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ELDER LAW AND SPECIAL NEEDS PLANNING

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Elder Law and Special Needs Planning.

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II. Elder law myths and realities.

A. It won't happen to me; I'm never going into a nursing home.

1. People are living longer past age 65 (average of 19.3 years for men, 21.6 years for women).[1] For individuals who are highly educated and with higher incomes, the average lifespan is even longer.

2. According to AARP and the United States Census Bureau, over 40 million Americans are age 65 or older; by 2050, 20% of Americans will be age 65 or older.[2]

[1] Social Security Administration, Calculators: Life Expectancy, https://www.ssa.gov/planners/lifeexpectancy.html.
[2] Vincent, Grayson K. and Victoria A. Velkoff, 2010, THE NEXT FOUR DECADES, *The Older Population in the United States*: 2010 to 2050, Current Population Reports, P25-1138, U.S. Census Bureau, Washington, DC. https://www.census.gov/prod/2010pubs/p25-1138.pdf.

3. As demographics and societal norms change, the likelihood that a person will not have the option to rely on family and friends increases. With a decline in the number of elderly persons who live near their adult children, the fact that many people had fewer children than previous generations, and an increase in divorces and the resulting loss of lifetime commitment, this trend is not likely to abate. Elderly women are even more likely to be in a situation where they are outliving spouses and siblings, but not moving in with their adult children, resulting in the necessity of moving to a nursing home or other long-term care facility.

4. According to the U.S. Department of Health and Human Services ("HHS"), 70% percent of Americans turning age 65 will need some form of long-term care during their lifetime.[3] Over 5 million individuals in the United States have Alzheimer's disease. That number is expected to triple by 2050.[4]

B. Many people are under the misconception that Medicare will pay for the cost of their long-term care.

1. Medicare does not pay for long-term care.

a. Medicare will pay some costs for very specific kinds of care. While "skilled nursing care" may be covered to some extent after a qualifying hospital stay, "custodial care" is never covered.

b. Similarly, while Medicare may cover certain care needs resulting from an acute illness, such as rehabilitation services, for a limited time, the long-term care related costs of a chronic illness, such as dementia or Alzheimer's disease, are not covered.

c. Long-term care is a range of services and support for personal care needs, including help with activities of daily living, such as bathing, dressing, toileting, transferring, caring for incontinence, and eating. It may also include assistance with instrumental activities of daily living, such as housework, managing finances, taking medication, shopping, or using the telephone.

C. Many people are surprised to learn how expensive long-term care is.

1. The average annual cost of long-term care often exceeds $100,000; in major metropolitan areas, it can easily exceed $200,000.[5]

2. The costs of long-term care often bankrupt middle-class families since the United States has no health insurance system for long-term care. Medicare does not

[3] HHS, Who Needs Care? https://longtermcare.acl.gov/the-basics/who-needs-care.html.
[4] Alzheimer's Association, 2017 Alzheimer's Disease Facts and Figures, https://www.alz.org/facts/.
[5] Genworth, Long Term Care Costs Across the United States (2017), https://www.genworth.com/about-us/industry-expertise/cost-of-care.html.

cover long-term care and Medicaid has very strict income and asset requirements that must be met before benefits are provided.

D. A common misconception held by married individuals is that they are not responsible for the cost of their spouse's care. Although the law does provide some spousal protections, spouses are generally responsible for the cost of each other's long-term care.

1. The well spouse living at home (the "community spouse") is entitled to certain allowances, including a community spouse resource allowance ("CSRA") and a minimum monthly maintenance needs allowance ("MMMNA").

2. Even for couples who maintain separate finances, the responsibility for long-term care costs of the spouse exists since the marital estate is deemed to be one entity for these purposes.

3. While divorce can extinguish a spouse's responsibility for payment of long-term care costs in the future, there will likely be an equitable, or some other, distribution of marital assets in most states. The sick spouse's share of those assets will be available to pay for the cost of his care.

4. Pre-nuptial agreements that include provisions limiting or eliminating the responsibility for the cost of a spouse's long-term care are typically disregarded by government agencies since they are not a party to the agreement.

5. In a second marriage situation, it often makes sense for the spouse with the greater net-worth to consider purchasing long-term care insurance for his spouse, if possible. If the purchase of such insurance is not feasible, then consider setting aside funds in a trust to pay for long-term care.

E. The ability to make one's own financial and medical decisions often diminishes with age. Such issues as who will make these decisions for oneself can be addressed through advance directives such as powers of attorney and health care directives.

1. Issues such as where to receive care, how much to spend on care and visitation rights can be a source of family conflict.

2. These issues can become extremely contentious, especially in a second marriage situation where children from a prior marriage do not agree with the individual's spouse.

