Vermont Bar Association

Seminar Materials

What You Really Need to Know About Elder Law

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VBA – What Elderlaw Attorneys Want You to Know

I. What We Do

Elderlaw lawyers work with older clients or the families of older clients who are or maybe be in the future facing issues of physical or mental disabilities, degenerative or incapacitating illness, nursing home issues and the like. Often our first look is at the client’s existing documents to be sure they are adequate. We also analyze the client’s financial situation: sources and amounts of income; assets such as real estate, investments, retirement accounts and other items, to determine what issues might arise with Medicaid and other benefits and what assets might be excluded or otherwise protected. Many clients come to us at the last minute and even with some foresight, some plans must be implemented at the last minute. This is why having the right provisions in the client’s documents are so important.

The essential documents for Elder Law work and Medicaid planning are really: 1. The Durable Power of Attorney; 2. The Advance Directive; and possibly 3. The Enhanced Life Estate Deed. There are many other documents we may use in the course of planning, Wills, Trusts, SNT’s, care agreements, promissory notes, etc. But the Power of Attorney is essential to allow last minute planning and the Advance Directive is essential to allow proper medical treatment.

II. Durable Powers of Attorney

The Durable Power of Attorney is one of the key documents to allow an elder to be cared for and Medicaid and estate planning to take place. The Durable Power of Attorney allows the Agent to engage in Medicaid planning when the elder is no longer competent. It gives the Agent flexibility to adapt to changing circumstances and regulations and to continue any plan which may have been begun by the elder prior to incompetence. The Durable Power of Attorney is also a method to avoid a guardianship for an incompetent elder. The Power of Attorney may not prevent a guardianship, but generally, the Power of Attorney allows greater flexibility in Medicaid planning than is afforded through a guardianship without the need for Court approval for every action.

Often the chosen Agent is the client’s child or other family member but that doesn’t have to be the case. Be sure to select an agent that is both willing and able to handle the duties the Power of Attorney confers.

When we evaluate Powers of Attorney we look for certain provisions to be in the document. The following is a list of the types of provisions we think should be in a Power of Attorney and why.
A. **Gifting Powers**

Gifting still is an important part of Medicaid planning. For that reason, the inclusion of provisions in the Durable Power of Attorney allowing the Agent to make gifts is imperative. These gifts **should not** be limited by the annual exclusion amount for gift and estate taxes. Generally speaking, this is a foolish limitation for most situations. With the current Gift and Estate Tax exemption amounts most Vermont clients do not need to worry about gift taxes.

B. **Self Dealing**

Generally allowing self dealing is advisable. Often the person appointed as Agent is a child or other relative that the client wants to receive at least a portion of the property. In order to treat themselves the same as other children they must have this power. Also, the person appointed may be the most reliable and financially astute and stable, so they would be the best person to make loans or other transfers to.

The Agent making gifts, loans or other transactions to themselves does present dangers that must be considered. Safeguards may be built into the Power of Attorney to deal with concerns of financial abuse, such as requiring the alternate agent to make the gifts to the primary, or having someone else approve all gifts.

There has been concern that by allowing such self dealing the DPOA may become a general power of appointment for the agent. However, limitations may be put on the power to avoid this problem. It seems this concern is really overblown, in that Estate Planners frequently discuss the problem, but nobody I have ever heard of has had the IRS raise the issue.

C. **Real Estate**

There should be specific language authorizing the agent to deal with the principal’s real estate matters, including buying property, selling property, and entering into leases or rental agreements. The agent should also be empowered to sign any documents necessary for any type of real estate transaction.

D. **Government Agencies**

Clients have dealings with lots of different government agencies, and many will want to see that the agent is authorized to deal with them. I generally specifically list the ones most clients are likely to deal with, the IRS, Treasury, Social Security, Veteran’s Administration and Post Office. Then I rely on more general language for all others. The Social Security Administration won’t accept a power of attorney, requiring their own determination of Representative Payee, but having them named can’t hurt and may assist in becoming Rep. Payee.

E. **Loans**

There should be a provision authorizing the agent to borrow money and give security for such a loan. There should also be language empowering the Agent to make loans and guaranty loans for third parties, including the Agent.
F. **Insurance**

Clients have all kinds of insurance products that will need to be dealt with; life insurance, homeowners, auto, health insurance, long term care, etc. It is useful to give some elaboration of the powers the agent has, canceling policies, buying new ones, changing limits and deductibles. Also, with life insurance it is often necessary to deal with cash values and there are elections, so allowing annuitizing, borrowing or cashing in policies is helpful. Recently a client had the legal department at National Life of Vermont review my DPOA and they did suggest that I include the ability to annuitize a policy.

G. **Retirement Accounts**

Be sure the agent has authority to deal with the client’s retirement accounts, not just obtaining information about them but also making elections regarding distribution electing distribution amounts. In Medicaid planning we can often protect retirement accounts by adjusting the annual or monthly distributions. To do so, it helps to give the agent specific authority in the document.

H. **Guardians**

The Vermont Power of Attorney statute authorizes the naming of a Guardian in the DPOA. Since it is allowed, it makes sense to name the person the client would want. This could be useful to forestall family squabbles, in that the Guardianship statute provides that deference should be given to appointments made in a DPOA, but also allows a Guardian to void a Durable Power of Attorney.

I. **Compensation**

If you want the agent to be paid for serving you must specifically allow it in the document. Most of the time the agent will not request payment, but if there is a lot of work involved it may help the agent. It can also be one more method of transferring funds to family members without Medicaid penalty.

J. **Other Services**

There are many other services that a client might need. Things such as visiting nurses, home health aides, housekeeping services, etc., allowing the agent to engage such help is useful. Also, allowing the agent to perform such services and be paid for them allows the use of Care Plans with the agent for Medicaid purposes.

