56th Mid-Year Meeting
What You Don’t Know CAN Bite You – Practical Tips from Elder Law and Disability Practitioners

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What You Don’t Know Can BITE you: Practical Tips

Powers of Attorney

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Drafting Considerations

1. Immediate v. Springing
2. Agents
3. Overlap with Advance Directive/Agent
4. Scope of Authority
5. Accountings

1. Immediate v. Springing
2. Agents

- Who?
- Dual v. Successor
- Authority to appoint an alternate or successor [14 VSA § 3504 (g) requires explicit authority]

3. Advance Directive Considerations

- NO Agent under PGA can make health care decisions [14 VSA § 3504 (b)(1)]
- But ~
  - Authority to admit to facility
  - Authority to engage caregivers
  - Authority to apply for public benefits

4. Scope of Authority

- Obvious powers – banking, real estate, investments

- GIFTING
  - 14 VSA § 3504(e) requires explicit authority
  - Limit amounts?
  - Limit donees?
  - Self-dealing?
4. Scope of Authority (cont’d)

- **ESTATE PLANNING**
  - Amend or create trust
  - Transfers to/from trust
  - Disclaim interests
  - Fiduciary actions: Trustee responsibilities if authorized by trust - 14 VSA § 3504 (b)(7)
  - Corresponding language in trust for any of these powers?

4. Scope of Authority (cont’d)

- **ELECTRONIC (ON-LINE) ACCOUNTS AND OTHER DIGITAL ASSETS**
  
  "To obtain password or login information and have complete access, use, and control of any electronic or digital account maintained by me or on my behalf, including without limitation, computers, tablets, storage devices, mobile telephones, electronic mail, financial accounts, cloud services, social network accounts, domain registrations, web hosting accounts, and all other online accounts which currently exist or may exist;"

5. Accountings

- **14 VSA § 3510**
  - Only Principal or DAIL commissioner (or designee) may file petition in superior court
- Require Agents to account to Principal
- Require Agents to account to each other
- Require Agents to account to others?
- Consequences for failure to account?
Real estate presents a variety of issues for Medicaid planning, because clients possess a variety of types of real estate. Many have a home. Some might have a camp or vacation home. Some might have a rental or business property. Some might own property with other people. All present different planning challenges. The home stands alone, with separate treatment, all other types of property will be countable unless it falls into one of the categories below.

The Home. Under the DRA and current Vermont Medicaid rules, the primary residence, up to $536,000.00 in equity value, is an exempt asset, and remains an exempt asset so long as the applicant would return home if they could. The trick is, to be sure that the house does not pass through probate on the person’s death. If the house goes through probate, it will be subject to a Medicaid reimbursement claim. Estate recovery is the rule in Vermont and the Medicaid Estate Recovery folks are diligent in submitting claims in probate. So the key to preserving the house is to avoid probate when the Medicaid recipient or the surviving spouse (yes, the Medicaid lien will extend to the estate of the surviving spouse) dies.

Another issue that often arises with the house, is what is included in the definition of the ‘homeplace’. Generally the house and all surrounding, contiguous acreage is included in the exemption. Contiguous includes any property divided by a road or stream, if the parcels would touch but for the road or stream. The parcels do not have to have been deeded to the owner in one deed, they can have been accumulated over time from different grantors.

Sometimes the ‘homeplace’ includes other structures or residences. Generally these have been exempt as part of the homestead. If they were producing income at all, the income would be included in the applicant’s income calculations. Recently the department may have changed its interpretation. There is one anecdotal case where the department asserted that a rental unit on the homestead property should be valued separately to determine if it met the ‘income producing’ test, or the value of the building would be countable.

Enhanced Life Estate Deed (ELED). The Enhanced Life Estate Deed (ELED), a/k/a “Life Estate Deed with Reserved Powers”, or the “Lady Bird Deed” or “Medicaid Deed” as it is known nationally; and the “Italian Deed” or “Granai Deed” as it is known in Central Vermont (named after the late C.O.Granai, Esq. of Barre, who used the form in numerous deeds and had the ‘honor’ of having the Vermont Supreme Court uphold the language in Aiken v. Clark, 117 Vt. 391, 1952) can be a powerful and important tool in the Elder Planning arsenal.
The benefits of the Enhanced Life Estate Deed are as follows:

A. Exempt for Medicaid. For the homeplace, at least, the property remains an exempt asset for Medicaid purposes, up to a maximum equity value of $536,000. Current Medicaid regulations promulgated by DCF particularly regulation 4241.6 have made clear that with a transfer, only the life estate with reserved powers is entitled to the full exemption. The exemption actually rests on the status of the property as the homeplace, and the Life Estate with powers retains sufficient control over the entire fee in the Grantors to avoid being a gift of any interest. With a ‘bare’ life estate, the home is still exempt, but there is a present gift to the remaindermen which could be subject to penalty.

B. Retain Control. Because the Grantors reserve for themselves the full power to mortgage, sell, lease or convey the property during their lifetimes, they retain full control over the property. There is no loss of control or even veto power given to the remaindermen. This is a major concern for many elders, especially if they are doing more long term estate and Medicaid planning rather than immediate or emergency Medicaid planning. For these clients it is comforting to know that while they are ensuring the property will pass to their children, they could still sell it and buy a condo or that motor home to travel the country if they wanted, without the consent of the children.

C. Avoids Probate. Many clients have a goal of Probate avoidance after their death. This deed accomplishes that goal. Avoiding probate is the second part of protecting the property from Medicaid. By having the property pass outside the probate estate, any possible Medicaid reimbursement claim will be avoided. If the property goes into the probate estate, it may have to be sold to generate cash to pay the Medicaid reimbursement claim. Currently, Vermont only employs estate recovery to obtain reimbursement of Medicaid expenses.

NOTE: This may change. Several years ago, the department was seeking rulemaking authority from the legislature and was looking at various methods to enable recovery against the primary residence. Many other states are employing ‘expanded’ estate recovery and asserting claims against remainder interests or treating the conveyance of a remainder interest as a transfer. It is still good planning, but clients should be warned that the rules may change in the future and the deed won’t have the Medicaid planning benefits it currently does.

D. Not Subject to Creditor Claims. The Enhanced Life Estate Deed does not subject the property to the claims of creditors of the remaindermen. It also protects against the claims of divorcing remaindermen and their spouses. And for the remaindermen, it does not qualify as an asset for scholarship applications or other such income or asset based programs. This is a major advantage over the simple joint tenancies often created in the past with the idea of avoiding probate.

E. Tax Rebate Preserved. The Enhanced Life Estate Deed can preserve the Home Owner’s property tax prebate/rebate for the Grantors. Suggestions: I recommend including specific language stating grantors are responsible for all taxes during their lifetime to avoid any issues with the tax department. Currently you should have the clients execute a new Homestead Declaration when you file the deed. It is also good practice to list the Grantor as the first Grantee on the Transfer Tax Return. Also, you should be aware that when the grantor moves to the nursing home, the Homestead status for property tax
purposes will be lost. Once the owner is no longer residing in the house, it does not qualify as Homestead property for property tax purposes.

F. No Medicaid Look-back. The Enhanced Life Estate Deed does not constitute a penalized transfer for Medicaid. Because the grantors retain full control during their lifetime, there is no present transfer. Therefore, there is no look-back or penalty period to be considered when using this conveyance.

G. Step-up in Basis. When the property does transfer to the remaindermen, upon the death of the Grantors, there is a step-up in basis of the property to the date of death value (26 USC §2036). This can be a significant benefit to the remaindermen, saving hundreds of dollars in capital gains taxes if they then sell the property.

H. No Gift Tax Return Required. There is no Gift Tax return required at the time of signing the deed because there is no present gift. There are contrary views on this issue.

With all of these benefits it would seem that the Enhanced Life Estate Deed is almost a perfect planning technique. It is, almost. As with most things there are some disadvantages.

The problems with an ELED include:

a. Medicaid/home expenses. If only one spouse survives and receives Medicaid Long Term Care benefits, all their income must be spent for their care first. This leaves no funds available to pay for the ongoing expenses of the property. While the elder may not be living in the house there are still expenses for taxes, insurance and other maintenance. These cannot be paid for from the elder’s income. The remaindermen may have to pay these costs to preserve the asset.

b. Sale. The ELED presents no major obstacle to the sale of the house. Vermont title insurers are familiar with these deeds, and while they may not like them, they accept that the Life Estate holders can sell without the remaindermen joining. The problem with a sale is that all the funds are paid to the elder(s) and, unless they purchase another home or another exempt asset, the sale proceeds will be a countable resource.

c. Transfer Tax. Currently, transfers using an Enhanced Life Estate Deed are subject to the Transfer Tax. Normally this is not a problem because the Grantees are usually the children. Since there is no consideration paid and it is a transfer between parent and child, it is exempt from the Transfer Tax. An issue does arise, though, when the transfer is not a between a parent and child or grandchild. A sibling or more remote relation or friend is not exempt. The Tax Department has taken the position that the full tax has to be paid on transfer, even though no actual change in ownership is taking place. The Department also requires that the non-residential tax rate be used because the property will not be the Grantee’s primary residence. You can, however, reduce the tax by using the mortality tables to calculate the value of the remainder interest and pay the tax only on that amount.
d. Mortgage. An issue has recently arisen among real estate practitioners regarding the effect of a mortgage subsequent to an Enhanced Life Estate Deed. While it is clear (hopefully with language in the deed) that the Life Estate holders may mortgage the property, the question is ‘what happens to the remainder interest?’ The present position of many in the real estate bar is that the subsequent mortgage divests the remaindermen. Clients should be warned of this. If they do an ELED and then take out a mortgage, they’ll have to do a new ELED to ‘reinstate’ the plan.

e. Rental. It is possible to rent the house while the elder is in the nursing home, but there are several problems. The lease must provide that the elder may return to the house at any time. The lease should be a net lease, so the costs of the house such as taxes and insurance are paid by the tenant. Currently the department is interpreting the Gross Rent received as income which must be used to pay for nursing home care, thereby reducing Medicaid’s contribution. The department is not looking at the Net in this situations now. Other drawbacks to renting: many children or POA agents will not want to take on the additional headaches of the rental; also does the rental, at some point, impact the capital gains exclusion? (I suspect so, but it bears more research.)