III. <u>Long-term care options.</u>

A. Home.

1. There are many advantages to receiving care at home for those who have the necessary support and finances to allow for this decision.

a. Often, individuals prefer to age in place, meaning that they want to remain in their homes with familiar surroundings for as long as possible.

b. If choosing to receive care at home, family and friends can provide much of the required care. In fact, it has been estimated that unpaid caregivers provide approximately 80% of care given at home, spending 20 hours a week, on average, giving care.[6]

c. In certain cases, it might make sense to compensate informal or family caregivers for their services. If the ultimate goal is Medicaid qualification, there generally must be a written caregiver agreement in place prior to the performance of services for which the caregiver is being compensated. The agreement should define the scope and duration of services being provided and the payments to the caregiver should be actuarially sound based on the life expectancy of the Medicaid applicant. To the extent all services required to be performed under the contract are not done, Medicaid may require a payback to the estate for the unused portion. Moreover, the rate paid for the services must be comparable to what is customary in that particular community.

d. The performance of caregiving services raises a number of significant income tax issues, including whether the caregiver is an independent contractor or an employee.

2. Although care at home is often an attractive option, there are pitfalls to be mindful of.

a. Home care can be very expensive, sometimes costing as much as or more than institutional level of care.

b. There is an increased risk of both financial and physical elder abuse by caretakers at home. Although there is significant under-reporting of cases, the National Center on Elder Abuse presents a variety of studies that find the perpetrators of elder abuse are most often friends, family members, and caregivers.[7]

c. In addition to the risks of abuse, sequester in the home often contributes to social isolation and may place an individual at risk for both physical and psychological medical problems.

B. Assisted living facility.

[6] HHS, Who Will Provide Your Care? https://longtermcare.acl.gov/the-basics/who-will-provide-your-care.html.
[7] NCEA, National Center on Elder Abuse, https://ncea.acl.gov/whatwedo/research/statistics.html.

1. An assisted living facility is an option for those who do not wish to, or cannot, remain in the community, but do not yet need the skilled level of care provided by a nursing home.

    a. A typical assisted living facility will provide for custodial care in an apartment-like setting, providing three meals a day, and supportive assistance. However, assisted living facilities are generally not licensed to provide medical care.

    b. While this is a good option for some, it should be noted that there are restrictions and requirements imposed on residents in an assisted living facility that do not apply to other settings. For example, many assisted living facilities have age and financial requirements for admission. In addition, as a provider of purely custodial care, there are no federal regulations governing these facilities, although many states have their own laws, regulations and licensing standards.

2. A signed admissions agreement is typically required prior to admission. This is a contract between the facility and the resident.

    a. The agreement is often non-negotiable. However, be wary of provisions regarding personal guarantors. If a family member is signing on behalf of a resident who cannot sign on his own, the signor should sign “as agent” or “as representative” to avoid being personally responsible for the costs of the facility.

    b. Additionally, assisted living admissions agreements typically contain a binding arbitration provision. Many such provisions are not consumer-friendly and families often feel pressured to sign the agreement because their loved one needs care.

3. Most assisted living facilities require private payment for services, and even those that accept Medicaid as payment often require that a resident prove that he has sufficient assets to cover a minimum period of time before having to rely on government benefits. Even where the resident is eligible for government benefits, the resident will sometimes remain private pay until the facility has a Medicaid bed available.

    a. The cost of an assisted living facility can range from $4,000 to more than $10,000 a month depending on location, quality of care provided, and degree of luxury.

    b. The cost could also be higher if private duty nurses are needed to supplement care provided due to the resident’s deteriorating condition.

c. In addition to the typical costs, add-ons to the daily rate for services such as keeping track of prescription refills, accompanying residents to doctor appointments, etc. are common.

d. Some of the costs of an assisted living facility may be deductible for income tax purposes as a medical expense, subject to the limitations of Section 213 of the Internal Revenue Code (the "IRC"). For this purpose, it is important to obtain a statement from the facility setting forth what portion of the cost is related to medical needs.

4. Notice requirements to vacate the facility vary widely but most provide for 30-days' notice.

a. A resident can be discharged for failure to timely pay for services rendered.

b. A resident may also be discharged if his level of care needs exceeds that which can safely and appropriately be provided at the assisted living facility.

C. Nursing home.

1. Skilled nursing facilities participating in the Medicare and Medicaid programs must meet certain requirements outlined in the Nursing Home Reform Act of 1987 (the "Nursing Home Reform Act") and the attendant federal regulations[8]. As such, residents of nursing homes have far more recourse in dealing with the facility than residents at other types of facilities, such as assisted living facilities, where their rights are typically governed by contract and/or state law.