K. **Trust Powers**

You may want to consider whether to allow the Agent to create a Trust on the principal’s behalf. You should also consider whether to give the agent authority to amend or revoke a trust or to remove and appoint new trustees of a trust. Sometimes this flexibility is useful, but other times you may want to have a trust stand alone and not be modifiable by an agent.

L. **Estate and Benefit Planning**

While it could be argued that the power to engage in Medicaid or other benefit planning and some Estate planning could be included in the other sections of a DPOA, it doesn’t hurt to specifically include them. Therefore, it can be prudent to include provisions that the agent is authorized to engage
in benefit planning and to hire professionals to assist in such planning. Note, I like the term 'benefit planning' because there could be benefits other than Medicaid to which the client may be entitled, Veteran’s benefits for example. I also allow the agent to engage in some estate planning to avoid or minimize taxes, and to hire professionals to assist with that as well. Note however that under Vermont law the agent may NOT create or modify a Will, DPOA or an Advance Directive.

This is not a comprehensive list of what should be included in a Durable Power of Attorney, there are many other things that could be helpful or useful to include in the document, such as specific language dealing with Digital Assets; Firearms; Motor Vehicles; and other types of assets or property. The items listed above are the types of provisions that are particularly useful for Medicaid planning. When I meet with a client who already has a DPOA I always ask to see it and try to evaluate how useful it will be in Medicaid planning context, and the things I generally look for are the items above.

III. **Advance Directives**

The Advance Directive is the document that generally both names a Healthcare Agent to make medical decisions, and states what type of treatment the client wants in the event of a terminal condition. It goes by many different names: Advance Healthcare Directive, Durable Power of Attorney for Healthcare, Living Will, Medical Directive, etc. The name is not important, but the intent should be.

Many Elderlaw attorneys have concluded that in AHCD’s brevity and a broad statement of wishes and powers is to be preferred over longer, more complicated and specific documents. Both the Vermont Health Department and the Vt. Ethics Network have model forms available online. However, many of us have created our own forms. There is NO required or default form specified in the statute.

Note that many clients are under the impression that their spouse or children automatically have authority to make medical decisions for them. That may be true in some states, but NOT in Vermont. When the legislature passed the AHCD Statute in 2004, they failed to include a Default Decisionmaker provision. This means that without an AHCD in place, it would be necessary to have a Guardian appointed to make medical decisions.

The following items should be clear in the document.

**A. Agent**

It should be clear who is named as the primary agent or decision-maker. There can be co-agents, although if there are, it should be clear if they can act independently or must act together. There should also be an alternate agent named, if the primary is unable to act.
The client should be sure the person they pick is both willing and emotionally able to make difficult medical decision, including the strength to make the decision to terminate life sustaining treatments.

B. End of Life Treatment
The document can state what type of ‘end of life’ treatment the client wishes. Usually this is oriented towards whether they want to be kept alive by artificial means, or if they want treatment to prolong their life if they will not recover. The vast majority of my clients do not wish this treatment and say so in the document. If there are specific treatments the client wishes to be tried, or specific treatments they wish to decline, they can do so in the document. These can also be dealt with more directly with their physician using a COLST. Some practitioners may omit this statement. I like to include a broad statement. Some forms, such as the Vt. Ethics Network form, had a list of ‘value’ questions as a guide. I do not like that approach, as it seems open to interpretation, disagreement and litigation.

C. Agent’s Authority
I do not like to ‘micro manage’ in this section of the document. Again, some forms will specify types of treatment to be give or not given or when it can be given or withdrawn. Occasionally someone wants a waiting period before treatment can be terminated. Generally, I believe in including a broad statement of the Agent’s authority and not getting into specifics is best, allowing flexibility at the time decisions need to be made. I advise clients to ‘give your agent as much power as you could ever want them to exercise – if you want them to be able to “pull the plug”, then we should say so.’

It is good practice to advise the client that once the documents are in place the next, and equally important, step is to have a discussion with the agent, and other family members if possible, so that everyone understands your wishes. During ‘the Talk’ is a good time to talk about life values and feelings to help guide the agent in their decision.

D. Guardian
The Vermont Advance Directive Statute allows a person to nominate their own Medical Guardian in the document, similar to the provision in the Durable Power of Attorney statute. Since the Guardianship statute says deference and consideration should be given to such nominations, it is a good idea to include them in your document.

E. Other Directions
The Vermont statute allows other things to be inserted in the Advance Directive. You may include the following: Organ Donation; Burial Instructions; Specific Treatment directions; allow named agents to designate a successor.

F. Revoke Prior Documents
The current Vermont statute does allow amending an Advance Directive and mandates that if there are more than one document, they should be read together or compared to give effect as much as possible to all documents. I strongly encourage everyone to include a paragraph in their AHCD forms that specifically revokes all prior documents. This is similar to the language in a Will that revokes all prior
Wills. It could avoid a lot of delay and confusion trying to locate and compare and interpret several different documents.

G. Proper Execution
Be sure the document is properly signed. It requires two witnesses, who should not be related to the principal. There is no requirement for a notary, but some states do require it, so having a notary clause can’t hurt. If the client is signing in a hospital or nursing home, there are specific disclosure requirements. Be aware that although the law does not prohibit employees of such facilities from being witnesses, the general practice seems to be that facilities will not allow their employees to act as witnesses. Some facilities might allow certain designated employees to be witnesses, but this accommodation seems to be fading out.

H. File with the Registry
The 2004 law directed that the Health Dept. establish an electronic registry for Advance Directives. The Department wisely found a company already operating such a service commercially and contracted with them. It is a free service for Vermonters and I routinely file copies of my client’s documents with the registry. There is a separate registration form the client will need to sign.