There is no officially prescribed language that must be used to create a retained life estate with the necessary powers. The DCF office is pretty flexible, although in the past the deed had to include powers to “sell, lease, mortgage and otherwise convey” and a clear statement of the right to all proceeds. This does not seem to be the case now, as I have seen some very basic language pass review. In 2008, the Vermont Supreme Court interjected itself into this issue in the case of Weed v. Weed, 2008 Vt. 121, August 29, 2008. The Court was construing the reserved powers and decided that a reservation of “the right to sell the subject property in fee simple absolute or in any lesser fee” required an actual sale, with real consideration, and did not allow transferring by gift. I now recommend that you include in your language “sell, lease, mortgage and otherwise convey, with or without consideration.”

The bigger problem is having language that is concise enough to not make the deed unwieldy while at the same time having it comprehensive enough to allow Title attorneys to feel comfortable allowing the Reserved power holder alone to sign conveyancing documents without the remaindermen joining in. Usually this is not a problem but be aware it does crop up from time to time. All the major Title Insurers in Vermont do recognize these types of deeds and don’t require the remaindermen to sign. If you run into a reluctant Title attorney, call their Title insurer. If you encounter resistance be certain the insurer knows the exact language in the deed and be certain that you are dealing with an attorney at the title company who is familiar with Vermont practice. I once had the situation of meeting resistance with the title company attorney, until I discovered it was a regional attorney who was not from Vermont, covering for the Vermont attorney.

For convenience, the following is the language that I use, a part of which was developed by Al Overton and the attorneys in his office, and which has been modified to include language which I think meets the Weed vs. Weed standard. And yes, I do put it all capitals just to set it off from the rest of the description so it is easy to find.

( INSERT AFTER PROPERTY DESCRIPTION PARAGRAPHS)
“RESERVING UNTO THE GRANTOR(S), ____________________, A LIFE ESTATE IN THE ABOVE-DESCRIBED PROPERTY WITH FULL POWER TO MORTGAGE, LEASE, SELL OR OTHERWISE CONVEY SAID PROPERTY, WITH OR WITHOUT CONSIDERATION, WITHOUT JOINDER OF THE GRANTEES IN SUCH CONVEYANCE, AND THE RIGHT TO ALL INCOME AND PROCEEDS FROM SUCH TRANSFER, FREE OF THE INTEREST OF GRANTEES, DURING HIS/HER/THEIR LIFETIME. GRANTOR(S) SHALL BE SOLELY RESPONSIBLE FOR THE PAYMENT OF TAXES ON SAID PROPERTY.

THE REMAINDER INTEREST HEREIN GRANTED SHALL PASS TO GRANTEES SUBJECT TO ANY LEASE OR MORTGAGE CREATED BY THE LIFE TENANT(S); AND SHALL BE EXTINGUISHED BY ANY SALE OR OTHER CONVEYANCE BY LIFE TENANT OR BY A FORECLOSURE SALE BY A MORTGAGEE, WITHOUT THE NECESSITY OF JOINING THE REMAINDERMEN IN SUCH FORECLOSURE.”

Who can be a grantee of an ELED? Usually the grantees are the grantors’ children, but it could be anyone (keep in mind the Transfer Tax issues). Often, if my clients already have a Revocable Living Trust, or wish to make some special provisions about the sale of the property after their death or if they just have a lot of children and wish to simplify the handling of the property when they are gone, they can transfer the remainder interest to a Trust.

**Reserved Life Estate without Power of Sale**: The Reserved Life Estate without Power of Sale or a “bare life estate” as it is more commonly called is an excluded resource, 4241.1. The “Look Back” period will apply and a penalty will be assessed on the value of the remainder interest in the land which was conveyed if the conveyance was made within 5 years of applying for Medicaid.

At the present time the main benefit of using a Deed with a Retained Life Estate without Power of Sale is Probate avoidance. This can be an added benefit by avoiding not only the expense and delay of probate but also the possibility of a Medicaid reimbursement claim against the Probate Estate. Another use of the Life Estate is to obtain a discount on the value of a gift.

This type of transfer does not allow retention of control, because the remaindermen do have an interest and therefore would have to sign any documents affecting the property. There is also less creditor protection, as the interest of the remaindermen may be subject to attachment and divestment, subject to the life estate, of course.

In the event of a sale of the property, a portion of the sale proceeds would belong to the remaindermen. This could be a benefit in reducing the amount going to the elder. At the same time, be cautious in having an elder transfer their life estate to the remaindermen, that is a penalized transfer based on the actuarial value of the life estate.

This type of ownership does not provide all of the tax benefits of the Enhanced Life Estate. For capital gains tax, if the property is sold during the life tenant’s lifetime the remaindermen will share in any sale proceeds and will have to pay capital gains tax on their share (with carry over basis), thus losing
some of the capital gains tax exclusion. The capital gains step-up on death, however, is preserved by the retention of the life estate.

**Joint Ownership:** Joint ownership also avoids probate and therefore the possibility of a Medicaid reimbursement claim. It can exempt the house if it is the elder’s primary residence. Also, a jointly owned property is not a countable resource if the joint ownership was created more than 3 years prior to applying for Medicaid. However, if it was created by the elder adding joint owners to the deed, the transfer of those interests is subject to penalty if done within 5 years of applying for Medicaid. Joint ownership also has many of the drawbacks of the ‘bare life estate’ as far as control, creditor protection and taxes.

**Tenants in Common:** Ownership as tenants in common with others gets no special treatment under the Medicaid rules. If the property is the elder’s home, it can be exempt. If not it is a countable resource unless otherwise exempt (the 3 year rule for joint ownership doesn’t apply). Transfers of the elder’s property into Tenants in Common ownership within 5 years of applying for Medicaid will result in a penalty. And of course, Tenants in common property does not avoid probate.

**Caretaker Child Exception:** Medicaid does allow the transfer of the home to a child without penalty IF the child has resided in the home for at least 2 years and provided care which allowed the parent to stay at home and not in a nursing home during that time. If you plan to use this, be sure you have a doctor’s statement to back up the issue of the care provided keeping the elder out of the nursing home.

**Purchasing a Life Estate:** An elder can purchase a life estate in a child’s (or someone else’s) property and have it be exempt as their residence. The purchase price should be “reasonable” and the **elder must reside there for 1 year**. This could be a troublesome requirement for many elders and mandates caution in the use of this planning technique.
What You Don't Know CAN Bite You

When Long-term Care Medicaid Meets Estate Planning

Often the focus in estate planning is on minimizing estate tax exposure and achieving a fair distribution of assets among potential heirs. For example, clients often know how much "the government" lets them gift tax-free each year, i.e. the annual exclusion of $14,000.00 for 2013. There are a few problems with this knowledge. First, the people citing the rule may not understand that this limit will only impact people with taxable estates. For federal estate tax, taxable estates begin at $5.25 million for 2013, and for Vermont estate tax the starting value is $2.75 million. Second, the idea that this number is a blanket permission from the government obscures the real difference among the rules governing different parts of the government. This I.R.S. gifting rule does not give someone any protection from the zero-tolerance gifting rules that control applications for assistance with long-term care costs through the Medicaid program. Third, even the best estate plan can be destroyed if all of the testator's assets are used to pay for long-term care before the testator dies. Just as people put off their estate planning because, at some level, they fear that thinking about dying makes it more likely to occur, people may not want to initiate a discussion about long-term care. However, the reality is that death comes to us all, and the longer we avoid death, the more likely we are to need some type of long-term care.