2. The nursing home cannot require or request a third party guarantee of payment to the facility as a condition of admission or continued stay in the facility. However, the facility may require a resident representative, who has legal access to the resident's income and resources available to pay for nursing home care, to sign a contract, without incurring personal liability, to provide financial payment from the resident's income and resources. The person who has legal access to the resident's funds is often referred to as a "responsible party." Many nursing home admissions agreements attempt to impose additional liability on the responsible party above that which is permitted under the Nursing Home Reform Act. Nursing home admissions agreements must be reviewed carefully, especially the provisions relating to the definition of a responsible party and the obligations and responsibilities of that person.

3. A nursing home may not require a security deposit, as a condition of admission, from an individual who is being admitted to the facility for skilled nursing care after a qualifying hospital where the individual is eligible for Medicare coverage

[8] 42 C.F.R. § 483

for a portion of his stay in the nursing home. If the prospective resident does not have a qualifying hospital stay (discussed below) prior to admission to the nursing home, then there is no Medicare coverage available for the nursing home stay. In these cases, the facility is permitted to require a security deposit and often requires payment in advance for the first month's charges as well as a two-month security deposit.

4. Mandatory pre-dispute arbitration provisions are common in nursing home admission agreements. The Centers for Medicare and Medicaid Services ("CMS"), a federal agency within HHS responsible for administering the Medicare and Medicaid programs, had announced on September 28, 2016 that, as of November 28, 2016, mandatory pre-dispute arbitration provisions were no longer permitted. However, on November 7, 2016 the United States District Court for the Northern District of Mississippi, Oxford Division, issued an order preliminarily enjoining CMS from enforcing the arbitration ban.[9] On December 9, 2016, CMS announced that it would no longer enforce the ban. On June 8, 2017, CMS issued a proposed rule which would remove the provisions prohibiting binding pre-dispute arbitration and strengthen requirements regarding transparency of arbitration provisions in nursing home admission agreements.

D. Continuing care retirement community.

1. CCRCs offer the entire residential continuum, from independent housing, to assisted living, to nursing home care.

2. For many seniors, there is nothing more important than living out their final years with the highest quality of life possible. Thus, a CCRC offers the ability to age in place and is very attractive to an individual who wants to remain in familiar surroundings for the remainder of his life, but does not have the support system to facilitate long-term care at home.

3. For married couples, admission to a CCRC can aid in ensuring that they are not separated as a result of their differing care needs. Spouses at varying care levels can remain near one another while receiving the appropriate level of care.

4. The foregoing benefits, however, come at a price. CCRCs can be very expensive. Typically, there is an entrance fee, which can range from over one hundred thousand ($100,000) dollars to more than one million ($1,000,000) dollars. The disposition of the entrance fee money when the resident dies or moves is a major issue to be addressed when reviewing the residency agreement. Depending on the CCRC, all or a portion of the fee may be refundable. Sometimes the amount of the refundable portion is a function of how long the person has resided in the CCRC.

[9] *Am. Health Care Ass'n v. Burwell*, 3:16–CV–00233, 217 F.Supp.3d 921, 2016 WL 6585295 (N.D. Miss. Nov. 7, 2016).

5. In addition to the entrance fee, the CCRC will require a monthly fee of several thousand dollars. The amount of the monthly fee varies based on, among other things, the level of care provided and the geographic area of the facility.

6. The financial health of the CCRC (and possibly a parent company) must be examined. In 2003, the Continuing Care Accreditation Commission (CCAC) merged with the Commission on Accreditation of Rehabilitation Facilities (CARF) to form CCAC-CARF. CCAC-CARF sets forth accreditation standards for CCRCs in the United States. Not all CCRCs are accredited, but that does not mean that their financial health is not sound. Conversely, CCAC-CARF accreditation is not a guarantee of the entity's financial solvency. Prospective residents and their counsel (and accountant) should perform their own due diligence, especially if the CCRC has a substantial amount of debt.

7. A portion of the monthly service fees and the non-refundable entrance fee may be deductible as a medical expense, subject to the limitations set forth in Section 213 of the IRC.

IV. Planning and paying for long-term care.

A. Private Pay.

1. As discussed above, long-term care is expensive. If paying privately using their own funds, individuals should maximize the available income tax benefits, if any.

2. Long-term care expenses, together with all other unreimbursed medical expenses, must exceed 7.5% of an individual's adjusted gross income in order to be claimed as an itemized deduction for federal income tax purposes.

3. The definition of medical expenses includes the cost of long-term care if a doctor has determined that the individual is "chronically ill." A "chronically ill" individual is someone who needs help with the activities of daily living, such as eating, toileting, transferring, bathing, dressing or continence.