I. HIPAA Release
HIPAA is a Federal Law that prohibits and punishes disclosure of ‘individually identifiable personal medical information’ without a proper release for such disclosure. As a matter of convenience I suggest having the client sign a HIPAA release listing the DPOA Agent, the Healthcare Agent, any Trustee, and the client’s family and friends who they want to be able to get information. I include copies of the Release with the AHCD when I send it to the physician and the Registry.

J. Additional Information
There is a wealth of information available to those who wish to delve more deeply into the issues of Advance Directives and end of life decisions. The ABA has published an excellent book on the topic, Advance Health Care Directives, a Handbook for Professionals, by Krohm and Summers, which discusses considerations in making advance directives, crafting language, various practical, cultural and religious issues and other matters. It goes well beyond being a practice guide.

There is also the booklet “Taking Steps “published by the Vermont Ethics Network (VENs) and available online at www.vtethicsnetwork.org. This booklet contains excellent information and guides to assist clients in making decisions about what they want in their health care documents. It also contains a do-it-yourself Advance Directive, which I DO NOT recommend using, but which I have included as Exhibit 2, for your review and information. The VENs site has other useful information. For a broader look at advance directive policy issues nationally you can refer to www.lastacts.org , www.americanhospice.org , www.hospicefoundation.org , www.agingwithdignity.org , www.rwjf.org and other sites.
To assist you in your drafting I have included as Appendix 1-a form which I have drafted and similar to the one I am presently using for most of my clients. I would appreciate any comments, suggestions or even constructive criticisms, which can be emailed to me at Michael@vtestatelaw.com.

IV. Enhanced Life Estate and “Bare” Life Estate Deeds

Life Estate Deeds can be an important part of the Medicaid planner’s arsenal, used generally to pass property outside probate and thereby to avoid any Medicaid claim for reimbursement. The two deeds are similar in operation, but vastly different in Medicaid treatment.

In this section, we’ll first look at the differences between the two types of deeds in general and then look at how each deed is treated for Medicaid and other purposes.

A. Life Estate Deed Differences

1. “Bare” Life Estate Deed

A “Bare” Life estate deed is the general life estate that is well known in property law. It is a conveyance in which the grantor either reserves for himself or grants to another a “life estate” in the property. Under caselaw this is recognized as the right to use and possess the property during the person’s lifetime. It carries with it the obligation to maintain the property and generally to pay the expenses of the property during the life tenant’s lifetime. The remainder interest granted to the remainderman is a vested interest and not subject to termination or defeasement by the life tenant.

2. Enhanced Life Estate Deed (ELED)

The Enhanced Life Estate Deed or ELED as I prefer to refer to it has a variety of names, including: “LadyBird Deed” or “Medicaid Deed” or “Life Estate Deed with Reserved Power of Sale” as it is known nationally, and the “Italian Deed” or “Granai Deed” as it is known in Central Vermont. The thing that sets this deed apart is that not only does it reserve the traditional life estate, but also the rights to unilaterally sell, lease, mortgage or otherwise transfer or convey the property without the consent or joinder of the remaindermen and without a sharing of any of the proceeds of such actions. This reserved bundle of rights needs to be spelled out in the document.

B. “Bare” Life Estate Deed Treatment

1. Medicaid

Medicaid treats the creation of a such a life as a transfer of assets, specifically the value of the remainder interest in the property. This transfer is subject to a Medicaid penalty if made within the 60 month ‘Look back’ period. This is true no matter what the property is, there is no exemption for the primary residence.

Medicaid treats the reserved life estate interest as a non-countable resource. This is true no matter what type of property it is. There is no differentiation between primary residence and other property.
If the property is sold during the life tenant’s life, a portion of the proceeds go to the life tenant, and a portion goes to the remaindermen. The share of the life tenant will be a countable resource.

2. Taxes
At the transfer of the property to the remaindermen on the death of the life tenant, the remaindermen get a ‘step up’ in tax basis to the date of death value of the property. The property is includable in the life tenant’s estate for purposes of estate taxes.

If the property is sold during the life tenant’s life, the remaindermen are entitled to a portion of the sale proceeds, and that portion is subject to capital gains tax. This is true, even if the remaindermen give all the proceeds to the life tenant. It is also true even though the property might be the life tenant’s primary residence and the proceeds exempt from capital gains tax for her.

3. Control
The life tenant does not have complete control of the property during her tenancy. If the life tenant desires to sell or mortgage or give away the property, the remaindermen have to agree and join in any conveyance.

4. Claims
The interests of the remaindermen, being vested, can be subject to the claims of their creditors, and the property is an asset for purposes of school loans, and general credit issues.

C. Enhanced Life Estate Deed Treatment

1. Medicaid
The creation of an ELED is not considered a transfer for Medicaid purposes. Because of all the reserved rights, Medicaid basically says nothing has been given away, and effective ownership has not changed. Therefore, there is no issue with the 60 month ‘Look back’ period and no penalties.

An ELED does not change how the subject property is viewed by Medicaid. If the property is the applicant’s primary residence, it is an exempt asset for Medicaid. If it is other property, it is probably still a countable resource, unless it is non-countable for some other reason, such as being ‘income producing’ property. Putting property in an ELED will not, by itself, make it non-countable.

If the property is sold during the life tenant’s life, all the proceeds belong to the life tenant, and generally will become countable resources for Medicaid purposes.

2. Taxes
At the transfer of the property to the remaindermen on the death of the life tenant, the remaindermen get a ‘step up’ in tax basis to the date of death value of the property. The property is includable in the life tenant’s estate for purposes of estate taxes.
If the property is sold during the life tenant’s life, the remaindermen are NOT entitled to a portion of the sale proceeds. All the sale proceeds belong to the life tenant. If the property is the life tenant’s primary residence all or a portion of the proceeds should be exempt from capital gains tax.

