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Special Family and Lifestyle Tax Issues

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I. Introduction

A. Life Transitions and Differences Between Generations

1. Capacity to Incapacity. Fortunately or unfortunately, the transition from capacity to incapacity usually does not happen overnight. In most cases, there is some period of decline where the elder can still function, physically, mentally, or both. On the positive side, this provides the family with time to plan. On the other side, however, an extended decline can strain both relationships and finances, and can even place additional stress on the health of those in the caregiver position.

A diagnosis of dementia or a terminal condition should put the elder and her family members on notice that now is the time to review and update the estate plan, or if there is not an estate plan in place, to get a plan implemented immediately. Unfortunately we often see people who, even when faced with a diagnosis, will not take action whether out of fear, insecurity, or simply a desire not to burden family members. Because of this, it is crucial that family members and professional advisors work together to ease these concerns and encourage open, honest discussions and planning. When the planning is not done before mental incapacity sets in, there will be additional legal and financial issues to deal with which could have been avoided.

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2. Independent Living to Assisted Living to Skilled Care. The transition from independent living at home to any other living arrangement should be made by the elder herself, if at all possible. Unfortunately, more often than not, the decision is forced upon the elder because she was not proactive in planning. The "American dream" for seniors is that they will die quietly at home in their sleep and that there will be no nursing home, no incapacity, and no loss of independence prior to death. Unfortunately this is just not realistic. We can all hope for the dream, but very few of us will actually receive it. So, we need to make arrangements while we can so that we get what we want, not what is forced upon us.

Change is not easy for anyone, but it is much easier to accept when it comes on your own terms. As advisors, this is an area in which we can all work together to encourage our clients to be thinking ahead. All of my clients who are proactive in making arrangements for their future living arrangements, whether that be building on to a child's home, buying into a continuing care retirement community, or voluntarily moving into an independent or assisted living facility, do much better and are happier because the decision to move is their own. That still doesn't mean it's an easy decision, but having a plan in place before a crisis occurs will make dealing with the crisis that much less stressful, on both the senior and her family.

3. Living With a Child. There can be many advantages to living with a child, but there are just as many, if not more, challenges. As discussed below, some of the advantages center around asset protection. Paying a child rent is more appealing to many seniors than paying a facility or retirement community, and it usually costs less. A

child can also often help with caregiving needs and provide other support such as meal preparation and transportation services. However, if the arrangement will involve the exchange of money from the elder to the child, there should be a comprehensive agreement in place documenting the arrangement, and the child providing the services must report the payments as income on her tax return. The agreement should also address whether the child will be treated as an employee or an independent contractor for tax purpose.

The living arrangement may involve the parent moving into the child's home, but could also involve the child moving into the parent's home. If the parent moves in with the child, one popular Medicaid "spenddown" technique, the life estate, would be available. This involves the parent "purchasing" a life interest in the child's home. So long as the transaction is actuarially sound based on the fair market value of the property and the life expectancy of the parent, the transaction does not constitute a gift to the child and is a way of legally transferring funds from parent to child.

A variation of the life estate method could also work if the child moves in with the parent, but would involve either the parent "gifting" a remainder interest in the home to the child, which would constitute a transfer for Medicaid qualification purposes and may result in the imposition of a transfer penalty, or the child could "purchase" the remainder interest in the home from the parent, which would give the elder liquid assets in exchange. However, if the child moves in with the parent for the purpose of becoming a caregiver and thus keeping the parent out of the nursing home, the parent can transfer the home by gift to the child after two (2) years without the transfer being treated as an uncompensated transfer for Medicaid qualification purposes. This technique

is commonly known as the "caregiver child exception" to the transfer rules. The only requirement is that the child actually be living in the elder's home for the purpose of providing care which is keeping the elder out of a facility and must be so documented by the elder's physician.

Aside from the possible asset transfer options this living arrangement may provide, there are additional challenges which would normally result from blending the two households, regardless of who moves into whose home. Many such living arrangements till strain an already stressed parent-child relationship, and thus should be carefully considered from all possible angles.

4. **The Child Becomes the Parent.** If one or both parents become incapacitated or receive a diagnosis which will cause a physical or mental decline in the near future, it is necessary that someone step in to take care of their affairs. Advance planning on the part of both the elderly person and those who care about him will facilitate this process and be cheaper than waiting for a crisis to occur. Discussions should include the following questions:

- Have you met with an Elder Law Attorney and executed a Power of Attorney, Health Care Directive, Living Will, Will or Trust, and if so, where are these documents located?
- What is the name and address of the attorney you are working with?
- Who will take responsibility for you in an emergency health situation?
- Who will take the responsibility of managing your finances and paying your bills if you become incapacitated?
- What are your wishes regarding life-sustaining medical care and end of life decisions?

- Do you have a preference over where you would like to reside such as a retirement or independent living community, assisted living or long-term care facility if that should become necessary?

This discussion will not be easy and will depend on their mental, emotional, and physical condition along with the relationship they hold with the child. It is very easy to put off this conversation to avoid conflict or awkwardness, but it is better to have it then to wait for a crisis situation to occur. It is beneficial for the child to share her own feelings and help her parents maintain a sense of control. The child should also understand what the parents are expecting of her. The child may have a family, work and other obligations that will need to be considered. The child should also be honest in speaking with her parents about their conditions, both mentally and physically, and their prognosis.

The following are some warning signs that the child should look for to determine if one or both parents need extra help or a change in living arrangements:

- Disorientation to time and place such as showing up or calling at odd hours, getting dressed and ready to go to work at a job they retired from years ago, etc.

- General forgetfulness such as not paying bills, missing appointments, consistently forgetting names, and meal times.

- Sudden weight loss or loss of appetite or regularly eating processed foods.

- Lack of hygiene of person and residence.

- Mismanaging medications.

- Extreme suspiciousness or intense ungrounded fears.

•Inappropriate clothing choices such as wearing a winter coat and gloves in the summer.

•Evidence of small fires or soot on walls or ceilings.

•Car accidents and traffic tickets may indicate slowed reflexes, poor vision, physical weakness, or general inability to handle a vehicle.

•Increase in injuries such as broken bones, cuts and bruises, etc.

5. Death. Death is a part of life, and one day every living person will die. We don't have control over the how or the when, and it's not really something anyone wants to think too much about, but it is a fact of life. And, planning for death is really a part of life. So, why don't more people do it?

Fear is the primary reason for failure to plan. And yet most of us experience death more than once during our lives. We experience death through our parents and other family members; we experience the death of friends and co-workers; and some of us even experience the death of a spouse or a child. Death is not really something you want to plan for; after all, it's not like planning for a wedding. But there are some ways in which we can plan for death. Making funeral and burial arrangements ahead of time is becoming extremely popular, and is also a Medicaid spenddown technique. Not only will the individual get what he wants, but planning (and paying) ahead will ensure there are sufficient funds for these final expenses. If an individual wants to be cremated, preparing a written declaration in advance will avoid any potential disagreement among family members. Many people who desire to donate their organs for transplant or medical research will make arrangements ahead of time to ensure their wishes are followed. Finally, there may be some tax benefits to pre-planning either from an estate or income tax

standpoint. Advisors should discuss both the tax and non-tax planning options with clients and encourage clients to be as prepared as possible for death in order to ensure their wishes are followed and that the burdens on family and friends are minimized.

B. Distinguishing Between Professionals

1. "Specialization" and Focus of Practice. The Virginia State Bar prohibits attorneys from holding themselves out as an "expert" or "specialist" in any area of law. However, these days the reality is that the only way you can become proficient enough to practice with the degree of knowledge necessary to avoid malpractice is to specialize. So, although we don't "specialize," most attorneys focus their practices on a particular area or two of the law. Therefore these days it is possible to align yourself with an "expert" who can assist with questions and concerns you or a client may have which is outside your particular area of expertise. It is only by focusing our practice that we do become sufficiently knowledgeable to handle the depth and complexities of today's legal issues.

2. What we Do – Defining Yourself and the Professionals You Work With. It is crucial to align yourself with competent professionals who share your goals and who have the same desire to help others. Personal morals and ethics play a big part in selecting the professionals we work with. It is imperative to find people who focus on relationships rather than transactions.

Because attorneys tend to focus their practices in particular areas of the law, it is much easier to find an attorney with the skill set you are seeking. You should

be mindful of the reputations of the other professionals you elect to work with as their work may ultimately reflect on you or your relationship with your own client.

II. Disabled Children and Young Adults

A. Benefits Available – Disabled Child vs. Disabled Adult

1. Eligibility Rules – When Did the Disability Occur. Individuals who became disabled prior to age twenty-two (22) will qualify for Social Security Disability Income (SSDI) based on her parents' social security earnings records. In addition, children under the age of eighteen (18) may be eligible for Social Security Supplemental Income (SSI). A child under age eighteen (18) can qualify if she has a physical or mental condition, or combination of conditions, that meet Social Security's definition of disabled for children, and if her income and resources fall within the eligibility limits.