I. Long-term Care: what is it and who uses it?

The overall life expectancy in the U. S. has increased by thirty years since the last century, from 49.2 years in 1900 to 77.8 years in 2008. The improvements in life expectancy in the first half of the twentieth century came from public health measures affecting particularly infants and children. Since the 1950s, the increase has been mainly due to prevention and treatment of chronic diseases of adults.¹ People are living longer with diseases that once would

have quickly killed them, but they may need ongoing care and treatment. When a health crisis occurs, there may be new interventions to try to postpone death. This all increases the tendency to need more expensive care, in more intensive settings, for longer periods of time. In 1900, as many as 80% of people in this country died at home. By 1950, about 50% of people still died at home, while the other half died in hospitals. By 2004, 68% of people died in an institutional setting, 46% in hospitals and 22% in a long-term care facility.2

The older someone is, the more likely the person is to need assistance with some daily tasks. Long-term care is an elastic term, covering the medical or personal assistance that a person needs due to a chronic problem or disability. "Activities of daily living" (ADLs) are basic abilities, such as bathing, dressing, toileting, or eating without assistance. Another class of activities, called "instrumental activities of daily living" (IADLs) involve more complex abilities, like cooking a meal, doing housework or balancing a checkbook. A person's difficulties with ADLs or IADLs can impair the person's ability to live independently.

How likely is it that someone turning 65 will need long-term care at some point in his remaining lifetime? What level of care is likely to be needed? How long is care going to be needed for? These are the kinds of questions that people ask as they try to plan for future care. There are some average answers to these questions that appear regularly in articles and fact sheets on long-term care, often without any source given for the information. The common source appears to be a 2005 study ("2005 Study) that used computer simulations and existing data on care needs and use to make predictions to guide policy and personal long-term care decisions.3

The 2005 Study predicted that people turning 65 in 2011 will need an average of three years of long-term care, about two years for men and nearly four years for women. For purposes of the study, long-term care would be needed by people with at least a moderate level of disability, which was defined as needing help with at least one ADL or at least four IADLs.


Needing help with multiple IADLs signals the presence of significant cognitive impairment, such as would be seen in the middle stages of Alzheimer's Disease. Of the three years of long-term care, two years are predicted to be received at home and the remaining year would be received in a care facility, either in an assisted living or a nursing home setting. Looking at average needs does not reflect the large variation in care needs between individuals. About one third of the 65 year olds in the study will never need long-term care. At the other end of the care spectrum, about 1/5 of the group will need more than five years of care.

Most people hope to remain in their own home as they age. Having built a life in a place, people want to continue have their familiar base, even as they adapt to growing older. Giving up the home can become a symbol of the other losses imposed by time. For the one third of people aged 65 that will not ever need long-term care, remaining at home is a good option. Many people who need some degree of long-term care also manage to remain in their homes, mainly with the assistance of family and friends. The 2005 Study predicts that, of those needing long-term care, two thirds will receive that care at home. Three quarters of the care will come from informal supports and only one quarter of the care will be from paid caregivers. The value of the unpaid care received is estimated to be more than $375 billion each year. In 2007 the total amount spent by Medicaid for long-term care services was $97 billion. The long-term care system in this country could not function without the huge contribution of unpaid care.

II. The Cost of Long-term Care

A. Remaining at Home

Allowing for variation in the type of support needed, care at home can be the least expensive and most customized way to receive long-term care. As discussed above, most of the assistance seniors receive at home is provided at no cost by family and friends.

An occupational therapist from a local home health agency or hospital can come to the home and assess how well the home meets the senior's needs. The occupational therapist can

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4 Kemper et al., 2005 at 342-343.

suggest modifications to make the home safer and more manageable. It may just take hiring a carpenter to construct a ramp, to make it possible for someone using a walker or wheelchair to get into the house. More major alterations can cost many thousands of dollars, such as adding a ground floor bathroom to a house that lacks one.

Even a very frail, impaired senior can remain at home if there are sufficient financial resources to pay for the level of care needed. Home health agencies will charge at an hourly rate, starting with a minimum of three hours. In the Burlington area, a client would expect to pay in the range of $20-$25/hour, through an agency that handles the intricacies of payroll, including unemployment insurance and worker's compensation. Agencies generally charge a lower hourly rate for longer blocks of time. A caregiver who spends the night, with a patient who generally sleeps through the night, might cost around $250 for the twenty-four hour shift. Rates may be higher for more difficult care situations. In contrast, a person with advanced dementia who is agitated and wanders at night, might need the services of two full-time caregivers, so that someone is always awake with the person. At a conservative $1000/week/caregiver, with two caregivers, a month of care will cost in the neighborhood of $8,000. This is comparable to the cost of a nursing home.

B. Assisted Living

Across the United States "assisted living" is a broad term that covers the housing plus care options that are between independent living and nursing home care. Genworth, a financial services fund with a long history in long-term care insurance, prepares an annual survey of the costs of long-term in each of the states. Since assisted living facilities can vary so much in the type of living arrangement and the scope of services provided, it is hardly surprising that the monthly cost found in the 2011 Genworth survey ranged from about $2,000/month to over $6,000/month. Often there will be a stepped series of rates within an individual facility. There will be a base rate for someone who is functioning independently. Services are then added on as needed, with associated increases in the monthly rate.

In Vermont, by statute and regulation, a resident in an assisted living facility must have at least a bedroom, a private bathroom and a locking door. The assisted living unit must have a
kitchen area or access to a communal cooking area. The facility must be able to provide help with basic personal needs, such as meals, grooming and mobility. There must be a nurse to supervise care and medication management.

C. Nursing Homes

The cost of nursing home care can quickly run through a senior's savings. In 2011, the Arbors, which specializes in memory issues, was charging $315/day for a private room and $280/day for a double room. The rate at Burlington Health and Rehab, which is a non-specialized facility in Burlington, Vermont, is about $270/day and Starr Farm, a newer facility in Burlington, is about $279/day. That works out to about $8,200 per month, or close to **$100,000 a year**. To pay for that care out of investments earning 5% a year, without invading principal, and with no other source of income, you would need to have about $2 million to invest. **It is the cost of care that makes long-term care Medicaid a middle class issue.**

III. Paying for Long-Term Care

A. Long-term Care Insurance

Long-term care insurance may be part of the solution, but it cannot be the entire solution to the long-term care problem. Take as an example a good quality policy, with 4 years of coverage at $100/day, that has an inflation rider, and assume that the buyer will need care at age 85. If he buys the policy at age 65, the median age for the purchase of LTC insurance, the 20 years of premiums, at $2,560/year will cost a total of $51,200. If he waited to buy the policy until age 75, the premiums and the total cost would be higher: 10 years of premiums at $8,146/year = $81,460. If the buyer needed the full four years of benefits, the insurance company would pay out $146,000.

But remember the insurance is covering less than half the cost of nursing home care!

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6 33 V.S.A. § 7102(1); Assisted Living Residence Regulations, Agency of Human Services, eff. 3/15/2003.

7 33 V.S.A. § 7102(10); Residential Care Home Licensing Regulations, Agency of Human Services, eff. 10/3/2000 (basic care and medication management); 33 V.S.A. § 7102(1); Assisted Living Residence Regulations, Agency of Human Services, eff. 3/15/2003 (additional requirements for assisted living).
Using the $279/day cost of Starr Farm, the buyer would need to spend: $101,000 - 36,500 = $64,500 of his own income and resources each year over what the insurance covered.

Some general considerations in buying long-term care insurance are:

a. It is expensive, so it only makes sense for those with enough income to afford it and enough assets to protect.

b. Flexibility: does the policy allow care in various settings, such as home care, assisted living, and nursing home. Will the policy pay caregivers if they are family members?

c. Consider an inflation/cost rider - what seems like a large monthly payment may not look so big in twenty years when it becomes time to use the policy.

B. Medicare Coverage for Long-term Care is Limited.

In 2009 survey conducted by the MetLife insurance company, 2/3 of their respondents believed that long-term care costs would be covered by Medicare, health insurance or disability insurance. So, while the belief that the familiar Medicare coverage extends to long-term care is not uncommon, the reality is that Medicare provides only limited coverage for limited periods of time.

Coverage for care in a skilled nursing facility (SNF), like a nursing home, is only available if the need for skilled care arises within thirty days after a three day hospital stay. 42 U.S.C, §1395x(i). This requirement is not as straightforward as it seems, since not all three day hospital stays count. If the patient is only in the hospital for "observation", that time does not count toward the three days. The patient must need skilled care on a daily basis for the same condition he was hospitalized for. Skilled care is distinguished from custodial care. The type of care that a nursing home provides to a patient with a chronic condition that precludes independent living, such as advanced Alzheimer's Disease, is custodial, and not covered by Medicare.

If the patient qualifies, the first twenty days of care are fully paid for by Medicare. The maximum Medicare will cover is 100 days. For days 21 through 100, the patient has a co-pay of
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$148.00 (for calendar year 2013).

C. Veterans Benefits

The Veterans Administration has a number of benefits that help seniors. VA benefits fall into two main classes, income assistance and direct care. In particular, the Aid and Attendance Program helps some low income veterans by giving them additional financial support to offset medical and care costs.

D. Long-term Care Medicaid: Choices for Care

Long-term Care Medicaid pays for care when someone has run out of money and needs the level of care provided by a nursing home. The care can be given in a nursing home or in the community. Medicaid will cover the cost of adult day care which can allow people remain out of institutions even as their care needs rise. Medicaid will be dealt with in more detail below, and in other sections of the seminar.