B. Medicare.

1. Overview.

a. Medicare is a federally-funded health insurance program administered by CMS and designed to provide basic medical care to people age 65 and older and individuals receiving Social Security Disability (after an applicable waiting period) or certain other individuals with other specific illnesses.

b. Medicare coverage is limited in many respects and there are numerous deductibles and co-payments required.

c. Medicare does not have any income requirements for eligibility, but an individual's income does determine his monthly premium amount. Individuals with annual income over $85,000 pay an increased monthly premium for Part B.

d. Medicare is a secondary payer; thus, if an individual is employed and covered by his employer's health insurance, that insurance must provide coverage before Medicare will pay.

2. Enrollment.

a. There is a seven-month period to enroll in Medicare. The enrollment period begins three months before an individual's 65th birthday, includes the month he turns 65, and ends three months after his 65th birthday.

b. If the seven-month enrollment period is missed, an individual may enroll in Medicare during the general enrollment period, beginning on January 1 and ending on March 31.

(1) If this occurs, coverage does not begin until July 1.

(2) There is a late penalty fee for individuals who do not enroll within the seven-month period.

(a) The penalty is 10% of the monthly premium for every 12-month period when the individual was eligible for Medicare but didn't enroll. This comes as a surprise to many. There is a bill pending in Congress that would require notification to individuals as they approach Medicare eligibility of the imposition of a late enrollment penalty for failure to timely enroll.[10]

(b) This penalty is permanent and must be paid for as long as the person has Medicare. The goal is to try to prevent people from signing up for Medicare only when they think they will need it.

(c) Individuals who are actively working and who receive certain employer benefits past age 65, do not have to pay a late penalty fee. For these individuals there is a special 8-month enrollment period beginning on the first day after the employer health coverage ends.

[10] H.R.2575 - BENES Act of 2017 115th Congress (2017-2018), https://www.congress.gov/bill/115th-congress/house-bill/2575.

3. Part A.

a. Covers inpatient hospital stays, hospice, and limited skilled nursing and home health care costs.

b. Individuals (and their spouses) who have worked for 10 years or more and paid at least 40 quarters of Medicare taxes will receive Part A at no charge. Otherwise, the monthly premiums can be as much as $422.

c. Part A has a hospital deductible of $1,340 for each benefit period.

d. After the individual meets the deductible, the co-insurance amount is:

(1) $0 for the first 60 days;

(2) $355 per day for days 61 through 90, and then

(3) $670 per each "lifetime reserve day" starting with day 91 (up to 60 days over the person's lifetime).

(4) Individuals are responsible for all costs beyond the lifetime reserve days.

e. Skilled nursing home coverage under Part A is limited. Medicare will cover up to 100 days per benefit period in a nursing home, provided that the individual had a "qualifying" 3-day hospital stay in the 30-day period prior to being admitted to the nursing home. A benefit period begins upon hospitalization and ends when the recipient has not received any hospital care or skilled nursing care for at least 60 days. Provided the individual is receiving "skilled nursing care" and not "custodial care," the first 20 days are covered in full and days 21-100 have a co-insurance amount of $167.50 per day. After 100 days, there is no Part A coverage unless a new benefit period commences.

(1) Although Part A provides for up to 100 days of skilled nursing coverage, in many cases, the individual actually receives less than that amount of coverage. Often, the individual is denied coverage because his condition is no longer improving and the care is no longer medically necessary. This so called "improvement standard" appears nowhere in federal law or regulations.

(2) As a result of a class action lawsuit,[11] a settlement agreement was reached which clarified that Medicare coverage is available so long as the individual needs the skilled care in order to maintain

[11] *Jimmo v Sebelius*, No. 5:11-cv-17, 2011 U.S. Dist. LEXIS 123743 (D. Vt. Oct. 25, 2011).

function or to prevent decline or deterioration. Thus, the proper standard is one of "maintenance" and not "improvement."

f. The 3-day hospital stay requirement has also been the subject of litigation.

(1) A patient in a hospital is eligible for Medicare coverage for a nursing home stay only if he has a qualifying hospital admission, which does not include days on which the patient was physically receiving care in the hospital, but was not formally admitted. In these cases the patient is not eligible for nursing home services covered by Medicare since he was not "admitted" to the hospital but was merely on "observation status." Thus, it is possible to be hospitalized but not be "admitted" to the hospital. In this scenario, there is no nursing home Medicare coverage regardless of the length of stay in the hospital. This often comes as a surprise to individuals when presented with a large nursing home bill that they thought was covered by Medicare. Medicare does not allow individuals to appeal this issue.