The income of the child is considered in evaluating eligibility as well as the income and resources of other family members living in the child's home. The child must not be working and earning more than $1,090 a month (2015 figure). The child must have a physical or mental condition, or a combination of conditions, that result in "marked and severe functional limitations" which seriously limit the child's activities. The child's condition(s) must have been disabling, or be expected to be disabling, for at least 12 months; or the condition(s) must be expected to result in death.

2. Medicare vs. Medicaid.

a. Medicare. Medicare is primarily a federal health insurance program for people 65 years or older. However, certain people with disabilities, and people with end-stage renal disease (ERSD) will also qualify for Medicare. Individuals who have

been receiving Social Security Disability Income (SSDI) for two (2) years and individuals who were disabled prior to age twenty-two (22) will also qualify for Medicare. There are four (4) major parts of Medicare (A, B, C & D). Medicare is run by the Centers for Medicare & Medicaid Services, an agency of the federal government.

Medicare Part A – covers inpatient hospital stays, care in a skilled nursing facility, and some home health care. It entitles the individual to coverage in a skilled nursing facility if he has been an in-patient in a hospital for at least 3 days, not including the day of discharge and requires restorative services such as speech therapy, physical therapy, occupational therapy and/or skilled nursing services. As long as the criteria is met, the individual is entitled to 100 days of coverage in a skilled nursing facility with the first 20 days paid in full by Medicare; for days 21 – 100 days, there is a co-pay amount ($157.50 per day in 2015).

Medicare Part B – covers certain doctor's services, outpatient care, medical supplies, and preventive services. The beneficiary must pay a monthly fee for this coverage and it is automatically deducted from his Social Security benefits before benefits are paid out each month. The amount of the premium is based on the modified adjusted gross income as reported on the individual's tax return from 2 years ago ($104.90 in 2015 for most beneficiaries). The deductible for 2015 is $147 a year. The beneficiary pays 20% of the approved amount after deductible, except in the outpatient setting. The beneficiary also pays 50% of most outpatient mental health services and 20% for all outpatient physical, occupational, and speech- language services.

Medicare Part C – Medicare beneficiaries may stay with the original fee for service Medicare or choose a Medicare Advantage Plan (HMO, PPO, Private Fee-for-Service, Special Needs Plans, and Medicare Medical Savings Account Plans). The Medicare Advantage Plan includes both Part A and Part B. Medicare pays a fixed amount for the beneficiary's care each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how a beneficiary gets services (for instance, whether beneficiary needs a referral to see specialist or if he can only see doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care) These rules can change each year. Most plans include Medicare Part D or prescription drug coverage. There is a premium charged by the insurance company for these plans.

Medicare Part D – This coverage adds prescription drug coverage to original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans. There is a monthly premium in additional to the Part B premium, as well as a yearly deductible.

b. Medicaid. Medicaid is a jointly funded, federal-state health insurance program that helps many people who can't afford medical care pay for some or all of their medical bills. Medicaid is available only to people with limited income and resources. This program is not an entitlement program. To be eligible for Medicaid, the

individual must meet certain requirements. Medicaid does not pay money to the individual; instead it sends payment directly to the health care providers, assuming they are Medicaid-participating providers. The Medicaid patient may be asked to pay a small co-payment or spend down assets before qualifying for Medicaid. Each state has different regulations regarding Medicaid programs offered and costs covered. In most states, including Virginia, transferring resources will make the applicant ineligible for Medicaid for a period of time. There is a 60-month look-back on all transfers for Medicaid eligibility purposes.

Medicaid is administered by the Department of Social Services (DSS) in each locality. DSS evaluates an individual's income (any type of funds paid such as Social Security, wages, pensions, interest, dividends, annuity payments, reverse mortgage payments, veterans benefits, etc.) and resources (funds owned singly, jointly or in revocable trust such as checking, savings, certificates of deposit, stocks, bonds, brokerage accounts, life insurance cash value, annuities, retirement accounts, real property, vehicles, mobile homes, and any other property that can hold a cash value) in evaluating an individual's eligibility.

B. SSI vs. SSDI. Eligibility for Social Security Supplemental Income is based solely on need. The individual must meet the Social Security Administration's definition of "disabled" and must have limited income and resources in order to qualify for SSI. Social Security Disability Insurance is different in that there are no financial eligibility requirements. Eligibility is based solely on the applicant satisfying the disability requirement. SSDI payments are based on an individual's contributions to social security

(or his parent's contributions if the individual was disabled prior to the age of twenty-two), and therefore the monthly amount paid is not the same for everyone.

C. Maintaining Benefits – What Funds Can and Cannot be Used for – Protecting Against Loss of Benefits. Once a beneficiary is receiving SSI, Medicaid, or any other means-tested benefit, it is important not to do anything which will unwittingly cause a termination of those benefits. With most programs, a single month of excess resources can cause the loss of benefits, or at least the imposition of a pay-back penalty. The addition of resources can be due to an impermissible payment on behalf of the beneficiary to a provider, the receipt of funds such as with an inheritance, the improper distribution of assets from a trust, etc. Thus, understanding the rules is the key to avoiding any unintended loss of benefits.

Income that is received during the month is considered income throughout the calendar month of receipt, even if it is deposited in a bank account. However, if it is still in the account, it becomes a resource in the next month and is then subject to resource rules discussed above. The SSI income rules can be rather complicated, but basically SSI will treat distributions to or for the benefit of a beneficiary in one of four ways:

- Direct income to the beneficiary;
- Not income;
- In-kind income; or
- In-kind support and maintenance.

As an example of the rules, the following will address distributions from a special needs trust to a beneficiary.

(1) Direct Income is any cash or money given to the beneficiary directly. It will immediately be considered income to the beneficiary and will reduce his SSI benefits on a dollar-for-dollar basis. As a result, the trustee should avoid making direct cash payments to the beneficiary. The trustee should also not reimburse the beneficiary for purchases he makes, even if the purchases are for exempt assets.

(2) Not Income – These are distributions made by the trustee to a third party (someone other than the beneficiary) which result in the beneficiary receiving items that are <u>not</u> food, clothing or shelter. Examples of distributions that are not income for SSI purposes are payments made by the trustee to a provider of medical or social services for care rendered to the beneficiary. There is no reduction in Medicaid for medical expenses paid by the trust, but obviously there would be no need to pay any medical expenses covered by Medicaid as the purpose of the trust is to pay for those items not covered by Medicaid.

(3) In-kind income exists when the trustee gives the beneficiary something other than money. In most cases, it is safe to provide such income to the beneficiary. The reason is that the value of any non-cash item (other than food, shelter, or clothing) is not counted as income if the item will become an exempt asset when it is retained into the following month. As a result, the trustee may give the beneficiary things which would be considered exempt (such as books, furniture, or recreational equipment).

(4) In-kind support or maintenance – If the beneficiary receives food, clothing or shelter as a result of payments by the trustee to other persons, then the beneficiary will have income in the form of in-kind support and maintenance (ISM). This is why the trustee is directed to exercise discretion under the trust agreement to make distributions which will supplement rather than provide for the beneficiary's basic needs. The beneficiary's SSI benefits will be reduced or eliminated if he receives ISM. Therefore, the beneficiary's SSI check should be used for food, shelter and clothing.

There are sometimes rather fine distinctions between allowable in-kind income and countable ISM. For example, the trustee can pay for some travel arrangements but not others (for example, a plane ticket – but not a hotel room, because that is shelter). The trustee can pay for some entertainment expenses but not others (for example, a movie ticket but not a restaurant meal, because that is food).

Note that the trustee can also pay for certain medications and alternative health treatments which are not covered by Medicaid. The trustee would not, however, use the trust assets to purchase medical care, services or equipment which are furnished for free under Medicaid or other governmental assistance programs for which the beneficiary is qualified. Cars and homes deserve special discussion.

(1) Cars. A car in the name of the SSI or Medicaid recipient is an "exempt" asset which is not counted for eligibility purposes. However, two problems can arise in titling a car in the disabled individual's name. First, if the car is sold and not immediately reinvested in another exempt replacement asset, the beneficiary will have cash in his name which, if in excess of $2,000, will jeopardize SSI and Medicaid eligibility.

Secondly, the disabled individual may not have the legal capacity depending upon the nature of the disability to receive or convey title to the car.

(2) Homes. A home is considered a resource in Virginia for Medicaid purposes. Under SSA program guidelines, the beneficiary is considered to have "equitable" ownership in a home titled in the name of the special needs trust and, therefore, the home should not be counted as ISM. However, if an issue does arise, the beneficiary could use a portion of his or her SSI check to pay rent to the trust. Mortgage payments, utilities, and certain household operating expenses paid by the trust are counted as income by SSI in the month of payment but improvements to the home, such as handicapped accessible improvements, are not counted.