3. Control
The life tenant retains all control of the property during the tenant’s lifetime. The tenant can sell or mortgage the property and keep all the proceeds. The tenant can change her mind and give the property away during her lifetime or change the terms of the deed by doing a new one. All this can be done without the remaindersmen joining in any conveyance.

4. Claims
The property subject to the life estate, with an ELED is NOT subject to the claims of the remaindersmen’s creditors. Nor is it an asset for purposes of scholarships or other asset based programs.

D. Similarities
There are some similarities in how the deeds are treated that should be noted.

First and already mentioned is that there is a ‘step up’ in tax basis on the death of the life tenant and transfer to the remaindersmen, both making the property part of the life tenant’s estate for tax purposes, but affording a higher basis to the remaindersmen.

Secondly, the property tax ‘rebate’ should be preserved with either deed. I usually specify that the life tenant is responsible for the taxes, to be safe, but caselaw does state that that is the case. (With either type of deed, this will be lost when the person no longer occupies the property as their primary residence – the ‘intent to return home’ doesn’t work for tax purposes).

Thirdly, both types of deeds have the same treatment by the Vt. Tax Dept. for Transfer Tax purposes. If it is an exempt transfer to one of the exempt categories, there is no tax, if not, the tax should be calculated on the value of the remaindersmen’s interest. I do not necessarily agree with this treatment in the case of an ELED, but this may be the only opportunity the tax department has to collect the transfer tax, which is essentially the Tax Dept. position.

Note that with either Life Estate Deed, I list the Grantor (s) as both the Transferor and the first Transferee on the VPTTR, even though I don’t make the life estate holder a Grantee in the deed.

While there is no prescribed ‘magic language’ for an ELED, see Appendix 2 for a sample of the language I’m currently using.
ADVANCE HEALTH CARE DIRECTIVE

I, ____________, hereby appoint ___________________, of ___________________, as my agent to make ANY and ALL health care decisions for me in the event I become unable to make my own health care decisions. Should the person I have appointed above be unable, unwilling or unavailable to act as my health care agent, I hereby appoint _______________ of ______________-, as my alternate agent.

(A) LIVING WILL: If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I wish to die a natural death, and not have my life prolonged by extraordinary measures, including antibiotics, nutrition and hydration administered by medical means.

(B) LIFE-SUSTAINING TREATMENT: If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline, terminate or withdraw all treatment (including antibiotics and nutrition and hydration administered by medical means) the primary purpose of which is to prolong my life. I do request that medication be administered to alleviate suffering and pain even if it may shorten my life.

(C) SPECIAL PROVISIONS AND LIMITATIONS:

[ ] NONE  [ ] See attached sheet

(D) ORGAN DONATION: I [ ] do not [ ] do wish to donate Organs and Tissue for Transplantation. List here any exclusions or limitations:

[ ] Undecided

(E) BURIAL INSTRUCTIONS: I hereby grant my agent continuing authority to make decisions regarding the burial or disposal of my remains following my death. Such decisions shall be consistent with any prior arrangements or instructions made by me prior to death. Specific Instructions:

(F) GUARDIANSHIP: In the event a Guardian is to be appointed for me, I request the Agents named herein be appointed as my Guardian for medical decisions.

(G) REVOKE PRIOR DOCUMENTS: By signing this document, I hereby revoke all prior Advance Health Care Directives, Durable Powers of Attorney for Health Care, Living Wills, or other similar documents previously execute by me.

The original of this document or a copy will be held by my agent, and photocopies of the original will be given to the following:

Michael D. Caccavo, Esq.,

I hereby acknowledge that the effect of this document has been explained to me and that I understand it.

In witness whereof, I have hereunto signed my name this __________ day of ______________, 20____.

_________________________________  __________________________

Date of Birth
I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: __________________________________ Address:

Witness: __________________________________ Address:

I am an attorney licensed to practice in the State of Vermont, and I hereby affirm that I explained the nature and effect of this Advance Directive to the person signing it.

______________________________________________

Michael D. Caccavo, Esq.
Explanation

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

You may state in this document any treatment you do not desire or treatment you want to be sure you receive.

- Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions.
- Your agent will be obligated to follow your instructions when making decisions on your behalf.
- You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and give the agent the signed original or be sure the agent knows where the original is located. It is also helpful to discuss your wishes with other family members and close friends.
- Even after signing this document you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or health care provider orally or in writing.
- You should discuss this document with your physician or other health care provider to make sure that you understand the nature and range of decisions which may be made on your behalf. And to be certain your health care provider is aware of your wishes.
"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 EXTINQUISHED 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."
Countable Assets for Long-term care Medicaid and Strategies for Qualifying

In the Medicaid world, there are two types of assets—countable and excluded. Most assets are countable. The limit on countable assets for a single applicant is $2,000. If the applicant is seeking to have care at home, the exclusion is $5,000. A married couple gets a higher limit, because the spouse who does not need care (the “community spouse”) still needs to live. Currently, the limit for a married couple is $121,220. The most common exclusions include the primary residence, burial accounts and retirement plans.

A. Primary residence

A primary residence is excluded for qualification purposes unless the equity is substantial (exceeds $552,000, indexed for inflation). The limit does not apply if a spouse, a child under age 21 or a blind or permanently disabled child is living in the home.

B. Burial Accounts

Each applicant (and spouse) are allowed to put aside up to $10,000 for purposes of a funeral and burial or cremation. The amount must include the cost of a burial plot and headstone, if the applicant has purchased those. For a married couple, the cost of the plot and headstone can be divided between the spouses. In addition, a bank account or insurance policy can be dedicated to these purposes. There is a Burial...
Intention Fund Statement that the Economic Services Division has devised to inform the State of the assets that are to be excluded under this rule.