E. Reverse Mortgage

Reverse mortgages are useful for allowing a senior who owns a home to use the equity in the home to remain at home. Once the mortgage is approved, the senior can elect monthly payments or take money out as needed. Interest is charged on the money borrowed. The mortgage does not come due until the home is sold, or the senior moves out of the home, or dies.

There is mandatory counseling from a government approved counselor - who is not employed by the lender. The counselor's job is to make sure the senior understands the cost of borrowing against the home. If the senior intends to leave the home to his children, he must understand that the home will still be subject to the mortgage after he dies. At that point the children would have to pay off the loan, either from their own resources or by refinancing the property.

Reverse mortgages have a privileged position with respect to long-term care Medicaid. As long as the money is spent in the month it is withdrawn, it will not change the Medicaid status of the individual. It is neither countable income nor a countable resource for Medicaid. This
means that the senior can receive Medicaid assistance at home, and also have access to the cash from the reverse mortgage. While long-term Medicaid only pays for a limited amount of home care, the reverse mortgage can be used to pay for whatever additional care that the senior needs to remain at home.

IV. Talk to your clients about consulting a care manager

When a client comes to an attorney for help with long-term care issues, the kind of help the client needs will be tightly tied up with the care needs of the client. However, attorneys rarely have the knowledge and experience to guide clients and families through the intricacies of care decisions. There may be a number of choices to make about where someone should receive care, assessing the quality of those options, and their financial feasibility. Then there are clinical considerations, such as diagnosis and likely prognosis. There are psychological issues; often unresolved problems in the family resurface under the stress of a parent's illness. This is where a care manager can save the senior, the family and the legal advisor from drowning in a sea of complexities.

A geriatric care manager will have a degree in social work, psychology, nursing, gerontology or another human services field. By training and experience the care manager should be able to evaluate the senior's needs, determine what the senior wants, and use all available local resources to help the senior live safely in his preferred setting. Even if a private care manager is hired by the family, the care manager's first loyalty should be to the senior, as a resource and an advocate. The first thing that the care manager does is find out what the senior's abilities and limitations are. Can the senior walk unassisted or does the senior have poor balance, weakness and a high risk of falling? What is the senior's mental status? Can the senior direct his own care givers or does he need someone else to take charge of interviewing, hiring, training and supervising the care? Are there family members nearby who are willing and able to be part of a care team or do the children live many hours away? In some situations, the care

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8 National Association of Professional Geriatric Care Managers (NAPGCM), Standards of Practice, as revised through December, 2011 (Standard 1: "The primary client is the person whose care needs have initiated the referral to the geriatric care manager." Standard 2: "Geriatric care managers should promote self-determination of the primary client as appropriate within the context of their situation.").
manager becomes the absent child's avatar, doing what the child would do, if the child were living closer. The care manager may provide or arrange for companion services or medication management. The range of tasks can be from the short term and relatively impersonal, such as advice on different assisted living options for a competent senior, to intimate and long-term, helping a fragile senior remain at home and then serving the family as a bereavement counselor after the parent's death.

V. Long-term Care Medicaid for Individuals

A. Medical Eligibility

Choices for Care is the name for the Vermont Medicaid long-term care program which covers a nursing home level of care, whether it is provided in a nursing home or in a community setting. Medicaid is a state and federal program. Originally, federal law only permitted long-term care Medicaid for care in nursing homes. Most people would like to avoid living in a nursing home and nursing home care is very expensive for the state. So, Vermont asked the federal government to allow it to "waive" particular program requirements, and allow more coverage for long-term care in community settings. The intent of the Choices for Care waiver program was to remove the bias towards institutional care that long-term care Medicaid began with.

Once a person is eligible for Choices for Care, the recipient can receive care in one of three settings: (1) nursing home, (2) home-based, and (3) enhanced residential care (ERC) in an assisted living facility or residential care home. The Program for All-Inclusive Care for the Elderly (PACE) used to be a fourth option, but PACE found that it was not financially possible to run the program in Vermont.

Medicaid pays a nursing home for care it provides at a set daily rate, specific to that nursing home. When care is received at home, a care plan is developed that includes a certain number of service hours each week, including respite hours for a family caregiver. A plan might include a total of 30 or 40 hours of services each week. The home-based program is usually not enough for someone who does not have additional assistance, such as a family member who can provide care on evenings and weekends. The home care program is also not a good choice when
the recipient needs round-the-clock supervision, such as a person with Alzheimer's Disease who gets up and wanders at night.

The ERC program was developed to allow someone in an assisted living setting to remain there, rather than having to go into the less pleasant nursing home environment, as the person's care needs increase. The ERC benefit only covers the medical portion of the assisted living fee. The ERC recipient must continue to pay privately for the room and board portion of the assisted living fee.

Whether care is received in the community or in a nursing home, the requirements under Choices for Care are the same. An applicant must satisfy both medical and financial requirements. The same form is used to start both sides of the process. The form is called "Application for Choices for Care Long-Term Care Medicaid", ESD/DAIL form 202LTC (R 3/11). There is a tension between the two sides of eligibility. Why should a family assemble and divulge detailed financial information to the state, if the applicant may not be medically eligible? On the other side, the nurses who make the medical eligibility determinations do not want to waste time evaluating someone who is unlikely to meet the financial requirements. Under some circumstances, it may make sense to fill out an application with very little financial information, just to get the medical eligibility determination made.

The application form and supporting documentation are sent to the Central Application and Document Processing Center in Waterbury to be scanned into a central system. This was a new system when Tropical Storm Irene hit. Applications should still be sent to the Waterbury address - but then the applications are transported to the temporary offices in Williston for scanning. The eligibility determination still occurs in the local district office of the Economic Services Division of the Vermont Department for Children and Families (ESD/DCF), working from the scanned image. A Benefit Programs Specialist in the district office reviews the financial information. The Benefits Programs Specialist also prints out part of the application and sends it a Long-term Care Clinical Coordinator (LTCCC) for the district. The LTCCC's job is to determine the whether the applicant meets the medical eligibility requirements. The LTCCC is registered nurse employed by the state, under the Department of Aging and Independent Living (DAIL), who visits the applicant at home or in the care facility to assess the
applicant's care needs.

There are three medical eligibility categories under Choices for Care: Highest Need, High Need and Moderate Need. If the applicant is found to be Highest Need, the LTCCC has determined that the applicant needs the level of skilled nursing care that a nursing home would provide. All Highest Need applicants who meet the financial and other requirements for Long-term Care Medicaid receive benefits, as an entitlement. However, an applicant with serious health problems might be found to be only High Need. It is more a difference of the amount of care than of the type of care or the diagnosis. Where a High Need person might require extensive, daily help with one activity of daily living (ADL), such as bathing, dressing, eating, walking or toileting, the Highest Need person would need assistance in more than one of these areas. A person who needs skilled nursing every day, such as for wound care, could qualify as Highest Need but a person who needs skilled nursing visits only twice a week would be High Need. A High Need person might not be able to live alone, independently, but could function well in assisted living or home with part-time care givers. While these options are less costly than nursing home care, they can still cost several thousand dollars each month. Even so, a Medicaid applicant judged to be High Needs will only be helped if the Choices for Care program has the funds available. Those with still fewer care needs, in the Moderate Needs category, also receive assistance only when funds are available, and after the High Needs group has received assistance. The hope was that Medicaid would see overall expenses for long-term care decrease as fewer Highest Need people opted to receive the most expense category of care, i.e. nursing home care. Those savings would then be used to extend the program to people with less intense, but still costly, care needs.

B. Long-term Care Medicaid: Financial Eligibility - Resources

Unlike other states, Vermont Medicaid uses identical financial eligibility criteria for its nursing home and community long-term care programs. This was true even before the programs were brought together under the umbrella of Choices for Care. There are separate rules governing resources and income. If a potential applicant has more resources than the program permits him to have, he can pay privately for care until his resources are low enough to qualify for Medicaid assistance. This is called "spending down." There are other options which allow a
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Medicaid applicant to preserve some assets with or for his spouse, children or other trusted people.

While the medical side of eligibility determination is under the Department of Disabilities, Aging and Independent Living (DAIL), the financial eligibility determination is made by the Economic Services Division of the Department for Children and Families (ESD/DCF). Hard copies of the Rules are available for purchase from DCF for $150. The hard copies will be re-issued yearly. The updates to the rules during the year are available online. You can sign up to receive notification of rule updates via e-mail through http://dcf.vermont.gov/esd/rules. This is also the web address for finding Proposed, Adopted and Expedited Rules. You can also telephone DCF in Waterbury at (802) 241-2100 for more information.

1. **Resources: Countable and Non-Countable**

The basic rule is that the Medicaid applicant can only have $2,000.00 in countable resources. P-2420 (C)(1). There is an additional resource allowance for a single person receiving long-term care in the primary residence owned by the recipient. Such an individual can keep an additional $3,000.00, for a total of $5,000.00. Rule 4249.9. This accommodation was made to allow the Medicaid recipient to have some savings for larger expenses, such as property tax payments, that go along with home ownership. If the applicant is married or has a civil union partner, the applicant is still limited to $2,000.00 in resources, but the spouse can keep up to $115,920.00 in countable resources without jeopardizing the applicant's eligibility. Rule 4265; P2420 C3. This amount usually changes, increasing yearly. However, if both spouses need long-term care Medicaid, then the couple can only keep a total of $3,000.00 in countable resources.