D. Protecting Personal the Beneficiary's Own Assets

a. First vs. Third Party Trusts. Third party trusts are always exempt to the extent the trust qualifies as a "special needs trust" (discussed below). Third party trusts are funded with assets of a third party (not the disabled person). The disabled person is also not the trustee, and the trustee has total discretion in making distributions to the beneficiary. A special needs trust must not contain a standard HEMS (health, education, maintenance and support) standard. For tax purposes, the trustee should not be an immediate relative of the beneficiary.

Under § 674 of the Internal Revenue Code, trust income will be taxed to another person as owner of the trust if that person has the power to distribute corpus of the trust "to or for a beneficiary or beneficiaries or to or for a class of beneficiaries

(whether or not income beneficiaries)"[2] where the power is not limited by a reasonably definite standard such as a HEMS standard, which is set forth in the trust instrument. This is true even where that person did not receive any of the income of the trust. The key for inclusion is that the person has the unfettered discretion to make distributions to a "nonadverse party."

Section 672 of the Code defines a nonadverse party as a person who is not an adverse party[3], and defines an "adverse party" as "any person having a substantial beneficial interest in the trust which would be adversely affected by the exercise or nonexercise of the power which he possesses respecting the trust. A person having a general power of appointment over the trust property shall be deemed to have a beneficial interest in the trust."[4]

First-party trusts (also commonly referred to as "self-settled trusts") are used to hold assets of the incapacitated individual and are discussed in subparagraph (b) below. These trusts are intended to preserve the beneficiary's eligibility for public benefits while still allowing the beneficiary to get full use of the trust assets.

b. Self-Settled Special Needs Trusts. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) created the framework for the self-settled trusts we use today. OBRA '93 basically discouraged self-settled trusts (previously referred to as Medicaid Qualifying Trusts) by providing that when an individual establishes a trust with his own assets 1) the trust assets will be considered fully available to the grantor

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[2] IRC § 674(b)(5).
[3] IRC § 672(b).
[4] IRC § 672(a).

for purposes of SSI and Medicaid eligibility, and therefore must be "spent down" before the grantor will qualify for public assistance (even if the trust is irrevocable and the trustee has total discretion over if, when, and how distributions to the beneficiary will be made); or 2) if the trust is irrevocable and the trustee is prohibited from making distributions to the grantor, then the trust assets are not considered available, but they are treated as having been "transferred" to the trust, and therefore subject to the penalty period applicable to uncompensated transfers.

OBRA '93 created three exceptions: 1) the d(4)(A) "payback trust," 2) the d(4)(B) "disability income trust," and 3) the d(4)(C) "pooled trust." Assets held in one of these types of trusts will not disqualify the beneficiary from receiving public benefits and there is no period of ineligibility created by the transfer of assets to one of these types of trusts. These three types of trusts are commonly referred to as OBRA '93 trusts. All three are authorized under the provisions of 42 U.S.C. § 1396p of the Social Security Act. These trusts are often used to hold litigation proceeds awarded to a disabled person, but can also be funded with an inheritance that was received without the benefit of having a third-party SNT in place.

In order to qualify as an OBRA '93 trust, the beneficiary must be disabled, must not be able to revoke the trust, and must not be able to direct the use of the trust assets for his own support.

(1) The requirement that the beneficiary be disabled is satisfied if the beneficiary meets the definition of disabled under the Social Security Act. § 1614(a)(3).

(2) An adult is "disabled" under § 1614(a)(3)(A) of the Social Security Act "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months."

(3) A child is "disabled" under § 1614(a)(3)(C) of the Social Security Act "if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

b. 42 USC § 1396p(d)(4)(A) vs. 42 USC § 1396p(d)(4)(B) vs. 42 USC § 1396p(d)(4)(C).

(1) The d(4)(A) "Payback Trust". This type of trust permits a parent, grandparent, legal guardian, or a court to establish a trust using the assets of a disabled person under age 65. Although § d(4)(A) requires that the individual be "disabled," there does not need to be a determination of disability made prior to creation of the trust. The determination may be made at the time the trust is submitted to the Social Security Administration for approval. The trust will generally contain a statement to the fact that the individual qualifies as disabled under § 1614(a)(3) of the Social Security Act and that the trust is created under the statutory authority of 42 U.S.C. § 1396p(d)(4)(A).

The trust must provide that the state Medicaid agency will be reimbursed from trust corpus at the disabled person's death for any public assistance

given to the disabled person. Any excess trust corpus not needed for repayment can be directed to remainder beneficiaries as the disabled person (or person establishing the trust) desires. Because the disabled person's own assets are used to establish the d(4)(A) trust, there are no gift tax issues on formation. The residual corpus will be included in the disabled person's estate at death.

Note that a d(4)(A) trust can only be established with assets of a disabled individual under age 65. The trust can still operate for a beneficiary who is over age 65, but it cannot receive any additional funding after the beneficiary attains the age of 65. Because of this limitation, the drafter should take care in dealing with structured settlements where payments are expected to continue past the beneficiary's 65th birthday as any funds coming into the trust thereafter will not be protected. Due to the payback provisions, the d(4)(A) trust should not be used by others to make gifts to or for the disabled person.

(2) The d(4)(B) "Disability Income Trust". This trust is limited to use in "income cap" states such as Florida, to allow a Medicaid applicant's income to be paid directly to the nursing home. The trust must be composed only of pension, Social Security, or other income payable to the individual. The state Medicaid agency will receive all amounts remaining in the trust upon the death of the beneficiary up to the total amount of medical assistance paid on behalf of the individual. These trusts are very unique and very simple, but not commonly used.

(3) The d(4)(C) "Pooled Trust". This type of trust is created and managed by a nonprofit organization. Although separate accounts are maintained for

each beneficiary of the trust, the assets are pooled for investment and management purposes. The account is created for the sole benefit of a disabled individual by his parent, grandparent, legal guardian, or a court. And, unlike the d(4)(A) trust, the disabled individual himself can also create the account. Further, unlike the d(4)(A) trust, the disabled individual does not need to be under the age of 65. The pooled trust must provide that to the extent that funds in the account are not otherwise retained by the trust upon the individual's death, the state Medicaid agency must receive some portion of the trust remainder to reimburse the agency for benefits paid to or for the disabled individual. The remainder of the trust assets is generally retained by the non-profit organization to be used for the benefit of similarly-situated individuals.

Unlike the d(4)(A) and d(4)(B) trusts, there is not a requirement of payback under a d(4)(C) trust. Payback is only required "to the extent that amounts remaining in the beneficiary's account . . . are not *retained by the trust*." (Emphasis added).

Nonetheless, some states have attempted to require a payback from a pooled trust despite the plain reading of the federal statute. These laws exist even though state law may not usurp federal law. As such, disagreements between states and charities are normally settled by negotiation or abandoned.

Amounts retained in the trust do not go to the general operating fund of the charity but rather are used for paying services for other beneficiaries with disabilities or for operating expenses of the pooled trust.

Unlike the d(4)(A) trust, the pooled trust is established by a master trust agreement. Individuals join the trust through a joinder or enrollment agreement. The agreement may be signed by the disabled individual himself if he has capacity. Alternatively, the agreement may be signed by the parent, grandparent, or legal guardian of the disabled individual, or by the court. If the agreement is signed by a parent, grandparent, or legal guardian, that person must have the legal authority to act with respect to the assets of the beneficiary.

E. Estate Planning Issues

1. Elderly Parent With Disabled Child

a. HIPAA. The Health Insurance Portability and Accountability Act (HIPAA), often called the "Privacy Policy," restricts the release of personal medical and health insurance information by medical personnel, hospitals, and insurance companies to only authorized individuals. Who does that include? It does not automatically include your spouse, adult child, partner, parent or any other person. A Universal HIPAA Release identifies precisely to whom such information should be released. This is important, as you want to ensure that the people you have chosen to make your health care decisions if you cannot do it yourself can get important information regarding your diagnosis, prognosis and medical options from all of your health care providers and insurers, in order to make the best medical decisions on your behalf.

b. Guardianship and Standby Guardians. A guardian is a person appointed by the court who is responsible for the *personal and medical affairs* of an incapacitated person, including responsibility for making decisions regarding the

person's support, care, health, safety, habitation, education, therapeutic treatment. A standby guardian is a person appointed by the court that is empowered to assume the duties of guardian immediately upon the death or incapacity of the previously appointed guardian.