(2) On August 6, 2015, the Notice of Observation Treatment and Implication for Care Eligibility Act (the "Notice Act")[12] was enacted.

(a) The Notice Act requires that a hospital provide a patient with written and oral notice, within 36 hours that they are receiving care on an "observation" or other "out-patient" status for more than 24 hours. The notice must explain why the patient has not been formally admitted and must explain the benefits eligibility implications for the patient.

(b) CMS developed and implemented the Medicare Outpatient Observation Notice ("MOON") to fulfill the above requirement, and its use was mandated by CMS as of March 8, 2017. Some states had previously enacted their own state observation status notice laws.

(c) A class action lawsuit has been commenced on behalf of Medicare beneficiaries who have received "observation services" as an outpatient during a hospitalization.[13] The plaintiffs in the case are seeking the right to administrative review of the decision to treat their hospital stay as "observation" rather than "inpatient."

[12] Public Law 114 - 42 – "Notice of Observation Treatment and Implication for Care Eligibility Act" or the "NOTICE Act" https://www.gpo.gov/fdsys/pkg/PLAW-114publ42/content-detail.html.
[13] *Alexander v. Price*, No. 3:11-cv-1703 (MPS), 2017 U.S. Dist. LEXIS 119517 (D. Conn. July 31, 2017).

4. Part B.

    a. Covers doctor visits, outpatient procedures, diagnostic tests, medical supplies, vaccines, and certain screenings.

    b. Part B monthly premium is $134.

        (1) Those who receive Social Security benefits via direct deposit pay $130 per month.

        (2) Individuals with income above $85,000 per year pay up to $428.60 (based on a sliding scale) in monthly premiums.

    c. The Part B deductible is $183 per year. After meeting the deductible, the individual is responsible for 20% of the Medicare-approved amount for most doctor services, durable medical equipment, and outpatient therapy.

5. Part C.

    a. Medicare Advantage plans.

    b. Offered through Medicare-approved private health insurance plans for individuals enrolled in Medicare Parts A and B. Benefits are received through the Medicare Advantage plan instead of original Medicare.

    c. Medicare Advantage plans provide all of the Part A and Part B benefits, as well as certain other additional benefits such as vision, dental and hearing.

6. Part D.

    a. Prescription drug coverage.

    b. Offered by insurance companies.

    c. Each plan has a list of generic and name brand drugs covered. Each drug is assigned to a tier. The tier determines the cost of the drug paid by the individual.

7. Medicare supplemental insurance (Medigap).

    a. Supplemental health insurance sold by private insurance companies to cover co-payments, co-insurance, and deductibles. To participate, individuals must be enrolled in Medicare Parts A and B and pay the monthly premium for Part B as well as the Medigap monthly premium.

b. Individuals enrolled in Medicare Part C cannot purchase a Medigap policy.

c. Some Medigap policies cover the skilled nursing care co-insurance amounts for days 21 through 100. Otherwise, Medigap policies do not cover long-term care.

C. Medicaid.

1. Overview.

a. The Medicaid program, enacted by Congress as Title 19 of the Social Security Act of 1965, provides medical care to the indigent and disabled. Medicaid is the payer of last resort. The federal government provides the guidelines for the program and partial funding to the states. Federal, state and local governments share responsibility for administering Medicaid. At the federal level, CMS promulgates regulations and oversees the program to ensure that states comply with the federal guidelines.

b. The sources of law at the federal level include statutory provisions located at title 42 of the U.S.C. and regulations found at title 42 of the C.F.R.

c. Each state has its own policies and interpretations of the federal rules and thus the Medicaid programs and benefits available often vary from state to state. Although many of the programs differ, at a basic level the programs each provide a broad range of services to recipients.

d. The Medicaid program is a third-party payer system, meaning that recipients of Medicaid submit the bill for services provided to the state for payment. As such, Medicaid recipients are free to choose any Medicaid-approved medical facility/provider for their care.

e. The Affordable Care Act created a new category of Medicaid called Modified Adjusted Gross Income ("MAGI") Medicaid, for which eligibility is determined based on an income formula alone. MAGI Medicaid does not generally cover long-term care and thus will not be addressed in this outline, which will focus on traditional or "Non-MAGI" Medicaid for which eligibility is based on financial and medical need.

2. Medicaid eligibility.

a. Medicaid may be authorized for individuals who are over the age of 65 or those who are certified blind or disabled. In some states, individuals who receive Supplemental Security Income (SSI) from the Social Security Administration automatically qualify for Medicaid.

b. With certain exceptions for emergency medical treatment, an individual must be a United States citizen, permanent resident, or a qualified alien in order to receive Medicaid.

c. Medicaid is a means-tested program with restrictions on income and resources established by the state. There are Federal minimum standards for coverage and eligibility, but a state is allowed some flexibility to set its own standards within federal guidelines.

d. There are separate eligibility rules for single individuals and married couples, as well as for care at home as opposed to a nursing home.

e. Income and Resource limits.