The Medicaid regulations provide that anything that is not explicitly excluded (non-countable) is a countable resource that contributes to the resource total. Rule 4250. The two most common non-countable resources are a primary residence and automobiles. Rule 4241.1; Rule 4248.2. Prior to the enactment of the Deficit Reduction Act of 2005 (DRA), a home and contiguous property of any value was excluded. The DRA required states to limit the equity
value excluded to either $500,000.00 or $750,000.00. Vermont chose the lower amount. Rules 4241.1 and 4252.6. The amount is supposed to increase in increments of $1,000.00 following the consumer price index. So, effective January 1, 2013 the excluded equity value is $536,000.00. P2420 C4.

The vehicle exclusion is not limited to one car or a car of a certain value. Generally, boats or recreational vehicles are not covered by this exclusion. However, if the applicant lives on an island and the only way to get to medical care is to travel by boat, then the boat would be excluded. Household items, such as furniture and appliances are not countable either. Rule 4248.1. There are other exclusions that apply to income-generating assets, such rental properties or annuities. Rule 4241.7; Rule 4244. The Medicaid applicant can set up an account for burial containing up to $10,000.00. Rule 4243. Each exclusion rule has its own specific requirements that must be followed exactly or the exclusion may not apply, resulting in a denial of Medicaid eligibility.

2. Resource History and Current Eligibility for LTC Medicaid

Not only must the applicant be currently eligible for Medicaid at the time of application, but the applicant, or couple, must not have done anything prior to submitting the application that would delay eligibility. (See Jonathan Secrest's portion of the materials.)]

C. Long-term Care Medicaid: Financial Eligibility - Income

There are long-term care Medicaid income standards. They are somewhat convoluted. Generally, someone who requires long-term care would not be prevented from receiving long-term care Medicaid assistance due to income. If a person has more income, Medicaid will just require him to pay a greater share of his medical costs.

Consider a simple situation, where the person has monthly income below the amount that Medicaid would pay that specific nursing home for a month of care. That person turns over all of his income, less allowed deductions, to the nursing home. The amount the patient pays to the nursing home is called the "patient share." The nursing home then bills Medicaid for the difference between what the person has paid and the Medicaid rate. Things can get more
complicated if the person's income is not high enough to pay for care without Medicaid assistance, but is not low enough to be below the Medicaid rate for the particular nursing home. Medicaid will recalculate the patient share monthly is such a case, which is an administrative headache for all concerned.

The "patient share" is the amount that Medicaid determines a Medicaid recipient must pay toward his care costs. The calculation starts from the recipient's gross income. A person in a nursing home is allowed to keep $47.66 of his monthly income as a "personal needs allowance". Rule 4462.1; P-2420 B 6. For a person at home or receiving Enhanced Residential Care, there is a community maintenance allowance of $1,058.00 per month. P-2420 D 10 (1/1/13). The difference between the amount set for the personal needs allowance and the community maintenance allowance is that the recipient's room and board are already taken care of in a nursing home.

All health insurance premiums are allowed to be deducted from income. This makes sense because it saves the state money. If a Medicaid recipient needs physician services and has Medicare Part B, federal dollars pay the doctor. If the person has private insurance, private dollars are used. The doctors tend to prefer Medicare and private insurance since the reimbursement rates to providers are higher than what Medicaid pays them. So, there are specialists that the Medicaid recipient can only work with if he has some additional insurance. From the patient's point of view, continuing to pay Medicare or private insurance premiums is a cost-free way to get access to a wider choice of providers. If the Medicaid recipient stops paying Medicare or private insurance premiums, he does not end up with more available income. His patient share just gets increased to make up the difference.

For example, consider a single person with $2,000.00 per month of gross income. He has Medicare Part B, which has a standard premium of $104.90 for 2013. He has a supplemental Medigap insurance policy for which he pays quarterly premiums of $450.00. He is receiving his care in a nursing home. His patient share would be calculated as follows:

<table>
<thead>
<tr>
<th>Gross income</th>
<th>$2,000.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B premium</td>
<td>- 104.90</td>
</tr>
</tbody>
</table>
VI. Qualifying a Spouse for Long-term Care Medicaid

A. Resource Allowance for the Medicaid Recipient's Spouse

If the applicant is married, or has a civil union partner, then the couple can keep additional resources. In 1988, Congress tried to extend Medicare coverage to long-term care in the Medicare Catastrophic Coverage Act (MCCA). Although most of the provisions of MCCA were repealed, among the provisions that survived are the ones intended to prevent the impoverishment of the spouse remaining at home, when the other partner needed Medicaid benefits to pay for nursing home care. See 42 U.S.C. §1396r-5.

As of January 1, 2013, a couple can have a total of $117,920.00 in countable resources at the time of application, and have one spouse qualify for long-term care Medicaid benefits. The spouse who is applying for Medicaid benefits is referred to as the "institutional spouse" (IS), a term that was created when all long-term care Medicaid recipients received care in a nursing home or other institution. The spouse who does not require Medicaid help is called the "community spouse" (CS). The $117,920.00 resource total is really the sum of the $2,000.00 that the Medicaid recipient can keep and the $115,920.00 that the spouse can keep. The spouse's amount is called the Community Spouse Resource Allowance (CSRA, see below). The Community Spouse Resource Allowance is adjusted upward by the federal government each January. For simplicity, the IS will be referred to in these materials as "he" and the CS will be "she".

At the time of the application, Medicaid (i.e. ESD/DCF) looks at the total resources of the couple without concern for which spouse owns the resource. However, each year, the recipient's eligibility is reviewed. Any assets owned by the Medicaid recipient and someone else are presumed to belong solely to the Medicaid recipient. Rule 4251. Many couples have all of their
assets in joint ownership. In that case, by the first annual review, each of the assets must be re-titled, removing the Medicaid recipient's name so that he does not exceed the $2,000.00 limit. Usually at the end of the re-titling the Medicaid recipient has one bank account, jointly held with a spouse or trusted child, that receives his direct deposits of Social Security benefits and other income.

Other states use different methods for determining the assets that the community spouse is allowed to keep. In this, as in other specifics of long-term Medicaid eligibility, it is crucial to remember that Medicaid is both a federal and a state program. There can be huge differences from one state to another, which can trap the unsuspecting client or attorney.

B. Spousal Income Allocations

When Congress created the provisions to prevent spousal impoverishment under Medicare Catastrophic Coverage Act (MCCA) in 1988, it was concerned with the income, as well as the resources, of the community spouse. Then, as now, most of the community spouses were women and many of them did not have significant work histories outside the home. They relied on their husband's Social Security and pensions, since they might have little income from these sources themselves. Congress set up specific provisions to allow the community spouse to receive some or all of the institutional spouse's income. 42 USC §1396r-5(d).

If the community spouse or civil union partner has little income of her own, or has unusually high shelter expenses, she will be allowed to keep a portion of the Medicaid recipient's income each month. This is called a spousal allocation. The spousal allocation is also subtracted from the Medicaid recipient's gross income in determining his patient share. For example, if a person with same income and deductions as the person in the patient share example, above, also had a spouse, and the spouse's income allocation was calculated to be $1800.00, there would be a patient share of zero, since $1697.44 minus $1800.00 is less than nothing.

VII. Estate Recovery

1. The Basic Rule

By federal law, each state must have an estate recovery program to recover the
cost of long-term care expenses that have been paid by Medicaid for individuals aged fifty five and older. The states have the choice of limiting the pool of assets they can recover against to the probate estate of the deceased Medicaid recipient or of including other assets in an "expanded" estate recovery. The idea of a broader definition of estate is somewhat similar to how the I.R.S. defines estate assets in determining estate tax liability. For example, for federal estate tax purposes non-probate assets like life insurance proceeds are considered part of the taxable estate. Vermont limits its estate recovery to probate assets only. Rule 7108.3. When a Vermont probate court opens an estate, it sends a notice to the Estate Recovery Unit in the Office of Vermont Health Access. The Estate Recovery Unit calculates how much is owed to the state.

2. Special Rules for the Home

The primary residence gets special treatment in a number of ways. Under the transfer of assets rules the home can be transferred, without creating a penalty period, to certain family members. Rule 4473.2. Any asset can be transferred to the spouse of the Medicaid applicant/recipient without penalty, before the initial eligibility determination. Rule 4473.3 B. Transfers to children who are blind or permanently disabled are not penalized. Rule 4473.3 C. In addition the home may be transferred to a child under the age of twenty one, to a sibling who has had an equity interest in the home and resided there for at least a year before the Medicaid recipient started to receive covered services or to a "caregiver child". The caregiver child must have lived in the home for two years and provided care to the Medicaid recipient that delayed the need to the Medicaid covered services. Rule 4473.2. When transferring the home to one these Medicaid-favored people, remember that the tax rules do not give these people any special breaks. As with any gift, the donee takes the donor's basis. So, if the house has appreciated significantly while owned by the Medicaid recipient, the donee may get a large capital gains tax liability along with the home.