Every person over the age of eighteen (18) years of age is presumed to be able to manage her own affairs. In seeking a guardianship, the petitioner challenges this presumption and asks the court to: (1) find that the allegedly incapacitated person is not capable of managing her own affairs and (2) transfer the authority to make decisions from the incapacitated person to the petitioner. In sum, a guardianship results in a great loss of personal liberties for the individual. For example, the person will lose the right to vote, the right to marry and enter into contracts, and the right to operate a motor vehicle.

The Commonwealth of Virginia exercises its authority to protect persons with disabilities and its citizens generally by ensuring that guardianships are only granted when necessary. Furthermore, after a petitioner is appointed guardian, the Commonwealth ensures that the person appointed appropriately attends to the incapacitated person's physical and financial needs. A guardian shall maintain sufficient contact with the incapacitated person to know of the person's capabilities, limitations, needs, and opportunities. In addition, the guardian shall visit the incapacitated person as often as necessary. The purpose is to ensure that the best interests of the incapacitated person are represented and accounted for. A guardian serves as a fiduciary to the incapacitated person. A fiduciary is one who stands in a relationship of trust to another

and must act prudently and in the best interests of the person for whom he or she is appointed as a fiduciary.

2. Properly Setting Aside Funds for a Disabled Individual

a. Supplemental (Special) Needs Trusts.

A supplemental needs trust (also referred to as a "special needs trust") enables a disabled person to qualify (or maintain eligibility) for government benefits such as SSI and Medicaid. The main purpose of a supplemental needs trust (SNT) is to enhance the quality of life for the disabled person by providing funds that will supplement what the individual otherwise receives from the government.

A stand-alone SNT can be either revocable or irrevocable. An SNT can also be established as a sub-trust under a revocable living trust or by a testamentary bequest under a will.

(1) A stand-alone supplemental needs trust would primarily be used where the client prefers to create an *inter vivos* SNT, perhaps to act as the receptacle of gifts and/or inheritances from third parties such as grandparents or other relatives. The trust should be at least minimally funded when established.

(2) If the trust is revocable by the grantor, there is no current gift tax liability for transfers of the grantor's own funds to the trust. However, the grantor's ability to revoke the trust after a gift is received from a third party creates a general power of appointment in the grantor. Thus, if the grantor has a taxable estate, and gifting by third parties is anticipated, an irrevocable trust may be a better choice. A revocable SNT also remains subject to the creditors of the grantor.

•Note that both a special needs sub-trust created under a revocable trust and a testamentary special needs trust created under a will have the same features as a revocable stand-alone SNT (i.e. no completed gift, property remains in estate of grantor, and property remains subject to creditors of grantor during the grantor's lifetime).

(3) If the trust is irrevocable, funding of the trust during the grantor's lifetime would be considered a current gift that would not qualify for the federal gift tax annual exclusion. Because of the danger of disqualifying the disabled beneficiary from government benefits, Crummey withdrawal rights cannot be incorporated into the trust instrument. Therefore, gifts to the trust will not qualify for the federal gift tax annual exclusion. Similarly, gifts to the trust from persons other than the grantor will also create a gift tax liability in the donor.

(4) An irrevocable SNT is its own entity for tax reporting purposes. Thus, the SNT will need to have a federal tax identification number (TIN) assigned by the IRS. The trust will file annual tax returns and pay income tax according to I.R.C. § 1(e).

(5) A supplemental needs sub-trust established for a spouse under a revocable trust will not qualify as exempt for Medicaid purposes. In planning for an institutionalized spouse, the rules specify that only a testamentary trust is exempt.[5] If using a revocable trust-centered estate plan, Medicaid eligibility can still be preserved if

[5] 42 U.S.C. § 1396p(d)(2)(A)(ii).

the trust has a "pour-back" provision which permits the trustee or trust protector to subject a portion of the revocable trust assets to probate. The grantor's will can then contain a provision to establish a special needs trust for the spouse, and the requirement of a testamentary trust is satisfied.

An SNT strictly limits the beneficiary's access to the trust assets. Since the purpose of an SNT is to provide for supplemental or extra care which is over and above what the government provides (or will provide) for the individual, the standard provision permitting invasion of principal for health, education, support and maintenance is not appropriate. A properly-drafted SNT is going to limit the trust assets to being used for the supplemental comfort, safety, health, education, and welfare of the beneficiary which would be in addition to and over and above the benefits he would otherwise receive as a result of his disability from any local, state or federal government, or from any other private agency, which provides service or benefits to persons with disabilities.

There is a distinction between trusts which are intended to be funded using the assets of a disabled person and trusts that are intended to be funded using the assets of a third party. Where the disabled person's assets are to be used, the trust must conform to the requirements of 42 U.S.C. § 1396p(d)(4). These trusts, referred to as self-settled trusts, have been previously addressed in paragraph A(5) above.

b. ABLE Accounts. On December 19, 2014, the Achieving a Better Life Experience (ABLE) Act was signed into law. The law allows individuals with disabilities to establish special financial accounts similar to college savings accounts. The

provisions of the Act have been incorporated into the Internal Revenue Code in a new Section 529A. Since this process was established under federal law, the states individually must take action to make the accounts available within each state. Virginia was actually the first state to implement the ABLE Act and ABLE accounts have been available in Virginia since July 1, 2015.

Contributions to an ABLE account can be made by anyone and are treated as a completed gift of a present interest to the beneficiary of the account. As a result, contributions to an ABLE account qualify for the annual gift tax exclusion and, to the extent of the exclusion, are also exempt from the generation-skipping transfer tax exclusion. Contributions are not tax deductible to the donor and income earned on the accounts is not subject to tax so long as the funds are used for "qualified disability expenses." Distributions which would qualify as disability expenses under the ABLE Act include expenses incurred for the benefit of the beneficiary in maintaining or improving his health, independence, or quality of life such as housing, transportation, health and wellness, education, legal services, funeral and burial expenses, employment training, technology services, etc.

ABLE accounts can only be set up for individuals who are severely disabled prior to age 26. "Disabled" is defined as someone who is receiving Social Security Supplemental Income (SSI) or Social Security Disability Income (SSDI), or someone who is blind or has been determined to be physically or mentally impaired and such impairment results in severe functional limitations which can be expected to result in death or have lasted for a continuous period of not less than twelve (12) months. Where the individual

is not receiving SSI or SSDI, there must be a disability certification submitted when the account is opened. Each account must then submit to the Commissioner of Social Security electronic monthly statements reporting distributions and account balances.

c. I.R.C. § 529 College Savings Accounts. College savings accounts are governed by § 529 of the Internal Revenue Code. College savings accounts are used to set aside funds for the benefit of a child for future education expenses. These funds grow tax free, and to the extent they are used for qualifying education expenses, will never be subject to income tax upon withdrawal. College savings accounts are established for the benefit of one person, but the beneficiary can be changed and the funds redirected to benefit another individual without penalty. Investments in the account will qualify for the annual exclusion to the extent they do not exceed the exclusion amount available in the year in which the deposit was made. However, there is an exception to this rule. The donor may use up to five (5) years of annual exclusion gifts in advance to cover a larger gift to a college savings account with no loss of the federal lifetime estate and gift tax exclusion so long as the donor does not make additional gifts to the same beneficiary in any of the five years covered by the initial gift. And, if the donor dies prior to the expiration of the five (5) year period, the balance of the advance gift will be deducted from the available estate tax exemption at the donor's death.

At present, a 529 college savings account cannot be rolled into an ABLE account because such distribution would not constitute a qualifying higher education expense defined in I.R.C. § 529.

d. Uniform Transfers to Minors Act (UTMA). The Virginia Uniform Transfer to Minors Act[6] permits gifts to a savings or investment account for the benefit of minor. There are no fees assessed against these accounts. Interest earned may be taxed (wholly or partially) to the parent of the minor if the minor is under age 18 (or age 24 if a full-time student who is a dependent of the parent) to prevent parents from shifting income to the lower tax bracket of a child who has no earned income of her own. This is commonly referred to as the "kiddie tax," and applies where the unearned income of the child is more than $2,000.

3. Pre and Post-disability Planning – Building in Flexibility. Flexibility means the ability to adapt to changing needs and circumstances which is a feature of utmost importance in drafting irrevocable trusts, or revocable trusts that will become irrevocable. For example, if a beneficiary should become incapacitated at some future point in time, it would be beneficial to restructure how assets set aside for that beneficiary would be held, administered and distributed. It may be that the original plan was for the beneficiary to receive the assets upon attaining the age of thirty (30), but the beneficiary was involved in a serious car accident at age twenty-five (25) which rendered him unable to manage his own affairs. Assume that as a result of the injuries sustained, the individual could not work or make a decent living and ultimately qualified for SSI and Medicaid. If the beneficiary then receives the trust assets upon attaining age 30, he will lose his benefits. As has been previously addressed, it would be better if the assets could

[6] VA Code § 64.2-1900 *et seq.*

be protected for the beneficiary so he could maintain his benefits and the assets could then be used for supplemental, comfort-type purposes. The following are some of the best options for the estate planner desiring to give his client maximum protection with the ability to adjust to such a change in circumstances:

(a) Limted Power of Appointment. A trust beneficiary, such as the surviving spouse, could be granted a limited power of appointment to change the time and manner of a future distribution to the grantor's descendants. This power would give the surviving spouse the power to adjust the provisions for distributions to the beneficiary described above without causing any negative tax implications for the spouse.