(1) Income.

(a) Spend-down state v. income-cap state.

1. In income-cap states, to be eligible for Medicaid, the applicant's monthly income cannot exceed $2,250. The income cap states are Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Nevada, New Mexico, New Jersey, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, and Wyoming. If a person lives in an income-cap state, he will not be eligible for Medicaid unless his excess income is paid into a "Qualified Income Trust."[14]

2. In income spend-down states, if a person has income in excess of the monthly allowable amount but has medical bills that are greater than the excess, Medicaid will pay the difference up to the Medicaid rate. If the Medicaid recipient is a resident of a nursing home, all of his income must be spent on the cost of his care except for a modest amount (approximately $50, depending on the state), which will be deposited into a personal incidental account at the nursing facility.

(2) Resources.

[14] 42 U.S.C. § 1396p(d)(4)(B).

(a) A Medicaid recipient is entitled to have no more than $2,000 to $15,150 in non-exempt resources (depending on the state). In addition, the individual may retain certain exempt assets and may prepay funeral expenses, provided that such funds are placed into an irrevocable pre-paid funeral trust.

1. If an individual has more than the allowable resource amount, the excess must either be spent down on the cost of his care or transferred to someone else. If the assets are transferred, certain penalty period rules may apply.

(b) An individual's entrance fee paid to a CCRC is considered a resource available to the individual to the extent that he has the ability to use the entrance fee to pay for care, if necessary; the amount is refundable to the individual or his estate upon the individual no longer residing in the CCRC; and the entrance fee does not confer an ownership interest in the CCRC.[15]

3. Transfers of assets.

a. The look-back period is the 60-month period prior to the time that the individual applies for Medicaid benefits.

b. Penalty period.

(1) All non-exempt transfers of assets made by an individual or his spouse for less than fair market value (FMV) during the look-back period will generally make the individual ineligible for Medicaid for a certain period of time (the "penalty period"). Some states do not penalize asset transfers when applying for certain types of non-institutional Medicaid, such as community or home-care Medicaid.

(2) With respect to an institutionalized individual, the penalty period is equal to the total, cumulative, uncompensated value of all assets transferred by the individual (or spouse) during the look-back period divided by the average monthly cost ("regional rate") to a private patient of nursing facility services in the state (or the community where the individual is institutionalized). For example, a transfer of $400,000 where the average nursing home cost in the state is $10,000, would result in a penalty period of

[15] 42 U.S.C. § 1396p(g).

forty (40) months. The penalty period for nursing home care following a transfer can be unlimited, and in certain cases the individual should not apply prior to the expiration of the 60 month look-back period. The penalty period generally does not commence until the individual is institutionalized, has applied for Medicaid and is otherwise eligible for benefits.[16]

(3) When either spouse makes a transfer that results in a penalty period for the institutionalized spouse, some states apportion the penalty period equally between the spouses if the community spouse subsequently enters a nursing facility. If one spouse is no longer subject to a penalty (e.g., the spouse dies), the remaining penalty period for both spouses may be applied to the surviving spouse.

(4) When a transfer is made during an existing penalty period, a new penalty period cannot begin until the existing penalty period has ended. For multiple transfers made during the look-back period, in which assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, the penalty period is calculated by adding together the uncompensated value of all assets transferred, and dividing by the applicable Medicaid regional rate. When a penalty period ends at any time during a month and a subsequent transfer occurs at any time during that same month, the subsequent transfer is considered to have occurred in an overlapping penalty period and would be treated as a multiple transfer.[17]

(5) For purposes of the transfer of asset rules, assets include all income and resources of the individual and his spouse, including those which the individual is entitled to or would have been entitled to if action had not been taken to avoid receiving the assets, such as:[18]

(a) Irrevocably waiving pension income;

(b) Waiving the right to receive an inheritance or refusing to assert one's right of election against an inheritance;

(c) Not accepting or accessing injury settlements, although individuals are not required to initiate personal injury litigation;

[16] 42 U.S.C. § 1396p(c)(1)(E).
[17] 42 U.S.C. § 1396p(c)(1)(H).
[18] CMS Transmittal No. 64 § 3257.

(d) Settling a tort (personal injury) action so as to have the defendant place settlement funds directly into a trust or similar device to be held for the benefit of the individual;[19] or

(e) Refusing to take action to obtain a court-ordered payment that is not being paid, such as child support or alimony.

c. Life estates.

