress does not want you to move into a nursing home on Monday, give all your money

to your children (or whomever) on Tuesday, and qualify for Medicaid on Wednesday. So it has imposed a penalty on people who transfer assets without receiving fair value in return.

This penalty is a period of time during which the person transferring the assets will be ineligible for Medicaid. The penalty period is determined by dividing the amount transferred by what Medicaid determines to be the average private pay cost of a nursing home in your state.

However, Congress has created a very important escape hatch from the transfer penalty: the penalty will be “cured” if the transferred asset is returned in its entirety, or it will be

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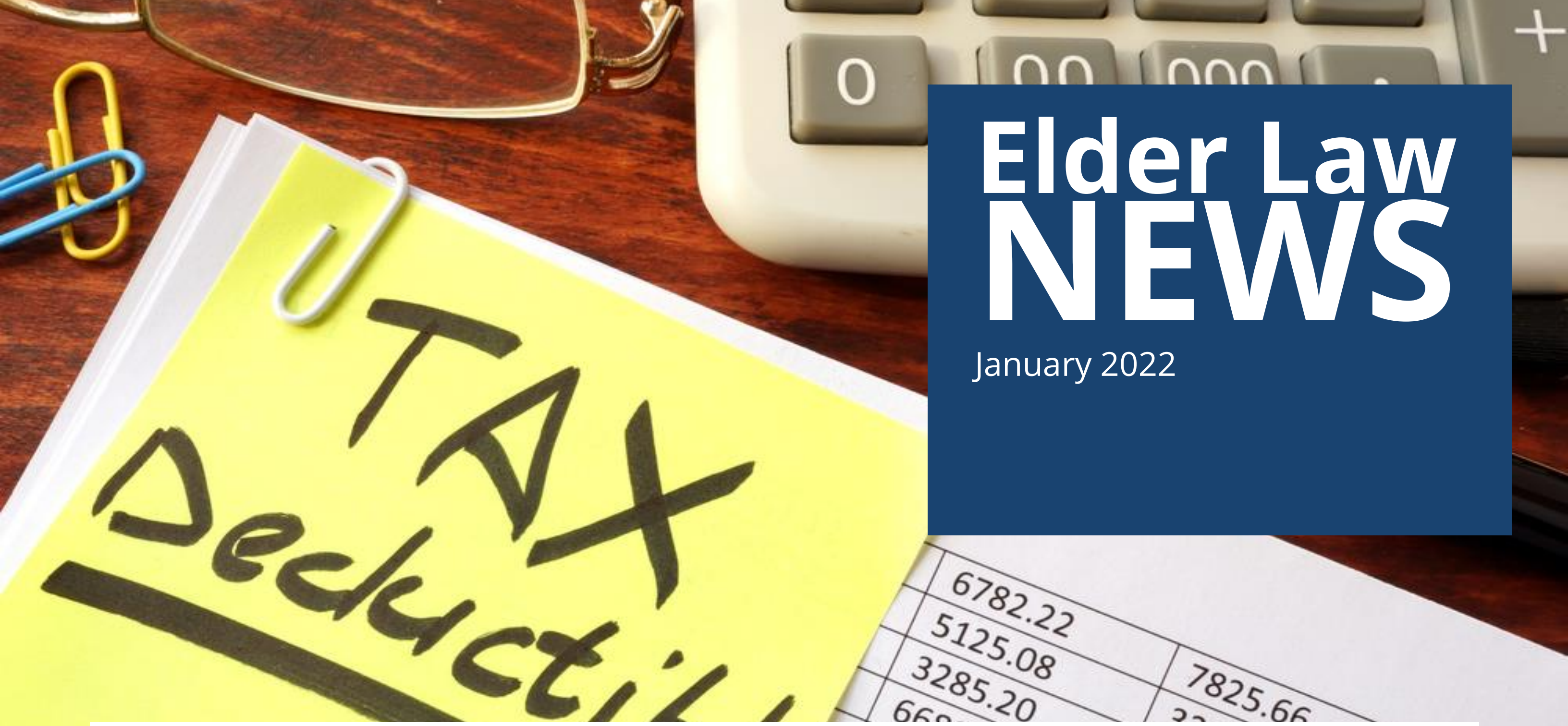

reduced if the transferred asset is partially returned (although some states do not permit partial returns and only give credit for the full return of transferred assets).

Partially curing a transfer can be a [“half a loaf” planning strategy] for Medicaid applicants who want to preserve some assets. In this case, a nursing home resident transfer all of his or her funds to the resident’s children (or other family members) and applies for Medicaid, receiving a long ineligibility period. After the Medicaid application has been filed, the recipients return half the transferred funds, thus “curing” half of the ineligibility period and giving the nursing home resident the funds he or she needs to pay for care until the remaining penalty period expires.

The person who returns the money needs to be the same person who received the gift; otherwise, it is not really a return of the original gift. But many people will have spent the gifted assets and no longer have any money to return. If the person who received the transfer no longer has the funds to cure, other family members could give or loan that person the funds to do so.

Returning the funds will likely mean the Medicaid applicant will have excess resources that will need to be spent down before the applicant will qualify for Medicaid. States vary on

how they handle returns. Some states may consider payments made directly to the nursing home on behalf of the Medicaid applicant to be a return of funds; others require that the payments go directly to the applicant.

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Your attorney can help you navigate Medicaid’s complicated rules and application process. To find an attorney near you, click here.