(b) Trust Protectors. Trust protectors can be given powers to modify dispositive provisions under certain circumstances or situations. The power must be carefully structured to avoid any negative tax implications to the trust protector or the trust as well as to avoid possible misuse or abuse by the trust protector. The individual named as trust protector should be someone the grantor trusts to do the right thing.

(c) Power of Attorney Authority to Establish SNT or change trust provisions. This is a power in the power of attorney to permit the agent to establish a new trust for the benefit of a disabled beneficiary (or the principal himself, such as a d(4)(A) trust) or to change the provisions of an existing trust. The power should be narrowly drafted to avoid unintended consequences.

F. Divorce

1. Interrelation Between Divorce and Estate Planning. A divorce affects an individual's estate plan, but many people do not think about updating their estate

planning documents or beneficiary designations after a divorce because they are so happy just to be done with the divorce. The Commonwealth of Virginia acknowledged this issue when § 20-111.1 of the Virginia Code was first enacted in 1993. Section 20-111.1 provides that certain provisions of a will or beneficiary designations are automatically voided by a divorce. If the situation qualifies, the former spouse will be treated as having predeceased the decedent. For example, if a will names the spouse as beneficiary and personal representative of the estate, and a divorce later occurs, even if no changes are made to the will prior to the testator's death, the former spouse will be treated as having predeceased the testator and will have no rights under the will, either as a beneficiary or as personal representative. Similarly, a beneficiary designation naming a spouse as beneficiary of a life insurance policy will be automatically terminated upon divorce and the former spouse will not receive the death benefit even if the decedent fails to make the change to his beneficiary designation prior to his death.

There is one exception to this rule regarding beneficiary designations. Any benefits which are governed by federal law, such as an employer-sponsored benefit (i.e. a 401K or an employee group life insurance policy) are not affected by divorce. Under federal law, the name on the form is determinative of who the decedent wanted to receive the benefits. So, if the decedent failed to change his beneficiary designation, federal law will assume that he wanted the former spouse to receive the benefits.

Under the conflict of laws rules, federal law always preempts a state law on the same issue, so there have been plenty of situations where a former spouse received benefits the decedent likely would have wanted to go to someone else. Therefore, in 2012,

Virginia law amended § 20-111.1 in an attempt to address this conflict between federal and state law by providing that if the former spouse receives benefits because of the rule of preemption, the former spouse will be personally liable to the person who would have otherwise been entitled to the payment under Virginia law.[7] This means that the former spouse will be required to pay over the funds received to the person who would be entitled to receive them notwithstanding the rule of preemption. Unfortunately, if the former spouse is not willing to voluntarily turn over the proceeds, the individual entitled to the funds under Virginia law will have to file a lawsuit to enforce the provisions of § 20-111.1D.

2. Protecting a Disabled "Child" of Divorcing Parents. Disabled children of any age can get caught up in the divorce of their parents. Where the child is under the age of majority (age 18 in Virginia), custody will be a part of the divorce proceedings. However, many older couples are also caring for disabled adult children in their home or provide support to disabled adult children living elsewhere. Because these "children" are over the age of majority, custody is not normally a part of the divorce proceedings. However, under Virginia law, the Court can order support to be paid by one or both parties if the child has a severe and permanent physical or mental disability which existed prior to the age of 18, the child is unable to support himself and live independently, and the child resides in the home of the parent seeking support.[8]

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[7] VA Code § 20-111.1D
[8] VA Code § 20-124.2C

Normally, guardianship has already been established for these disabled adults, which is not affected by divorce of the parents who are probably also serving as the guardians. That does not mean, however, that these children are not affected by the divorce. Where both parents still desire to remain involved in caring for a disabled adult child notwithstanding the divorce, there are other types of agreements that can be put into place to protect and preserve each parent's rights to participate in the care management and support of the disabled adult child. Provisions for financial contributions to the child's maintenance and support can be incorporated into the separation agreement. For example, the separation agreement can require one spouse to maintain health insurance coverage for the disabled child. It can also provide how future support will be divided between the parents, especially where the child is over age 18 or the situation is not such that the Court will order support.

It is also common in these situations for parents to establish a special needs trust for the child as part of the equitable division of property. Again, this is not something a court can impose on the parties, but assuming the parties agree, can be a wonderful way to ensure protection for the child's future. The parties can agree to fund the special needs trust with certain assets as part of the equitable division of property. In this manner, both parents are contributing to the security of the disabled child's future.

III. Disability Planning for the Elderly

A. What is "Elder Law"? Elder law is a special area of law which focuses on legal issues which impact senior citizens. It is best defined by the demographics of the clientele the elder law attorney serves – the elderly and the disabled. Actually, Elder Law

spans numerous areas of the law including estate planning, family law, disability law, health care law, Medicare, Medicaid, and Social Security.

B. Paying for Long-Term Care Costs[9]. Long-term care is very expensive and generally not covered by Medicare. Medicare pays only for necessary medical care provided by a skilled nursing facility or home-health care. Medicare does not pay for "custodial care" which is focused on assisting individuals with activities of daily living. Medicare will help pay for a short stay in a skilled nursing facility, for hospice care, or for home health care if the following conditions are met:

- There has been a recent prior hospital stay of at least three days;
- The patient is admitted to a Medicare-certified nursing facility within 30 days of the prior hospital stay; or
- The patient needs skilled care, such as skilled nursing services, physical therapy, or other types of therapy.

If any of these circumstances apply, Medicare will pay for some of the costs for up to 100 days. For the first 20 days, Medicare pays 100% of the costs. For days 21 through 100, the patient pays up to $157.50 per day (as of 2015), and Medicare pays the balance. The patient is responsible for 100% of the costs for each day spent in a skilled nursing facility after day 100.

The following are the most common funding sources for long-term care:

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[9] Much of the information in this section was reproduced from materials written by this author for a seminar sponsored by the National Business Institute in 2005 entitled *Elder Care in Virginia: Legal and Financial Issues.*

1. **Long-Term Care Insurance.** Many private insurance companies provide policies to cover long-term care expenses including both skilled and non-skilled care. Coverage can vary widely. Some policies only cover nursing home care while other policies will cover home care, assisted living facilities and/or adult day care facilities. The cost of long-term care insurance increases with the age of the insured and the coverage afforded by the policy. For most people, waiting to purchase long-term care insurance until it is actually needed or a need is anticipate makes it too expensive. The time to purchase long-term care insurance is when a person is young and immediate need is not anticipated.

These days, there are more options available, but coverage is also more expensive and usually for shorter duration. For example, you can no longer purchase an "unlimited" policy. Each policy will have a maximum amount of coverage over a maximum period of time. However, there are also policies that provide for refunds if the policy is never needed for long-term care. Some life insurance policies have long-term care riders which allow the insured to tap into the death benefit for long-term care expenses if needed during lifetime. Finally, there are annuity products which permit an individual to make an investment in a policy which the company will match (up to two or three times the initial investment) for long-term care expenses.

Long-term care insurance affords more flexibility in the selection of long-term care facilities because the individual can customize his care by choosing the types of services he needs or desires. Through long-term care insurance, the individual can also preserve her assets to provide for comfort care items and other things that Medicaid does not provide and still have assets to leave to family members at death.

2. VA Pension and/or Medicaid.

Medicaid is a combined federal and state-funded program for the payment of medical expenses of individuals who are deemed "eligible" under the guidelines established under Title XIX of the Federal Social Security Act and the individual state's plan for operation of the program in the state. Unlike Medicare, Medicaid is a need-based program for low-income individuals and families. For individuals who qualify. Medicaid does cover nursing home care and long-term care services at home and in the community through the EDCD (Elderly and Disabled Consumer Directed) waiver.

The Veteran's Administration provides nursing home care at VA nursing homes for qualifying veterans. The individual must meet eligibility requirements and there is usually a waiting list for VA nursing homes. In addition, VA Pension is a benefit provided to wartime veterans through the Department of Veterans Affairs which can be used to supplement an individual's income to help pay long-term care expenses. VA Pension is discussed in greater detail later in these materials.