There are also special exceptions to estate recovery for the primary residence. Some of these echo the transfer exceptions. There is no estate recovery for any assets during the lifetime of the surviving spouse, children under the age of twenty one or children who are blind or
disabled, as defined by the Social Security Administration. Rule 7108.3. For the primary residence, there is no estate recovery against the home if the Medicaid recipient's surviving sibling has been living in the home for at least one year before the decedent began receiving Medicaid long-term care services. Rule 7108.3.2 A. There is a general exemption to allow a caregiver child to inherit the home. A caregiver child must have lived in the home, providing care for the decedent that allowed the decedent to remain at home and delayed the need for Medicaid long-term care services, for at least two years. Rule 7108.3.2 B. In addition, there is a hardship exception for a child or grandchild who has provided medical services or financial assistance that delayed the decedent's need for Medicaid long-term care services for at least six months and has a gross family income below 300 percent of the federal poverty level. Rule 7108.3.2 C. Under this hardship exemption only the first $250,000.00 of the home's value is exempt from estate recovery.

3. Keeping the Home Out of the Probate Estate

If the primary residence is never part of the Medicaid recipient's probate estate, then it is not subject to estate recovery. When changing the ownership of the house to avoid estate recovery be mindful of the transfer of asset rules, so that solving one problem does not create another! (See Michael Caccavo's materials)
TRANSFERS AND MEDICAID PLANNING

A. Gifts

In general, any gifts made for less than fair market value within five years prior to the date of application for Medicaid result in a penalty period of ineligibility for the applicant. See Rule 4474. Spending good—gifting bad. Each gift triggers a new penalty period as to that gift. The penalty period is equal to the total value of the disallowed transfers divided by the average monthly cost to a private patient of nursing facility services as of the date of application. See Rule 4472.2.

Remember that deeding an interest in real estate (other than through a “Medicaid” or “Lady Bird Johnson” deed) may constitute a gift triggering ineligibility. For example, deeding a property to a child but retaining a traditional life estate is the gift of a remainder interest to which the Department will attach a value. See Rule 4252.2.

If an applicant has disclaimed any property such as an inheritance, that is a gift. Similarly, forgiveness of a documented loan may cause ineligibility.

IRS rules provide for an annual gift tax exclusion of $14,000.00 (in 2013) per beneficiary. However, Medicaid rules provide for no such exclusion, and in general any gift of any amount will result in a penalty.

If others were merely added to a bank account, it is not considered a gift, and does not trigger a penalty period. However, all of the funds in the count are considered to belong to the applicant even if the applicant is only a partial owner (unless it can be shown that the other owners contributed to the account). See Rule 4247.

For a client with at least five years of funds available for a nursing home, triggering the five-year clock by gifting a portion of funds to children may be a feasible way to “hedge” against loss of the whole to nursing home costs. Such a gift might be an outright gift, or possibly to an irrevocable trust. The latter helps to protect against the gift recipients losing the money (e.g., because of divorce, lawsuit, or mere irresponsibility) and being unable to return it if necessary. Irrevocable trusts can also allow for an ongoing income stream to the donors.

B. Dealing with the fallout of gifts previously made

Gifts may be “undone” by having them returned to the applicant. See Rule 4472(D). Thus, a child who was deeded property may undo the gift by deeding it back. Or money can be returned (hopefully!)

Alternatively, the beneficiary may demonstrate by “convincing evidence” that the resources were transferred exclusively for a purpose other than to become or remain eligible for long-term care. For example: (1) the transfer was not in the individual’s control (e.g., ordered by a court); (2) the individual could not have anticipated long-term care eligibility then, such as a
car accident leading to injury; or (3) diagnosis of a previously undetected disabling condition. See Rule 4473.

If all else fails, the applicant may apply for eligibility notwithstanding a prior gift, due to undue hardship. Undue hardship means “depriving the individual of medical care such that the individual’s health or life would be endangered; or of food, clothing, shelter or other necessities of life such that [they] would be at risk of serious deprivation.” Rule 4474.4. However, if an applicant is residing in a nursing home and is denied eligibility due to a transfer but has nowhere to go, the facility may not be allowed to release the resident, resulting more in harm to the facility than to the individual.

C. Other Issues

(1) Importance of Questionnaire

a. Having clients answer questions in writing for your file such as, “Have you made gifts to anyone within the last five years” is important both to remember to ask it, and to protect yourself.

b. Questionnaire as a forcing function to get clients to really look into what they have. (Life insurance? Annuities? Portfolio allocation? Veterans benefits?)

c. Ask clients if they anticipate an inheritance (from parents? From aunt/uncle/sibling?) Or have they named someone in their will who might be receiving Medicaid?

d. Ask about long-term care insurance

(2) Importance of focusing on beneficiary designations

(3) Whether to name spouse in the community spouse’s will

(4) Care contracts

(5) Don’t exhaust retirement accounts first

(6) Consider getting advice of elderlaw attorney, or referring where appropriate
V. Supplemental Needs Trusts

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an organization accredited by the American Bar Association)

I. First Party and Third Party Trusts

A. Introduction

Because two of the most common benefit programs available to persons with disabilities, SSI and Medicaid, are means-tested programs, it is important to consider the financial impact on a beneficiary of assets owned, acquired or inherited by such a beneficiary. Before 1985, some individuals attempted to set up discretionary trusts using their own funds without losing their eligibility for public benefit programs. These attempts rarely met with success. Courts held that assets held in self-settled discretionary trusts were available to the settlors and their creditors, including the state that provided the benefits these people were trying to protect. See, e.g., Vanderbilt Credit Corp. v. Chase Manhattan Bank, 473 N.Y.S. 2d 242 (A.D. 1984). In 1985, federal legislation declared such self-settled discretionary trusts to be against public policy. The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) provided no creditor protection to these trusts and the principal and income were deemed to be available to the settlors of such trusts. However, after COBRA, practitioners developed self-settled non-discretionary trusts that did protect the trust assets from being deemed available to the settlors. Only the distributions that were mandated by the trust could be considered by the state agencies.

The result of this development was that a settlor could establish an irrevocable trust and receive income from the trust. As long as the income from the trust was less than the income limits on public benefits, the principal of the trust and its undistributed income were not considered available to the settlor and therefore, to the state. Settlors could thus
protect the principal of the trust for their ultimate beneficiaries and provide an inheritance for their families.

Following the 1985 Act, Congress perceived that such self-settled trusts were abusing the Medicaid program. To correct that perception, Congress included in the 1993 Omnibus Budget Reconciliation Act of 1993 (“OBRA-93”) a new definition of trusts that disqualified their beneficiaries from public benefits.

However, the redefinition contained in OBRA-93 also included criteria for creating trusts that do not disqualify disabled beneficiaries from receiving public benefits. See Section 1917 (c) and (d) of the Social Security Act, 42 U.S.C. § 1396p (c) and (d): http://www.ssa.gov/OP_Home/ssact/title19/1917.htm

Such trusts have to be lawful under the laws of the state in which they are created and also have to comply with state Medicaid regulations and federal agency interpretations of federal law found in the State Medicaid Manual. These OBRA-93 trusts are frequently called Special Needs Trusts or Supplemental Needs Trusts. They will be referred to interchangeably in this section as SNTs. There are two primary types of self-settled SNTs. They are often referred to as (d)(4)(A) and (d)(4)(C) trusts for the statutory sections that authorize them (42 U.S.C. § 1396p). A (d)(4)(A) trust must contain a provision to repay Medicaid at the death of the beneficiary for the cost of services it paid for the beneficiary’s benefit during his or her lifetime. A (d)(4)(C) trust is often referred to as a pooled trust. Further discussions of these two types of trusts are in sections E and F, below. Self-settled trusts are very different than third party trusts, which will be discussed in section H. The primary distinction is that third party trusts do not contain assets of the beneficiary.

B. SSI and Medicaid Requirements

An individual may qualify for Medicaid directly or as a result of qualifying for Supplemental Security Income (“SSI”) through the Social Security Administration (“SSA”). The Supplemental Security Income program was signed into law in 1972 by
President Nixon to address gaps in federal benefit coverage for the aged, blind and disabled who had not been able to work a sufficient amount of time to qualify for benefits under the Social Security Act and who were poor. Before the SSI program was enacted, only state welfare programs provided cash income to such beneficiaries. In order to be eligible for SSI, an individual may have up to $2,000 in available resources and a couple may have up to $3,000. In addition, a person or couple is allowed to have a homestead, without any limitation on value, household goods, a car, and each individual can have a burial fund with not more than $1,500 in it.

The trust provisions of OBRA-93 also pertain to eligibility for SSI. The Foster Care Independence Act of 1999 (“FCIA”) (P.L. 106-169) changed the SSI rules for trusts, effective January 1, 2000. 42 U.S.C. 1382b. Section 205 of this law provides, generally, that trusts established with the assets of an individual (or spouse) will be considered a resource for SSI eligibility purposes. It addresses when earnings or additions to trusts will be considered income. The legislation also provides exceptions to the general rule of counting trusts as resources and income. The FCIA specifically exempts OBRA-93 special needs trusts and pooled trusts from being considered an available resource and provides that transfers to fund such trusts by an individual under age 65 will not incur a transfer penalty. In many ways, the SSI rules for SNTs are more restrictive than the Medicaid rules. The SSA will review SNTs for beneficiaries who are receiving both SSI and Medicaid, but only after the SNT is created. The Social Security Administration’s Program Operations Manual System (“POMS”) is an exhaustive set of regulations dealing with many issues, among them, SNTs. See, e.g., POMS SI 01120.200, SI 01120.201 and SI 01120.203. The POMS may be found online at http://policy.ssa.gov/poms.nsf/aboutpoms.