(1) When an individual transfers a remainder interest in property and reserves a life estate, a transfer of assets for less than FMV occurs. In order to compute the penalty period, the value of the remainder interest must be calculated. To do this, the value of the life estate is determined using the Medicaid life expectancy tables and this value is subtracted from the overall value of the property to determine the value of the remainder interest.[20]

(2) Generally, a life estate is not considered a countable resource, and no lien may be placed on the life estate. States generally do not require an individual possessing a life estate to try to liquidate the life estate interest or to rent the life estate property. Some states, however, have attempted to expand their estate recovery efforts to include life estates. If the holder of a life estate transfers the life estate during the look-back period, it must be determined if FMV was received for the life estate. If fair market value was not received, a transfer penalty is imposed.

(3) If an individual possessing a life estate rents the life estate property, any net rental income received is counted in determining eligibility. If under the terms of the life estate, the life estate holder must pay taxes and maintenance, then these costs should be deducted from the rental income.

(4) The purchase of a life estate interest in another individual's home using the values in the Medicaid life expectancy tables is not considered a transfer of assets for less than fair market value so long as the purchaser lives in the other person's home for a period of at least one year after the date of the purchase.

d. Joint accounts.

(1) In the case of an asset held by an individual with another person(s)

[19] This action is distinguished from the individual contributing the lawsuit proceeds to a first party special needs trust pursuant to 42 U.S.C. § 1396p(d)(4)(A).
[20] CMS Transmittal No. 64 § 3258.9(A).

in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of the asset) is considered to be transferred by the individual when any action is taken either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.[21]

(2) Adding another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. The individual may still possess ownership rights to the account or asset and have the right to withdraw all of the funds in the account at any time. However, actual withdrawal of funds from the account, or removal of the asset, by the other person would remove the funds or property from the control of the individual and would constitute a transfer of assets. If placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset, where no such agreement was necessary before), such placement would constitute a transfer of assets.[22]

e. Exceptions to application of the penalty period rules.

(1) Certain transfers are exempt from the penalty period provisions, even if made for less than FMV.[23]

(a) The asset transferred is the individual's home and title to the home is transferred to:

1. The spouse of the individual;

2. A child of the individual who is under age 21:

3. A child who is blind or permanently and totally disabled;

4. The sibling of the individual who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately before the date the individual becomes institutionalized; or

5. A son or daughter of the individual (other than a

[21] 42 U.S.C. § 1396p(c)(3).
[22] CMS Transmittal No. 64 § 3258.7.
[23] 42 U.S.C. § 1396p(c)(2).

child described above) who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who (as determined by the state) provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.

(b) The asset, other than the individual's home, is transferred:

1. To the individual's spouse.[24]

2. From the individual's spouse, or to another for the sole benefit of the individual's spouse;[25]

3. To the individual's child, or to a trust established solely for the benefit of the individual's child who is blind or permanently and totally disabled; or

4. To a trust established for the sole benefit of an individual under 65 years of age who is disabled.

(c) The individual intended to dispose of the assets at FMV or for other valuable consideration. Written evidence of attempts to dispose of the asset for FMV, as well as evidence to support the value (if any) at which the asset was disposed must be provided.[26]

(d) The assets were transferred exclusively for a purpose other than to qualify for Medicaid.[27] Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for Medicaid include, but are not limited to: the unexpected onset of a serious medical condition subsequent to the transfer; the unexpected loss, subsequent to the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or the existence of a

[24] It should be noted, that while transfers made from the institutionalized spouse to the community spouse are unlimited prior to a determination of eligibility for Medicaid, transfers made after Medicaid is approved are typically limited to the CSRA as per 42 U.S.C. § 1396r-5(f)(1). Further, the determination of eligibility referenced therein has been held to apply only to the first determination of eligibility. In a case where a Medicaid recipient lost Medicaid coverage after receiving additional resources from a lawsuit, the Court held that spousal transfers were restricted to the CSRA. *Fagan v Bremby*, 2017 U.S. Dist. LEXIS 41117 [D. Conn. Mar. 21, 2017, No. 3:16cv73 (JBA)].

[25] The above has also been held true for post-eligibility transfers made by the spouse to another for the spouse's sole benefit. *Hegadorn v Dept. of Human Servs. Director*, 2017 Mich. App. LEXIS 892 [Ct. App. June 1, 2017, Nos. 329508, 329511, 331242].)

[26] CMS Transmittal No. 64 § 3258.10 (C) (1).