C. Retirement Plans

This technique applies to both married and single individuals. If a retirement account (of either spouse, in the case of a married couple) is listed on the Medicaid application as an asset, it will be a countable asset. If, however, “enough” money is withdrawn from each retirement account of the person, the remaining balance will be an excluded resource. HBEE § 29.08(i)(5). Divide the balance of the account by the life expectancy of the individual (according to SSA Actuarial Tables found at https://www.ssa.gov/OACT/STATS/table4c6.html to find the required withdrawal amount. It will be more than the Required Minimum Distribution the IRS requires. ESD has not said whether the balance to be used is the 12/31 balance for the previous year (the IRS method) or the current balance of the retirement account. Leave a little leeway! It is better, after the year of application, to set up monthly withdrawals for the recipient spouse to avoid increasing his/her income in one month to the point where he or she would have too much income to qualify for Medicaid for that month. The withdrawals have to be recalculated each year for each spouse. Life expectancy is governed by Social Security tables cited above. Recently, the tables were updated to cover 2013 statistics. DCF requires the community spouse to continue making appropriate withdrawals from his/her retirement accounts, but since the community spouse’s income does not count against the Medicaid spouse, this is not a problem.

D. Asset Transfer Strategies Available

If the spouses’ combined assets are less than $121,220, no planning is needed and the application should be filed as soon as possible to stop the out-of-pocket private pay costs of the facility. If the assets are more than the combined limit, but within approximately $20,000-$50,000 of the combined limit, the dedication of assets for burial funds and the purchase of exempt assets, like a car, or using assets to fix up or improve
the home, or paying down debt or prepaying expenses may be all that is needed to reduce the couple’s countable assets below the limit.

For couples with more assets than can easily be used or spent, other tools are needed. It is important that the assets be liquid, or fit within the limited exemptions available. For example, if a couple owns a second piece of real property, unless it has very little value, it will most likely cause them to exceed the asset limit. If it is rental property and it meets the 6% test, it won’t be considered a countable asset. The property should be transferred to the name of the community spouse so that half the income is not required to be used for the applicant’s expenses.

1. **Transfers of Residence**

   Both federal law and the Vermont Medicaid regulations allow transfers of a residence in certain situations. These are transfers to: a spouse, a child under the age of 21, a blind or permanently and totally disabled son or daughter of the applicant, sibling of the applicant who lived in the home for one year prior to the applicant’s hospitalization and who had some ownership interest in the home, or an adult child who lived in the home at least two years before the institutionalization of the applicant and provided sufficient care to the applicant to permit him or her to remain in the home. 42 U.S.C. § 1396p (c)(2)(A), HBEE § 25.03(e).

2. **Transfers to Spouses**

   There are many ways a married couple can protect their assets and qualify one of the spouses for long-term care Medicaid. Married couples have a tremendous advantage over single individuals because of the Community Spouse Resource Allowance (CSRA) and the availability of transfers between the spouses that are not penalized. An individual applying for long-term Medicaid is allowed countable resources of only $2,000 ($5,000 if the care is to be provided in the individual’s home). However, a married couple can have countable resources of $2,000 plus the amount of the CSRA, currently $119,220. The latter figure changes almost every year, effective
January 1. When one spouse is applying for Medicaid, the couple’s assets are all considered, but the assets need not be separated out until the first recertification after eligibility is established, generally one year after Medicaid eligibility. While it is not required that the applicant spouse’s assets be separated before the first application is filed, it is good practice to start the process early in the representation. All assets that are able to be transferred from the applicant spouse to the community spouse should be transferred as soon as possible, because of the deadline mentioned above. With some techniques, this is essential to making things work. Also, jointly held assets should be transferred to the community spouse, to enable the use of some of the tools discussed below, and to avoid getting caught short when the first recertification rolls around.

Transfers from the applicant to the community spouse can only be done properly if the applicant transfers the assets or income himself or herself, if there is a Power of Attorney that allows gifting and self-dealing, see 14 V.S.A. § 3504(e) and (f), or if the gifting is done by a guardian with court approval.

In my opinion, the best tools to take care of excess liquid assets are annuities and promissory notes. The techniques are similar. With an annuity, after virtually all the liquid assets are transferred to the name of the community spouse, he or she purchases a single premium immediate annuity (SPIA). One problem with annuities is that with interest rates at historic lows, many insurance companies are not selling short-term SPIAs. It used to be possible to purchase SPIAs for a period of a year or two, or sometimes only a few months. Now it is increasingly difficult to purchase an annuity that will yield a positive return for less than five years. Even at the five year level, many quotes come back with a negative return. One advantage of using an annuity is that the payments will be made automatically by the insurance company and family members need not be involved. Of course, the financial health of the insurance company should be checked carefully.

Typically, the first payment will not be made until 30 days after the purchase of the annuity. DCF will not find Medicaid eligibility until the stream of payments has begun. Therefore, prepare your clients to have to pay privately a little longer. You will need to size the amount of the annuity to allow for the first payment to be received
without putting the couple over the combined asset limit, which will mean buying a larger annuity.

Because of the difficulty in finding short-term SPIAs, I have been using promissory notes much more often than annuities in the last few years. It is essential that the person receiving the loan, usually a child, be financially responsible and willing and able to make the required monthly payments. Often, a financial institution can set up automatic payments. Another issue is that interest has to be paid on the note by the borrower. With interest rates so low, this has not been a problem, but could pose more of one if interest rates begin to rise. The latest Applicable Federal Rates, for October 2016, are .66% for short-term loans (less than 3 years), 1.29% for mid-term loans (3-9 years) and 1.93% for long-term loans (greater than 9 years). The 7520 rate, which is used for life estates and other calculations, is 1.6%. The interest paid by the borrower cannot be gifted by the lender. When using promissory notes (or annuities), the shorter the payment period the better, as the risk of the community spouse dying and the remaining payments being diverted to Vermont Medicaid is reduced. Also, the first payment may be made more quickly than the 30 days it takes an insurance company to make it with a SPIA. I have begun having the first payment be made within days after the note has been signed. Keep in mind that the interest received by the lender will be taxable income.