3. Private Pay. Private pay is merely using one's own income and assets to pay for one's own care expenses. People with high income are often able to "self insure" because they have enough money coming in on a monthly basis that they are not dipping too much into principal every month, and thus the principal lasts longer. People who pay for their own care will likely see a reduction in their annual income tax liability because as the costs of care increase, these individuals are entitled to more of a deduction against gross income. Some options available to those who want to go the private pay route

include tapping into the equity of the home and accessing built-up cash in life insurance policies.

a. Reverse Mortgages. Reverse mortgages are special types of loans used to convert the equity in a home into money which can be applied for any purpose but especially for long-term care costs. The amount an individual can receive through a reverse mortgage will depend on the individual's age at the time of the loan, the amount of equity in the home, the market value of the home, and the current interest rates. The payout can be in the form of a lump sum or line of credit. The money is tax-free, but it does count as income for purposes and Medicaid eligibility. No payments need to be paid on the loan so long as the individual is living in the home. However, the loan must be paid back (with interest) when the individual sells the home, moves out, or dies. As a result, this is really only an option for an individual who is receiving home care or where there is a spouse who will continue living in the home. What's the drawback? Reverse mortgages are extremely expensive; closing costs are much higher than with a traditional loan and because of the possibility of a future reduction in the home's value, there is often a life insurance component tied into the loan which will provide additional funds to pay off the loan if the debt exceeds the home's value upon eventual sale.

b. Life Insurance. Life settlements permit an individual to sell life insurance on his life to a third party for more than the present value of the policy but less than the full death benefit. The money received is taxable income to the insured. Life settlements have been around for a very long time but are not used much today because the industry is so heavily regulated. Many states have waiting periods which can be as much

as five years before a policy can be sold. The technique grew out of a U.S. Supreme Court Case, Grigsby v. Russell[10]. The technique goes against the requirement that in order to own life insurance on another individual, the owner must have an "insurable interest" in the insured. Where there is no insurable interest, the insurance proceeds are 100% taxable to the beneficiary.

Viatical settlements permit a terminally ill or chronically ill individual to sell her life insurance policy to a third party. The insured person must have a life expectancy of less than five (5) years. The insured receives an amount less than the death benefit from a third party payor. The third party must then wait for the insured to die, at which time he will receive the full death proceeds provided by the policy.

Many policies accumulate cash within the policy which can provide cash to the insured by borrowing against the policy. The loans will generate interest until repaid and any outstanding balance remaining upon the death of the insured will be subtracted from the death benefits payable to the beneficiaries.

Finally, accelerated death benefits can be added to an existing life insurance policy to provide cash advances against the death benefit to be used during the lifetime of the insured. These types of policies cannot be used unless the individual has a terminal illness, needs permanent nursing home care or cannot perform the activities of daily living. Accelerated death benefits are an alternative to long-term care insurance, but the monthly benefit provided by an accelerated death benefit might be less and the coverage period

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[10] 222 U.S. 149 (1911).

shorter than can be achieved through a traditional long-term care insurance policy. Additionally, the face value of the policy might not be large enough to cover all long-term care costs.

C. Veterans Benefits

1. Compensation vs. Pension.

a. Compensation is available to veterans who were injured or suffered an illness during their military service which resulted in a partial or total disability that is expected to last for the remainder of the veteran's life. The veteran must prove a connection between his service and the injury or illness causing the disability. Veterans qualifying for compensation are assigned a rating of 0 to 100 percent based on the severity of the disability and its overall affects on the veteran's everyday life. The rating determines the amount of monthly compensation paid to the veteran. For example, a veteran can be assigned a disability rating of 0%, which means that the VA acknowledges the veteran suffered an illness or injury as a result of military service, but the condition does not affect the veteran's everyday life.

In addition to qualifying for the monthly payment, all veterans assigned a disability rating of 0% or above are also entitled to certain other benefits provided by and through the Veterans Health Administration such as prescription medications. Because the purpose of compensation benefits is to repay the veteran for what he lost through serving his country, eligibility for compensation is not based on the veteran's income or net worth. However, eligibility for certain other benefits provided by

the Veterans Health Administration can be affected by the veteran's other "means" of support.

b. Pension (called "special monthly pension" for veterans and "death pension" for surviving spouses) is the VA's version of SSI. It provides a monthly income to eligible disabled wartime veterans, or their surviving spouses, to help meet expenses. Eligibility for pension is not based on any illness or injury that occurred during service. Instead, pension is provided as a way of honoring disabled wartime veterans by ensuring they have at least a basic means of support. There are three (3) levels of pension – base pension, pension with housebound, and pension with aid and attendance. Pension is often erroneously referred to as "aid and attendance" because aid and attendance provides the highest monthly income and is thus the most common type of pension application.

2. Eligibility Rules for Pension. The pension program is intended to afford beneficiaries a minimum level of security, and is not intended to protect substantial assets or build up the beneficiary's estate for the benefit of heirs. The Veterans Service Representative (VSR) reviewing the application determines whether or not the claimant's financial resources are sufficient to meet his basic needs without assistance from the VA. If a claimant's assets are large enough that the claimant could use these assets to pay living expenses for a reasonable period of time, net worth is considered a bar.

The Department of Veterans' Affairs uses a 3-part qualification process which includes: 1) service requirements; 2) disability requirements; and 3) a means test.

a. Service Requirements. A veteran is "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions, other than dishonorable." Active duty wartime service means 90 days of continuous active duty if prior to September 7, 1980, or entered service after September 7, 1980 and has completed a continuous period of active duty of at least 24 months; and at least one day was served during a declared war period. There is no requirement that the veteran have served in a combat zone or even that the veteran have been "in-country" during any portion of his service. The eligible wartime periods are:

	Start	**End**
WW II	12/7/41	12/31/46
Korea	6/27/50	12/31/55
Vietnam	8/5/64 (2/28/61 if in country earlier)	5/7/75
Gulf War	8/2/90	No end date set yet

The veteran (or surviving spouse) must be able to prove service. This is best accomplished by producing the veteran's discharge papers (Form DD 214).

b. Disability Requirements. To meet the basic disability requirement, the veteran (or surviving spouse) must be age 65 or older, or, permanently and totally disabled AND the impairment must be "reasonably certain" to continue throughout life. Where the veteran is living, it is the veteran, not the spouse, who must qualify as disabled. Once the veteran is deceased, the veteran's surviving spouse may receive pension benefits if she meets the disability requirements. Once the disability requirement is met, the payment amount is based on the extent of the disability. The

pension amounts are adjusted annually. For 2015, a veteran qualifying for base pension can receive up to $1,072 if single and $1,404 if married; a surviving spouse can receive up to $719. However, as discussed below, the VA considers the individual's other available income, and if that income exceeds these maximum benefit amounts, the VA will not pay anything.

(1) The veteran (or surviving spouse) will qualify for the additional "housebound" benefits if:

(a) he has one single disability rated at 100% disabling plus a second rated at 60%; or

(b) there is a showing that the claimant is "permanently housebound," which means substantially confined to her home (or ward if institutionalized) and immediate premises; and

(c) the disability is expected to continue throughout the claimant's lifetime.

Housebound is not construed to mean unable to leave the house at all, but rather unable to leave for the purpose of earning an income. In 2015, a veteran qualifying for pension with housebound benefits can receive up to $1,310 if single and $1,642 if married; a surviving spouse qualifying for pension with housebound benefits can receive up to $879.

(2) The veteran (or surviving spouse) will qualify for the additional "aid and attendance" benefits if:

(a) blind or in a nursing home; or

(b) needs assistance with at least 2 ADLs (activities of daily living). ADLs include the ability to dress or undress, keep oneself clean and presentable, frequent need of prosthetic adjustment, ability to feed oneself, ability to use the bathroom independently. In addition, the VA will consider any other incapacity (physical or mental) that requires care or assistance on a regular basis; or

(c) is bedridden

In 2015, a veteran qualifying for pension with aid and attendance benefits can receive up to $1,788 if single and $2,120 if married; a surviving spouse qualifying for pension with aid and attendance benefits can receive up to $1,149.

There must be medical evidence substantiating the disability. Such evidence may be in the form of medical reports and findings by VA or private physicians or from VA or non-VA facilities. If the individual is in an assisted living facility, the physician's report must state the claimant needs to be in a "protective environment." The medical evidence will be used to substantiate housebound or aid and attendance status.

c. Means Testing. The VA will look at the veteran's (or surviving spouse's) income and net worth in determining eligibility for pension.

(1) Income. Income includes payments of any kind from any source. The VA counts "household income" which means not just the veteran's income, but the income of all persons in the house (such as a spouse and/or dependent child). Income includes recurring income, regularly received such as wages or pensions, irregular income received or anticipated but received in unequal amounts or at irregular

intervals, interest on a savings account, as well as nonrecurring income received or anticipated on a one-time basis such as in inheritance or sale of an asset.