There are critical elements required to establish a SNT under 42 U.S.C. § 1396p (d)(4)(A) that are contained in the following paragraph from the statute:

A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3) [of the Social Security Act]) and which is established for the benefit of such individual by a parent, grandparent, legal
guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.

The Social Security Administration has included additional criteria for approval in the POMS that are not apparent from the statutory language:

- **Disability**—There is no requirement that the disabled individual have been determined to be disabled before the trust was created. That determination can be made when the trust is funded and submitted to SSA for approval. POMS SI 01150.121.

- **Sole benefit requirements**—Until a few years ago, there were some SSA Regional Counsel who took the position that payment of taxes, trustee fees or other administrative expenses violated the requirement to repay Medicaid first. Since the Medicaid repayment is only accomplished after the death of the beneficiary, it would be impossible to administer the trust. The POMS were amended to clarify that the “sole benefit” requirement is not violated if certain administrative expenses are paid during the life of the beneficiary and certain others after death, but before repayment to Medicaid. The prohibited and allowable expenses are found in POMS SI 01120.203.B.3.

- **Doctrine of Worthier Title**—Some of the SSA Regional Offices (including the Boston Region, which includes Vermont) have published regional instructions to guide staff in evaluating trusts. These instructions describe what is necessary to have an irrevocable trust under state law. A recent change to the Boston Region POMS indicates that a Vermont trust may provide that assets will go to “the heirs of John Smith” or the “Estate of John Smith.” See POMS (SI BOS01120.200.D.3). This is a change from the prior practice of the SSA, which would disqualify a Vermont trust if
the beneficiary's heirs were contingent beneficiaries. Note that the State as a creditor does not constitute a beneficiary.

- Funding by Competent Adult Beneficiary—Until the issuance of the new trust POMS by SSA in January, 2009, it was unclear whether an adult beneficiary of a Supplemental Needs Trust who had capacity could fund his or her own trust. The new POMS make it clear that it is permissible for the person "whose actions created the trust" to seed it with a token amount, like $10.00 or $25.00, and have the adult beneficiary transfer his or her own assets to the trust. SI 01120.203 B 1 f. This clarification will make it easier to fund a trust and will eliminate the necessity of establishing a guardianship for an adult beneficiary with capacity.

The Vermont Department for Children and Families may be helpful in reviewing SNTs before they are signed. Contact Robin Chapman, Attorney/Policy Analyst, at 802-279-3996 or at robin.chapman@ahs.state.vt.us. A new procedure adopted by DCF calls for all SNTs to be sent for scanning to DCF/ESD, ADPC, 103 South Main Street, Waterbury VT. 05671.

C. The (d)(4)(A) Trust

One important thing to keep in mind is that a (d)(4)(A) Trust cannot be established for a person aged 65 or older. This means the trust must be in place and funded before the beneficiary reaches his or her 65th birthday. While the trust can continue after the individual turns 65, additions to the trust cannot be made after that birthday without counting as income to the beneficiary. In the case of a structured settlement annuity in place before the beneficiary reaches age 65, payments can continue to be made after the beneficiary turns 65. The other salient characteristic of a (d)(4)(A) Trust is that there is a mandatory payback to the State at the death of the beneficiary. The amount to be paid back from trust assets is an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan.
D.  The (d)(4)(C) Trust

In a (d)(4)(C) Trust, the trust is established and maintained by a non-profit association. A separate account is maintained for each beneficiary of the trust, but the trust pools these accounts to invest and manage the assets. Accounts in the trust are established by a parent, grandparent, or legal guardian of such an individual, by the individual himself or herself (a difference from the (d)(4)(A) trust), or by a court. The trust must be for the sole benefit of the disabled individual. If there are amounts left in the beneficiary’s account at his or her death, some or all of them may be retained by the non-profit sponsor. If they are not retained, the trust pays the State back, much as in a (d)(4)(A) Trust situation. The (d)(4)(C) Trust is very similar to the (d)(4)(A) Trust.

While there is no requirement that the beneficiary be under the age of 65 in the federal law, the Center for Medicare and Medicaid Services and many states now consider amounts put in a (d)(4)(C) Trust for someone over 64 to be a non-exempt transfer of resources. The Vermont regulation, M 4473.1, formerly M 440.31, is unclear on this point, but DCF is interpreting the regulation to prohibit people over 64 from establishing (d)(4)(C) trusts. Unlike (d)(4)(A) Trusts, the individual whose assets are being transferred to the pooled trust may establish the trust himself or herself. One pooled trust that is available to Vermont residents and has been approved (informally) by DCF is Enhanced Life Options, located in Bedford, NH. See www.elonh.org. Nina Hamberger is the Executive Director and is very helpful. She can be reached at (603) 524-4189.

E.  The (c)(2)(B) Trust

In 1988, the Medicare Catastrophic Coverage Act added provisions that allowed an individual to transfer assets to certain individuals without penalty. These included transfers to the individual’s spouse or to another for the sole benefit of the individual’s spouse, to a blind or disabled child or to a trust for the benefit of such a child. 42 U.S.C. § 1396p (c)(2)(B). In 1993, OBRA-93 added subsection (iv) to (c)(2)(B). Subsection (iv) allowed a transfer to a trust established solely for the benefit of an individual under the
age of 65 who is disabled (as defined in section 1382c(a)(3) of the Social Security Act). The amendment included a (d)(4)(A) trust in subsection iv.

The effect of this provision is to allow a third person to transfer assets to a trust for a disabled person without being penalized for the transfer. Creating the trust will not disqualify the donor from receiving Medicaid benefits if he or she is otherwise eligible for them. This can be very helpful for a person applying for long-term Medicaid benefits who has a family member or friend with disabilities.

The trust must either be a (d)(4)(A) trust and provide for a payback to Medicaid after the death of the beneficiary or must be for the sole benefit of the disabled individual and must provide for spending the funds on an actuarially sound basis determined by the life expectancy of the beneficiary. Health Care Financing Administration (HCFA) Transmittal Letter 64, §3257.6. http://www.sharinglaw.net/elder/Transmittal64.htm

One question that arises is whether naming a remainder beneficiary violates the law. This possibility would arise where the trust is not a (d)(4)(A) trust, but a (c)(2)(B) trust that is actuarially sound. An examination of the State Medicaid Manual, Transmittal Letter 64, §3257.6, leads to the conclusion that the trust must contain a payback provision to Medicaid following the beneficiary’s death or provide for distributions that are actuarially sound based on the sole beneficiary’s life expectancy in order for a remainder beneficiary to be named without disqualifying the trust. A recent exchange with the attorney for policy decisions at DCF confirmed the option for (c)(2)(b) trusts.

A (c)(2)(B) trust could be a Qualified Disability Trust, which would provide favorable tax treatment by allowing the trust the equivalent of the individual personal income tax exemption each year instead of the $300 simple trust exemption. See §642(b)(2)(c) of the Code. http://www.law.cornell.edu/uscode/text/26/642

F. Third Party Trusts

A third party SNT is a special needs trust established by one person for the benefit of another and funded with assets that do not belong to the beneficiary. The purpose of a third party SNT is to preserve public benefits for the beneficiary while using the trust
funds to enhance the beneficiary’s lifestyle. A key issue in creating a third party SNT is whether or not the funds in the trust are “available” to the beneficiary. If the income from the trust is considered available to the beneficiary, he or she may be driven over the income limit for the applicable program.

 Relatives of disabled children have several options in considering estate planning for the child with disabilities. They can disinherit the child, distribute assets directly to the disabled child, distribute assets to siblings or others with the understanding that the beneficiaries will use the inheritance for the benefit of the disabled child or distribute assets to a special needs trust.

 Disinheriting the child may be an option if the estate is small and there is not enough money to make a meaningful difference in the child’s life. Leaving the disabled child an inheritance may result in the reduction or elimination of government benefits that are means-tested. Medicaid, SSI or federally assisted housing may become unavailable. Medicaid is especially important because it provides health coverage for the child. If the child is a patient in a public institution and inherits money, the State may not only charge the child for his or her care, but seek to be repaid for past care.

 Leaving money or assets to a sibling or other relative with the understanding that it will be used for the benefit of the disabled child can be risky. The assets are subject to misappropriation by the relative or loss to creditors or in a divorce.

 The fourth option is to leave the inheritance to a special needs trust. A properly drafted special needs trust allows individuals on means-tested programs to retain their benefits. It also provides management of assets by a qualified trustee, instead of risking loss because of the disabled child’s lack of ability to manage money. A special needs trust is designed so that the assets are not “available” to the disabled child. The child cannot compel distribution and it is set up as a discretionary spendthrift trust.