3. Transfers to Relatives or Caregivers and Disabled Individuals

Besides transferring a home to family members, as described above in 1, there are other ways to make gifts to relatives. If there is a family member who is disabled, the community spouse could transfer an unlimited amount of assets to the disabled family member or to a trust for them, as long as it meets certain rules. HBEE § 29.05(g)(3) allows transfers to a disabled child or to a sole benefit trust for such son or daughter. HBEE § 29.08(e)(1)(ii)(F) (II) contains the rules for a sole benefit trust, although it is narrower than federal law (42 U.S.C. § 1396p(c)(2)(B)(iv)) because it is limited to a trust established through the actions of a parent, grandparent, guardian or a court, while federal law allows the transfer of assets to a sole benefit trust for any...
disabled individual under the age of 65. A sole benefit trust for this purpose must either pay out to the beneficiary over the beneficiary’s life expectancy, or contain a Medicaid payback provision like a (d)(4)(A) special needs trust. In practice, if the beneficiary is receiving either SSI or Medicaid, the actuarially sound payments would probably make the person ineligible, so the Medicaid payback is usually the preferred option. HBEE § 29.05(g)(4) allows transfers to a trust established solely for the benefit of an individual under the age of 65 who is disabled. Note this provision is not limited to children of the applicant.

Transfers to a caregiver, whether a child of the applicant or not, must be judged to see whether they were made in return for goods or services. If the payments were made in return for the goods and services, they should not be considered to be transfers, assuming adequate consideration. The Centers for Medicare and Medicaid State Medicaid Manual is fairly clear that in almost all cases, payments made for services may be treated as a transfer for consideration only if they were made pursuant to a written agreement that predated the performance of the services. Fleming and Davis, Elder Law Answer Book, 3rd edition, Q 17.84. Vermont Medicaid will accept after the fact evidence that the services were provided, such as logs of services and affidavits, but reasonableness is a key. In addition, the permitted rate is only $10 or $12 an hour.
A. First Party and Third Party Trusts

1. Introduction

There are two basic types of special needs trusts (SNTs): first-party and third-party trusts. The key distinction is “whose money is it?” In a first-party, or self-settled trusts, the money or assets belong to the special needs beneficiary. By contrast, the assets in a third-party SNT do not belong to the beneficiary. This is a most important distinction. It is important to understand the statutory background of special needs trusts.

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.

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 first party, or 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 4 and 5, below. Self-settled trusts are very different than third party trusts, which will be discussed in section 7. The primary distinction is that third party trusts do not contain assets of the beneficiary.
2. 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 burial funds worth up to $1,500.

3. Legal Requirements for Self-Settled SNTs

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 01150.121D.

- 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 if these restrictions were in place. 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.

- The allowable expenses include taxes due from the trust because of the death of the beneficiary and reasonable fees for
administration of the trust estate, including an accounting and other actions associated with termination and wrapping up of the trust.

- **Doctrine of Worthier Title**—Some 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 Vermont trust may provide that assets will go to “the heirs of John Smith” or the “Estate of John Smith,” or “heirs at law,” “next of kin,” “survivors,” or a charity. 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, and have the adult beneficiary transfer his or her own assets to the trust. See POMS (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 802-241-2990 or at robin.chapman@vermont.gov. A new procedure adopted by DCF calls for all SNTs to be sent for scanning to DCF/ESD, ADPC, 280 State Drive, Waterbury VT. 05671, or to Ahs.dcfesdltaops@vermont.gov.

4. **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.

5. **The (d)(4)(C) Trust**

In a (d)(4)(C) (pooled) 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 (unlike the (d)(4)(A)), or by a court and must be solely for the benefit of the disabled individual. If there are amounts left in the beneficiary’s account at his or her death, they may be retained by the non-profit sponsor. If they are not retained, the trustee repays the State for Medicaid expenses, much as in a (d)(4)(A) Trust situation. Therefore, 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, 29.08(e)(1)(G) VI, specifically says that transfers to a pooled trust for people over age 64 may be subject to a transfer penalty. Unlike (d)(4)(A) Trusts, the individual whose assets are being transferred to the pooled trust may establish the trust himself or
herself. A bill is pending in Congress called the Special Needs Trust Fairness Act, S. 349, which would allow a disabled person with capacity to establish his or her own (d)(4)(A) trust, without the necessity of a parent, grandparent, guardian or court being involved. The bill has passed the Senate, unanimously and the House Energy and Commerce Committee. It needs to be reconciled in the lame duck session if it is to become law. 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.

6. 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 for Medicaid purposes. 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
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 an actuarially sound (c)(2)(B) trust. 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. The choice will usually be to include a payback provision; otherwise, payments will have to be made to or for the benefit of the beneficiary annually, which may be difficult to manage while retaining the eligibility for benefits the beneficiary is receiving.

A (c)(2)(B) trust can be a Qualified Disability Trust, which would provide favorable tax treatment by allowing the trust the equivalent of the personal income tax exemption each year. See IRC § 642(b)(2)(C). A grantor trust can never be a QDT—the QDT must be a separate taxpaying entity and grantor trusts do not file a separate return. Self-settled (first party) special needs trusts will always be grantor trusts. However, there both advantages and drawbacks to using this treatment. The main advantage is that the QDT receives the personal exemption (currently $3,950) instead of the $100 exemption for most trusts. Since the trust is not a grantor trust, it reaches the maximum tax rate of 39.6% at an income level of $12,400 in 2016. The use of the personal exemption would save a trust over $1,500 in taxes. In order to qualify as a QDT, the trust must only have a single beneficiary who is under the age of 65 and who is receiving SSI or SSDI benefits. The trust must be funded before the beneficiary reaches his or her 65th birthday.