(a) When a claimant applies for pension, the application asks for projected income for the next twelve (12) months. The VA will allow certain exclusions from income such as unreimbursed medical expenses (UMEs). The expenses must have actually been paid, and must recur on a regular basis. At the time of application the claimant reports UMEs that will be incurred over the next 12 months. There is no UME deduction if the product or service is being provided free of charge. For example, if a friend or child of the veteran (or surviving spouse) is actually the one paying for the product or service, there can be no deduction.

Documentation is required for an expense to be allowed as a countable UME. The following items can be used as documentation: a receipt of payment, cancelled check, statement on the provider's letterhead, computer summary printout, ledger, or bank statement.

Wages paid to a caregiver who has been rated in need of aid and attendance or housebound are proper UMEs, even if the provider is a family member. However, if the family member is caring for a person who has not been rated in need of aid and attendance or housebound (i.e. pension only), the attendant must be a licensed health care professional in order to deduct the wages as UMEs. The documentation submitted must include: the amount paid, the date payment was made, the purpose of the payment (the nature of the product or service provided), the name of the

person to or for whom the product or service was provided, and identification of the provider to whom payment was made.

Other allowable medical expenses include: health insurance premiums, long term care insurance premiums, non-prescription drugs if directed by a physician, prescription drugs, medical supply items, assisted living and nursing home expenses, medical co-pays, and other expenses directly related to the care of the claimant. The expense must be recurring in order to qualify as a UME.

b. To calculate income for VA purposes (IVAP), subtract qualifying unreimbursed medical expenses from gross income. Unreimbursed medical expenses must exceed five percent (5%) of the maximum annual pension rate (MAPR) in order to be counted. The VA will only pay to the extent the amount of the individual's income is less than the maximum annual pension rate. Assuming the individual's income is less than the maximum annual pension rate, the VA will pay the difference between the individual's IVAP and the MAPR. Thus, the lower the IVAP, the higher the pension payment.

c. Other expenses, such as food and shelter expenses cannot be deducted from income.

(2) Net Worth. Net worth for VA purposes includes the market value of all real and personal property (i.e. bank and investment accounts, IRAs, stocks and bonds, etc.) which is owned by the claimant and spouse (except the claimant's primary residence and up to two (2) acres of surrounding property) and personal effects

consistent with claimant's reasonable mode of life. Unsecured debts do not decrease a claimant's net worth.

Prior practice was to exclude up to $80,000 of net worth in determining eligibility for pension. In recent years, however, the VA revised its procedure to one that analyzes the claimant's assets, income, and expenses in determining eligibility. Pension will be denied or discontinued when the corpus of the estate of the veteran and the veteran's spouse are such that when considering annual income, there are sufficient assets available to cover the anticipated expenses for the remainder of the claimant's life expectancy. In determining whether the veteran's net worth is sufficient to last for the remainder of his lifetime, the VA considers the following factors: 1) the amount of household income, 2) whether the property can be readily converted into cash at no substantial sacrifice, 3) the claimant's life expectancy, 4) the number of dependents, and 5) the anticipated rate of depletion based on current expenses.

However, the VA has recently proposed a new net worth limit which would be equal to the maximum Medicaid community spouse resource allowance (CSRA), currently $119,220. In determining a claimant's net worth, the VA will now add the applicant's annual income and assets to determine whether the claimant is under or over the limit. Note that the amount is still significantly higher than the traditional Medicaid and SSI limit of $2,000.

3. **Exempt vs. Non-Exempt Resources.** Unlike Medicaid, a claimant's home is exempt regardless of whether either the claimant or spouse is living in the property so long as the claimant intends to return home, whether or not such intent is reasonable

considering the claimant's medical condition. If the home is later sold, however, the sales proceeds are not exempt and may result in pension being discontinued for excess resources. One car and all tangible personal property, regardless of value, are also exempt.

4. **Transfer Rules.** Previously there were no penalties for transferring assets to reduce net worth for purposes of qualifying for VA pension. However, in January of this year, the VA announced it will soon be implementing a 36-month look-back period on asset transfers. Such transfers made for the purpose of qualifying the claimant for pension benefits could result in a penalty period not to exceed ten (10) years. The length of the penalty period would be based on the total value of the assets transferred during the look-back period if but for such transfers the claimant's net worth would have disqualified her for pension benefits. Any transfer made during the thirty-six (36) month look-back period would be presumed to have been made for the purpose of qualifying the claimant for pension benefits. Such presumption can only be overcome by clear and convincing evidence that the transfer was actually made for another purpose. The length of the penalty period will be based on the total value transferred (in excess of the maximum limit) divided by the maximum annual pension rate at the level of aid and attendance, resulting in a total number of months of ineligibility.

5. **Link between Department of Veterans Affairs and the IRS.** The VA used to require an annual Eligibility Verification Report (EVR) to be filed by every individual receiving pension benefits to ensure continued eligibility. However, the EVR requirement was discontinued a few years ago. Individuals are no longer required to submit

updated information of income and assets. Rather, the VA accesses income information reported to the IRS to determine whether an individual still qualifies for pension benefits.

D. Virginia Medicaid for Long-Term Care

1. Eligibility Rules. The following requirements must be met in order for an individual to qualify for Nursing Home Medicaid in Virginia: 1) at least 65 years of age or disabled; 2) citizen of United States or non-citizen in lawful immigration status; 3) must provide or file for a social security number; and 4) resident of Virginia. Anyone residing in a nursing home or assisted living facility certified for Medicaid is considered a resident of the last county and city that he resided in prior to institutionalization. If the patient was moved here by a family member, even if he was immediately placed in an institution, residency would be based on the family member's residency.

Medical need for care is established by a pre-admission screening if the individual is not in an institution or has resided in the institution less than 30 days (including hospitalization) by the County or City's Department of Social Services eligibility worker. Otherwise no pre-admission screening is required. The individual:

- Must be appropriately placed in a Medicaid facility that is able to provide the needed level of care, and must be actually receiving the needed services;
- Must have assets of less than $2,000 at least one day of each month of Medicaid eligibility;
- Spouse's assets must be no more than $119,220 (2015 limit) at time of Medicaid application;
- Be under no penalty for transfer of assets; and
- File for all other benefits to which applicant may be entitled.

a. Income. Under Virginia law, the community spouse is entitled to retain all of her own income, regardless of how much it is. If the community spouse's income exceeds the maximum Minimum Monthly Maintenance Needs Allowance (MMMNA), the community spouse will be required to contribute to the institutionalized spouse a small percentage of the amount which exceeds the maximum MMMNA. If the community spouse's income is less than the MMMNA, then some of the applicant spouse's income can be allocated to the community spouse to make up the difference. The MMMNA is between $1,991.25 and $2,980.50 in Virginia for 2015 (increases, if any, occur annually). In addition, the community spouse can receive more than the MMMNA by way of court order, where expenses justify it.

The institutionalized spouse's income, less any authorized contribution to the community spouse's income, and less the $40 personal needs allowance retained by the institutionalized spouse, is applied to the individual's nursing home costs. Where the income exceeds the Medicaid pay rate for services, the individual will be deemed to have too much income and will not qualify for Medicaid.

b. Resources. In order to qualify for Medicaid, an applicant can have no more than $2,000 worth of countable assets. If married, the community spouse can have up to an additional $119,220 of countable assets (subject to potential annual increases), unless increased by a judge's order. This is called the Community Spouse Resource Allowance (CSRA). Available assets are counted toward these limits and excluded (or exempt) assets are not.

In Virginia, the total assets of both spouses are combined and then divided in half to determine the share of the assets attributable to each spouse. If the amount (one-half of the total assets) falls between the minimum and maximum resource allowance, that's the amount the community spouse is allowed to retain. If the amount is less than the minimum, additional resources are allocated to the spouse to bring her up to the minimum. If the amount is greater than the maximum, the excess is allocated to the institutionalized spouse. The community spouse will only be allowed to retain the maximum CSRA.