 A special needs trust can be set up as an *inter vivos* trust. An advantage of an *inter vivos* trust is to provide a vehicle for grandparents or other relatives to leave money for the person with disabilities. If the parents are divorced, it provides an opportunity for each of them to leave money for their child without an inordinate amount of concern that
the other parent will misappropriate the money, since if that parent is acting as trustee, he or she will have fiduciary obligations.

A third party trust can be revocable or irrevocable from its inception, but will become irrevocable at the death of the grantor. Having the trust be revocable will avoid the necessity of filing fiduciary income tax returns as long as the grantor is alive. A trust can provided that the trust will become irrevocable after it has received a certain amount of assets. Making the trust irrevocable from the beginning is favored by many lawyers who focus on preparing SNTs.

The lawyer creating a third party SNT should take income, gift and estate tax issues into consideration. Some income tax rules pertaining to third party SNTs are, first, that all transactions should be reported under the taxpayer ID for the trust, not the grantor’s or beneficiary’s social security number; second, if the trust is a grantor trust, it reports net income distributed to a beneficiary via a Schedule K-1; and, third, the beneficiary’s income tax returns will reflect income at lower individual tax rates. Filing an income tax return for the beneficiary will not, in and of itself, impair benefit eligibility, but the SSA reviews IRS income tax data by Social Security Number, which can generate a notice to the beneficiary to explain the income reported; and the trustee must be able to show that income amounts were distributions made for extra and supplemental items.

Federal Medicaid law only allows assets of a spouse to be put into an SNT for the other spouse’s benefit through a will, rather than an *inter vivos* trust. If the couple has planned with revocable living trusts, provisions can be inserted to allow the trustee to pay assets over to the Personal Representative of the deceased spouse’s estate to allow the funding of a testamentary special needs trust. A testamentary special needs trust may be subject to the surviving spouse’s rights to an elective share. There is no law in Vermont stating that a testamentary special needs trust satisfies the state’s elective share law. Therefore, if the surviving spouse is receiving Medicaid benefits, the State may require an election against the testamentary SNT.
G. Drafting Considerations

OBRA-1993 (“OBRA-93”), The Omnibus Budget Reconciliation Act of 1993 codified the first party supplemental needs trust and prohibited some types of trusts that had been used previously, such as a Medicaid Qualifying Trust. OBRA-93 amended portions of the Social Security Act and made sheltering assets in all but specified types of trusts ineffective to shelter the trust creator’s assets from Medicaid consideration. The law also expanded the definition of self-settled trusts. See 42 U.S.C. § 1396p(b)(2)(A). These subsections establish that an individual will be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if the individual, his or her spouse, a person or court acting on behalf of the individual or spouse or at the direction or request of the individual or spouse, established the trust. Subsection (C) states that the subsection applies without regard for the purposes for which a trust is established, whether the trustees have or exercise any discretion over the trust, whether there are restrictions on when or whether distributions may be made from the trust and whether there are any restrictions on the use of distributions from the trust.

In OBRA-93, Congress recognized that disabled persons have financial needs beyond essential medical care. The legislation made it possible to create trusts that retain the assets of disabled persons without disqualifying their owners from receiving Medicaid benefits. 42 U.S.C. § 1396p (d)(4)(A) and (C) permit the use of self-settled supplemental needs trusts and pooled trusts.

I believe that with self-settled trusts, it is especially important to include on the first page of the trust all the information that the Social Security or Medicaid caseworker needs to verify that the trust meets the program requirements. For example:

This Trust is being established pursuant to the provisions of Section 1917(d)(4)(A) of the Social Security Act (42 U.S.C. § 1396p(d)(4)(A)), as amended by OBRA 1993, for the sole benefit of ________________, a disabled person under age 65, as defined in the Social Security Act § 1614(a)(3), (42 U.S.C. § 1382c(a)(3)), hereinafter referred to as “the Beneficiary,” by her
guardian,_______________. This Trust is an irrevocable, purely Discretionary, Non-Support, Spendthrift Trust and is an Excluded Trust pursuant to Rule M 4542.2 of the Vermont Medicaid Rules, 10/7/05 and SI 01120.203-B of the Social Security Administration’s Program Operations Manual System (“POMS”).

This one paragraph identifies the statutory basis for the trust, that it is a “sole benefit” trust, provided the basis for the person whose actions established the trust to do so, stated that the trust is irrevocable and is a purely discretionary, non-support spendthrift trust and cited the Medicaid rule and POMS provision that allow such trusts to be considered excluded trusts. Of course, the body of the trust will flesh out these statements, such as the distribution standard and the spendthrift provision.

It is important to provide a limited power of amendment and a savings clause:

**Limited Amendment by Trustee**

The Trustee shall have the power to amend or reform this agreement in any manner that is required for the sole purpose of ensuring that it qualifies and complies with applicable laws and regulations that governs exclusion of resources for Federal or State (including any subdivision thereof) benefits, with the approval of a court having jurisdiction over the trust. Notice of such request for amendment shall be given by the court having jurisdiction over the Trust to the Department of Vermont Health Access, or its successor agency, or a similar agency of any state that is then providing medical assistance or benefits to the Beneficiary.

**Savings Clause**

If any provision of this trust disqualifies the Beneficiary for any type of government assistance, such a provision may be voided by the Trustee or Trust Advisor to avoid such disqualification.

The Social Security Administration amended the POMS in 2010 to address a concern about first-party trusts that contained early termination provisions. POMS SI
01120.199. Included are provisions allowing for termination of the trust when the beneficiary is no longer disabled or becomes ineligible for SSI and Medicaid or when the trust is too small to justify its continuation. The change to the POMS provides that if the trust contains such provisions, the trust must be amended within 90 days of notification to the beneficiary or representative payee by SSA. Making such changes may be difficult to accomplish in that short time frame. Therefore, a first-party trust should not contain provisions for termination other than at the death of the beneficiary. Existing first-party trusts should be reviewed to make sure there are no early termination provisions. If there are, be proactive and amend them before the SSA writes a letter.

What provisions should the trust contain regarding termination at the death of the beneficiary? The SSA allows only limited disbursements before the Medicaid payback required in all (d)(4)(A) trusts. They are taxes due from the trust to the State or federal government because of the death of the beneficiary and reasonable fees for administration of the trust estate such as an accounting to a court, completion and filing of documents or other required actions associated with termination and wrapping up of the trust. POMS SI 01120.203-B 3 a. Funeral expenses are specifically prohibited. A Trustee of a first-party trust should strongly consider a pre-paid funeral for the beneficiary. Also prohibited are the payment of debts to third parties and payments to residual beneficiaries. Here is my provision for termination:

**Payment and Distributions on Death of the Beneficiary**

This Trust shall terminate at the earlier of the death of the Beneficiary or when there are no assets remaining in the trust during the lifetime of the Beneficiary.

a. **Allowable Administrative Expenses**

To the extent there are Trust assets remaining at the death of the Beneficiary, the Trustee may use such remaining Trust assets to pay allowable expenses under the Social Security Administration's POMS or any successor set of rules, such as taxes due to the federal or state government as a result of the death of the Beneficiary and reasonable fees for administration of the trust estate, such as an accounting of the Trust to a Court, completion
and filing of documents, or other required actions associated with termination and wrapping up of the trust.

b. **Reimbursement of Government Benefits**

All amounts remaining in the Trust at the Beneficiary’s death after payment of allowable administrative expenses shall first be distributed to the Department of Vermont Health Access, or its successor agency, or a comparable agency in any state, as reimbursement to the Medical Assistance Program of any state that may have provided medical assistance or benefits to the Beneficiary during the Beneficiary’s lifetime, up to an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary. This provision is intended to meet the requirements of 42 U.S.C. § 1396p and POMS SI 01120.203-B 1 h.

c. **Distribution of Trust Residue**

To the extent there are Trust assets remaining after reimbursement of government benefits and payment of allowable administrative expenses, the Trustee shall divide and distribute, free of trust, the residue of the Trust as follows:

The remaining Trust assets shall be distributed to the beneficiary’s descendants, per stirpes. If the beneficiary has no living descendants at the time of her death, the remaining trust assets shall be distributed in accordance with Article Six.

POMS SI 01120.203-B 1 h provides that the trust must provide payback for any state that may have provided medical assistance under the state’s Medicaid program. Therefore, it is important not to limit the reimbursement to Vermont or any other state where the beneficiary may reside at the time the trust is drafted.

If the trust is to be allowed to own a depreciating asset, like a house or a vehicle, that power should be spelled out.

If a family caregiver may be providing care to the beneficiary and is to be paid, that arrangement should be authorized by the trust. Note that Medicaid may well challenge such payments, especially if there is an obligation of support, as for a minor child. However, the SSI program allows this practice.
This discussion of drafting considerations is obviously not exhaustive. The sample language may well be surpassed by your efforts. They are meant to be a starting point, not the ultimate expression of drafting expertise.

Special Needs Trusts are a vital tool for families with members who have disabilities. The proper creation and administration of such trusts is complex, but essential to prevent disqualifying the beneficiary from important benefit programs.