7. 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 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, loss to creditors or in a divorce. What would happen to the money if the relative died, with the account in his or her own name?

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. In 2014, a trust reaches the maximum federal tax rate of 39.6% at a mere $12,150 of income.

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.

**B. When can SNTs be used and which type to use?**
Following the initial precept mentioned above will determine which type of SNT to use. Analyze a fact situation by asking, “whose money is it?” If it belongs to the special needs beneficiary, whether from work, inheritance or personal injury or malpractice action, a first-party trust is required. If someone other than the beneficiary is creating the trust and is putting assets into it, or using it as a vehicle for transferring assets at a later date, including the death of the Settlor, a third-party trust is the right vehicle. Remember, the biggest advantage to having a third-party trust is the lack of a payback to Medicaid. Sometimes a beneficiary will have both types of trusts, if he or she has assets of his/her own and someone wants to create a trust to receive inheritances or other gifts from family and friends.

The implementation of the Affordable Care Act (ACA) in January, 2014 provides unprecedented opportunities for disabled beneficiaries to have an alternative to the traditional SSI/Medicaid benefit route. Because the ACA allows people with disabilities to purchase health insurance without having to worry about pre-existing conditions, renewal or lifetime limits on coverage, it presents an entire new opportunity to people with disabilities. Until ACA, the only choice for most persons with disabilities was public insurance through Medicaid or Medicare, which generally requires a determination of eligibility for SSI or SSDI disability benefits. Now, disabled persons with funds, such as people who acquire wealth through a personal injury settlement or an inheritance, will have a choice between private and public health insurance. However, the rules for purchasing private health insurance do not allow Medicare recipients to purchase insurance on an exchange.

If a client chooses to have private health insurance rather than Medicaid, the client will avoid the required payback to Medicaid in first party trusts and may have access to much better health care than through Medicaid. The client may be able to avoid the necessity of creating and administering a special needs trust, and the concomitant restrictions on distributions and gifts, attorney and trustee fees. Freed of the many restrictions on beneficiaries of special needs trusts, a disabled client with the capacity to manage his or her own assets may
feel empowered compared to the beneficiary of a special needs trust. Or, a beneficiary may have a special needs trust, but may have the trustee purchase private health care insurance despite keeping his or her eligibility for SSI and Medicaid. Private health insurance is primary to Medicaid, so the Medicaid lien at death will be reduced, but the client can continue to collect SSI and have the backstop of Medicaid eligibility if needed for things the private health insurance will not cover.

It is crucial that the special needs attorney change his or her thinking from the traditional “SNT, SSI, Medicaid” approach to consider the additional options the ACA provides.

C. Testamentary SNTs

SNTs can also be created through a will. While this technique will certainly work for probate assets, it has some shortcomings. If a testator wants to direct his or her retirement account to the testamentary SNT, there may be resistance from the retirement plan custodian, since the SNT does not exist until the testator dies.

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. In recent years, I have suggested to clients that they leave their spouse with disabilities only the elective share, 50%, in their wills and leave the remainder of their probate assets to
children or other beneficiaries. They may also choose to plan with beneficiary designations for many of their assets.

D. Choosing a Suitable Trustee

In a SNT, appointing a proper trustee and including powers in the trust to remove the trustee are very important. Should a family member be the trustee? This is often the desire of clients, but it may cause problems down the road. One the other hand, a family member has the most knowledge about the beneficiary of the trust. Some authorities recommend the use of an independent, non-family trustee to serve alone or as a co-trustee. This can eliminate conflicts that may arise if a family member is serving as a trustee and can also provide expertise that a family member may lack. One of the problems in implementing this advice is that if the assets in the trust are not sizeable, there may not be enough to pay an independent trustee, or the independent trustee may not be interesting in administering a small trust. A small amount of assets in a trust would be a good reason to suggest a pooled trust to a client.

Should a trustee, especially an independent trustee, be able to be removed? If so, for cause or for any reason or no reason? Who will have the right to appoint a successor trustee? In the initial trust drafting, at least one successor trustee should be named. In addition, there should be provisions to appoint additional successor trustees.

The beneficiary of the trust should never be a trustee. The doctrine of merger of title or SSI and Medicaid rules will make the assets of the trust a countable resource.

In some cases, a Trust Protector or Trust Advisor or Trust Advisory Committee may be desired. A Trust Advisor may have the duty of reviewing financial records, deciding disputes between the trustee and beneficiary and making sure the trust is being administered properly. A Trust Advisor may also have the power to remove or replace a trustee. A family member is a good
choice to be a Trust Advisor, so he or she can bring her knowledge of the beneficiary to the attention of an independent trustee.

E. Working with the Special Needs Trust Attorney

Plaintiffs’ attorneys who foresee a large settlement or judgment should consult with a qualified attorney regarding the preparation of a SNT early in the course of the claim or suit. It is much better to carefully analyze the planning issues involved for the special needs beneficiary than to get a phone call saying, “I need a special needs trust by the day after tomorrow.” There are many family, tax and special needs planning issues involved in the creation of a SNT. The elder law attorney may be helpful participating in the financial planning for a large settlement, such as helping work out the right structured settlement solution. This only works if the elder law attorney is brought in with enough time to fully develop the issues so that the clients can make informed decisions.