•Example: H & W combined assets = $200K
½ = $100K
$100K is between minimum & maximum CSRA
Community Spouse will keep $100K
$98K must be spent down before the Institutionalized Spouse qualifies for Medicaid

2. Exempt vs. Non-Exempt Resources.

a. Exempt Resources. The following assets are *excluded* for Medicaid qualification purposes and not counted in the asset limit:

•Primary residence if equity is less than or equal to $552,000 and applicant intends to return home (excluded for 6 months only in Virginia)

•Primary residence, regardless of equity, if spouse, child under age 21, or blind or disabled child of any age lives there

•One vehicle

•Life insurance with no cash value

•Life insurance with cash value if the total face value of all such policies is less than or equal to $1,500.00

•Irrevocable burial contracts

•$1,500 designated for burial expenses (revocable burial contracts, burial savings accounts, or life insurance policies)

•One burial plot per family member

b. Non-Exempt Resources. The following assets are *available* for Medicaid qualification purposes and counted in the asset limit, whether owned by the applicant or the applicant's spouse, or owned by either of them jointly with someone else:

•Checking accounts

•Savings accounts

•Brokerage accounts

•Certificates of deposit

•Stocks and bonds

•U.S. savings bonds

•Primary residence after 6 months of institutionalization

•Cash value of life insurance if the total face value of all such policies is greater than $1,500.00

•Vehicles other than the one excluded vehicle

•Boats, unless excluded as a primary residence

•Recreational vehicles, unless excluded as a primary residence or only vehicle

•Loans payable to applicant

•Deferred annuities and some immediate annuities, depending on how they are structured and the date purchased

3. **Transfer Rules and Penalties.** Virginia Medicaid presumes that all transfers made for less than fair market value within sixty (60) months prior to an application for Medicaid (the "look-back period") were made *for the purpose* of qualifying the individual for Medicaid. Overcoming this presumption is next to impossible. Such transfers made within the look-back period result in the imposition of a penalty period during with the individual will be ineligible for Medicaid. Medicaid will not count transfers that occur outside of the look-back period. The look-back period begins when an individual is otherwise eligible for Medicaid.

The penalty period equals the number of months a Medicaid applicant is ineligible for Medicaid because of an uncompensated transfer made during the look back period. The penalty period can actually extend beyond the look-back period because it is calculated based on the value of the property transferred. For example, if Joe gifted $20,000 to his grandson on June 2, 2012 and entered the nursing home 3 years later, the gift to his grandson will be considered an uncompensated transfer made during the look-back period and will result in Joe being ineligible for Medicaid for a period of time.

The penalty period is calculated based on a "penalty divisor" established by the state (currently $8,367 for northern Virginia and $5,933 for rest of Virginia). The total amount of the gift is divided by the penalty divisor to get the penalty period. For example in Joe's case, the penalty period will be three months and eleven days, calculated as follows:

$20,000 / 5933 (penalty divisor) = 3.37
5933 x 3 = $17,799

$20,000 - $17,799 = 2,201
5933/31 = 191.39/day
2,201 /191.39 = 11.5 days

This is true even though Joe likely did not make the gift for the purpose of qualifying for Medicaid three (3) years later.

When does the penalty period start? Under 42 USC §1396p(c)(D) the penalty period starts when the applicant is determined to be **"otherwise eligible"** for Medicaid. Otherwise eligible means the applicant is both medically eligible and financially eligible. Financially eligible means the applicant's assets are determined to be below the allowable resource amount; medically eligible means the applicant is receiving (or requires) an "institutional level of care."

Exempt transfers are uncompensated transfers which do not trigger a penalty period. The most common exempt transfer is the transfer of the home to certain qualifying individuals. For Virginia Medicaid purposes, the home can be transferred to:

- a spouse
- a child under 21 or a child who is blind or permanently disabled
- a sibling who has an equity interest in and who has lived in the home for one year prior to institutionalization of the institutionalized sibling
- a child who resided in the home and provided care to the applicant for the prior 2 years for the purpose of keeping the applicant out of the nursing home

Any transfer to a disabled child or to a trust for the benefit of a disabled child is also treated as an exempt transfer for Virginia Medicaid purposes. Finally, using assets to purchase an

annuity will not be considered a disposal of assets for less than fair market value so long as the following criteria are met:

- the annuity is 1) irrevocable; 2) unassignable; 3) actuarially sound; and 4) pays out in equal payments with no balloon payment; and

- the state is named as the first beneficiary (or second after spouse or disabled child); the state will only get up to the amount paid out on behalf of the institutionalized individual

E. Tax and Non-Tax Considerations in Planning for Eligibility

1. Differences in VA and Medicaid Eligibility Transfer Rules. Certain spend down techniques will impose a penalty period for Medicaid but not for VA pension. For example, the house is always exempt for purposes of VA pension. And, therefore, the transfer of the house to anyone will not be considered a transfer which would disqualify the applicant for benefits. However, since the house is not considered an exempt asset under Virginia Medicaid, transferring the house to anyone other than the community spouse (or disabled child, etc.) will result in the imposition of a penalty period based on the value of the house at the time of transfer.

2. Spenddown Techniques – Tax Issues. Whenever an advisor counsels a client (or a client's family) on transferring assets to qualify for government benefits, the advisor must ensure she addresses both the tax and non-tax consequences of each proposed technique.

a. Capital Gains vs. Step-Up in Basis. Normally we are not concerned about estate and gift taxes in a Medicaid situation, but we should always consider the income tax implications of a transfer. Where a transfer is made for less than fair market value (i.e. an uncompensated transfer for Medicaid purposes), the person receiving the transfer (or gift) will take the asset at the donor's basis (carryover basis). Thus, when the asset is sold, the donee may be facing significant capital gains tax that could have been avoided had the donor not made the transfer during lifetime and instead passed the asset to the beneficiary at death. Notwithstanding the additional tax to the donee, it may nonetheless still be beneficial to make the transfer for purposes of qualifying

the individual for Medicaid. This is a cost-benefit analysis that must be done on each individual situation. Complicating the analysis is the fact that we normally do not know how long the individual will live and thus we can't always tell whether it would be more beneficial to make the gift and get the individual qualified for benefits or to hold onto the assets and forego Medicaid qualification. Ultimately this is not the advisor's decision; the advisor must advise on the pros and cons of each possible action, and it is the client (or his family) that must make the call.

b. Preserving the IRC § 121 Exclusion. If the home is sold rather than transferred, capital gains tax of up to $250,000 for a single taxpayer can be avoided if the taxpayer resided in the home for at least two of the five years prior to the sale. Recall that the house is not an exempt asset for purposes of Medicaid, but is an exempt asset for purposes of VA pension. However, if an individual gives away his home so he can qualify for pension, the recipient will take the donor's basis in the home and may incur capital gains tax when the house is ultimately sold. However, if the individual sells the home himself, there is no capital gains tax (assuming the criteria of § 121 can be satisfied), but the individual will no longer qualify for pension because he just took an exempt asset (the home) and converted it into a non-exempt asset (cash).

There is a way to protect the I.R.C.§ 121 exclusion while still transferring the home. It requires the use of a trust. This technique can be used for a Medicaid situation as well as a VA pension situation, but remember that since the home is not an exempt asset for Medicaid purposes, the transfer will result in the imposition of a penalty period. The trust will be partially a grantor trust and partially a non-grantor trust.

The grantor (owner of the home) must retain certain rights in the home only (not the other assets of the trust) sufficient to satisfy the criteria in § 121. The trustee can then sell the home within the appropriate time limit and obtain the capital gains exclusion of § 121. This is a complicated process and should only be attempted by a qualified attorney with experience in both tax and benefits planning law, but it can be an extremely beneficial technique.

3. Maintaining the Incapacitated Individual During the Penalty Period. When an individual engages in transferring (or gifting) assets as a means of spend down, there must be some funds set aside to provide for the individual should he require medical assistance during the penalty period. As discussed, there is a sixty (60) month look-back period for Medicaid and will soon be a thirty-six (36) month penalty period for VA pension. Often transfers are made with the hope the individual will be able to get through the look-back period without needing assistance. But because it is usually impossible to know when someone's health will deteriorate, any plan should consider the possibility of the need for assistance prior to the termination of the look-back period.

F. Marriage and Divorce of Seniors

1. Divorce as a Spend down Technique. Since the assets of both spouses are counted for Medicaid eligibility purposes, and since the community spouse is only permitted to retain up to $119,220 (plus the house) of the total household assets, sometimes divorce is the only option to protect the community spouse. Divorce is distasteful and against public policy, and as a result is normally a last resort for couples in this situation, but is occasionally employed for the security of the community spouse.

2. **Premarital Agreements.** Stated simply, marital agreements do not protect against having the assets of both spouses counted for Medicaid eligibility purposes. Despite anything contained in a marital agreement which would protect the assets of either spouse, the assets of both spouses are counted in determining the eligibility of one spouse. It is for this reason that divorce is often pursued as the only way of implementing the asset protection provisions of the marital agreement.

IV. Conclusion

Being proactive is the best way to prepare for life's transitions. Capacity to incapacity; independent living to assisted living to skilled care; life to death – many people do not plan, mistakenly believing that they will be the ones who never suffer tragedy, who never become incapacitated, who fall asleep one night at age 95 and die quietly. But the reality is that very few are lucky enough to escape the normal transitions of life. As professionals, we must recognize the need to plan, and encourage our clients to do so. We must have the candid discussions about the "what ifs." We must ask the tough questions that force our clients to face the possibility that there will be bumps along the road and that things do not always turn out perfectly, for it is only by planning that we can obtain a true sense of peace. Even if you don't know exactly what the future holds, you can have peace in the knowledge that there is a plan in place to help ease our transition, both personally and financially, through incapacity into death.