F. Medicare Secondary Payer Statute

The purpose of the MSP statute was to ensure that Medicare was only secondarily responsible for paying the medical expenses of individuals covered by Medicare if they also were covered by another type of private insurance. Under the MSP statute, Medicare does not pay for medical services when payment “has been made or can reasonably be expected to be made” by a primary plan, including workers’ compensation, liability insurance plans, and self-insured plans. (42 U.S.C. § 1395y(b)(2)(A).

Medicare serves as the back-up medical insurance plan to an injured party who does not receive payment from a primary insurance plan. In other words, the insurance company or other responsible party remains the primary payer. As secondary payer,
medical benefits are payable by Medicare only to the extent that payment has not been made and cannot reasonably be expected to be made under coverage by the primary payer. Any secondary payment made by Medicare is considered a “conditional payment” subject to reimbursement.

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) enforces Medicare’s basic right of recovery and ensures that Medicare serves as a secondary payer, whenever possible. Section 111 contains reporting requirements for insurance companies that have been extended several times.

CMS is the agency responsible for enforcement of the MSP Act. The Website: http://www.cms.gov/. CMS is short for the “Centers for Medicare & Medicaid Services”

CMS is a sub-agency under the U.S. Department of Health and Human Services ("HHS").

CMS has consolidated all activities in support of the collection, management, and reporting of other insurance coverage of Medicare beneficiaries under a single entity, the Coordination of Benefits Contractor (COBC). The COBC is basically the information gatherer to coordinate benefits of Medicare recipients.

CMS contracted with the MSP Recovery Contractor (MSPRC) in 2006 to consolidate all functions related to MSP recovery. The MSPRC manages all MSP after the COBC completes a record. Once the file is transferred from the COBC to the MSPRC, the claimant will receive a “rights and responsibilities” letter (RAR) signed by the MSPRC.
There are reporting requirements set up by statute and regulation. 42 U.S.C. § 1395y(b)(8) and 42 C.F.R. § 411.25 require all settlements, judgments, awards or other payments resolving medicals for a Medicare beneficiary claimant must be reported—by the Payer, not the claimant or Plaintiff. There are penalties for failure to report.

In every liability settlement involving a Medicare beneficiary, the parties, including any group health plan or liability insurer, now has three distinct obligations:

1) report the settlement to CMS (the present);
2) resolve any conditional payments (the past) and
3) provide for payment of future medical expenses as a term of the settlement, taking into consideration Medicare’s interests (the future).

Each obligation carries its own penalty for failure to fulfill it.

Medicare has the right to recover any conditional payment made against the settlement proceeds of a Worker’s Compensation or third-party liability case. This is sometimes referred to as a “super lien” because of the broad power CMS has. Conditional payments are those made by Medicare from the time of the incident to the date of settlement when another payer is responsible.

There is a process for dealing with conditional payments involving the MSPRC issuing a conditional payment notice and that can progress to a demand for repayment.

Medicare reduces its recovery to take into account the cost of procuring the settlement or judgment, which includes attorney’s fees, expert witness fees and court costs. The claimant’s attorney must provide a copy of the fee
agreement along with documentation of costs incurred during litigation. 42 C.F.R. § 411.37.

Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance.

Medicare has the right to scrutinize any settlement of worker’s compensation case or third-party liability case to determine if its right must be protected against a shift to Medicare of any third parties’ liability as it relates to future medical care. Unless funds are set aside that will meet the participant’s future medical bills, Medicare will not assume liability for future medical treatment when a third party is responsible.

Medicare set aside arrangements (“MSA”) have been developed as a device to comply with the law. There is no definition of “MSA” in the Medicare Secondary Payer law or regulations. An MSA is an allocation of settlement proceeds among the various damage components of a settled case. MSAs have become common-place in Workers’ Compensation cases and CMS has accepted MSAs as a preferred way of complying with the Secondary Payer law and minimizing future conditional payments. MSAs are becoming more common in third-party liability cases, but do not have the same extensive history as in Workers’ Comp cases. CMS has issued a series of memoranda explaining the use of MSAs in Workers’ Comp cases.

When should an MSA be considered? Does the settlement involve a medical claim? Is it reasonably likely that the injured person will have ongoing or
future medical expenses related to the claimed injury? Are these medical
expenses otherwise covered by Medicare? Is the beneficiary likely to be a
Medicare beneficiary when such medical expenses are incurred? What about in
third-party liability cases? CMS Regional Offices have indicated they will review
MSAs in tort cases to protect CMS’s interests, and the same criteria used in
Worker’s Compensation cases should be used
If the parties make a good faith effort to allocate the MSA, if CMS later reviews,
the burden is on CMS to prove the allocation as unreasonable.
Failure to adhere could cause the Medicare beneficiary to be denied
benefits. The defendants and their insurers might be forced to pay for future care
that was already compensated for as a component of the settlement. The
plaintiff’s attorney is faced with the possibility of a CMS recovery action against
his/her fee from the settlement. Attorneys on both sides may face malpractice
actions. CMS retains a retrospective review to determine if its rights were
protected.
There are arguments against submitting MSAs in third-party liability cases
to CMS for review. 42 C.F.R. Sections 411.46 and 411.47 expressly provide a
manner by which Medicare must adjust its benefits, should an allocation for
future medical expenses be provided in a workers’ compensation settlement; no
such regulation for liability cases. A CMS memo in July, 2001 indicating MSAs
would now be recommended in certain instances of case settlement, the memo
mentioned only workers’ compensation claims. There was no language,
processes, or procedures that
applied to liability claims and CMS has refused to review any MSA in a third-party
liability action.
This is still an evolving area and lawyers should proceed with caution.

G. Conclusion

Working on planning with the families of persons with special needs can be extremely satisfying. There is far more involved than just the production of “magic documents.” An attorney can be a valuable asset for a family faced with difficult decisions for a family member with special needs.