[27] 42 U.S.C. § 1396p(c)(2)(C)(ii).

court order specifically requiring the transfer of a certain amount of assets. Estate planning gifts (i.e., gifts up the annual exclusion amount) are often done for purposes other than Medicaid planning. A prior history establishing a pattern of such gifts is often helpful in showing that the gifts were made for a purpose other than to qualify for Medicaid.

(e) All or part of the assets transferred for less than FMV have been returned to the individual.[28]

1. If all transferred assets are returned to the individual prior to the Medicaid eligibility determination, no transfer penalty is imposed. If a portion of the transferred assets is returned prior to the Medicaid eligibility determination, the uncompensated value of the transfer is generally reduced by the amount of assets returned.

2. If all transferred assets are returned after the Medicaid eligibility determination, the existing penalty period is rescinded and the individual's eligibility for Medicaid during such period must be re-determined as though the assets were never transferred. If a portion of the transferred assets is returned after the Medicaid eligibility determination, the existing penalty period is recalculated, reducing the uncompensated value of the transfer(s) by the amount of assets returned; if the recalculated penalty period has already elapsed, the individual's eligibility for Medicaid subsequent to the penalty period must be re-determined as though the returned assets were never transferred.

3. For purposes of these rules, assets transferred by an individual are considered to be returned if the person to whom they were transferred uses them to pay for nursing facility services for the individual or provides the individual with an equivalent amount of cash or other liquid assets.

(2) Imposition of a penalty period and denial of Medicaid eligibility would work an undue hardship. Undue hardship exists when:[29]

[28] 42 U.S.C. § 1396p(c)(2)(C)(iii).
[29] 42 U.S.C. § 1396p(c)(2)(D) and CMS Transmittal No. 64 § 3258.10(C)(4) and (5).

(a) The individual applying for nursing facility services is otherwise eligible for Medicaid;

(b) Despite his best efforts, as determined by the state, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive FMV; and

(c) The individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered. Undue hardship does not exist when the application of the penalty period provisions merely causes the individual inconvenience.

(d) States have considerable flexibility in deciding the circumstances under which the undue hardship provisions will be applied.

4. Exempt assets.

a. Retirement accounts.

(1) In some states, a Medicaid applicant's retirement account can be an exempt resource so long as the account is in "payout status." An account is deemed to be in payout status if the applicant is receiving distributions from the retirement account. In these states, the amount distributed is considered income and the corpus of the retirement account is not considered a disqualifying resource for Medicaid eligibility purposes.

b. Annuities.

(1) Under certain circumstances, an annuity can be an exempt asset for Medicaid eligibility purposes. By purchasing an annuity, the individual converts an otherwise non-exempt resource into an income stream. Subject to certain exceptions, the purchase of the annuity will be considered a transfer of assets for less than FMV unless the state is named as the reminder beneficiary for at least the total amount of Medicaid benefits paid on behalf of the individual.

(2) For purposes of calculating an individual's eligibility for Medicaid, his non-exempt assets will include an annuity unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for equal payments during the term of the annuity, with no deferral

or balloon payments.[30]

c. Promissory note.

(1) Similar to annuities, promissory notes are also sometimes treated as exempt assets for Medicaid eligibility purposes. Purchasing a promissory note or lending resources to another person may convert an otherwise non-exempt resource into an income stream.

(2) In order to be considered an exempt resource, the promissory note must have a repayment term that is actuarially sound, have a reasonable interest rate, provide for payments in equal amounts during the term of the loan, with no deferral or balloon payments made and prohibit the cancellation of the balance upon the death of the lender. Thus, if the individual dies prior to the repayment of the loan, the remaining payments must be made to his estate.

(3) If the promissory note does not satisfy all of the foregoing requirements, then the value of the note is considered an outstanding balance due as of the date of the individual's application for Medicaid.[31]

d. Residence.

(1) Generally, the primary residence of an individual is considered an exempt resource as long as he continues to reside there, subject to a home equity cap of $572,000 to $858,000.[32] There are exceptions to the home equity cap if the applicant's spouse or minor, blind or disabled child resides in the home.

(2) If the individual is in a nursing home or other facility, so long as he maintains a subjective "intent to return home" the primary residence remains exempt. However, as discussed below, this does not mean that Medicaid may not place a lien on the property. In addition, if certain individuals reside in the home, the home may also be considered exempt. Examples include a spouse, minor child, sibling with an equity interest who has resided in the home for at least one year prior to the date the individual enters a nursing home, or a son or daughter who resided in the home for a period of at least two years prior to the date the individual enters a nursing home and who provided care to the individual that allowed him to remain at home rather than

[30] 42 U.S.C. § 1396p(c)(1)(G).
[31] 42 U.S.C. § 1396p(c)(1)(I).
[32] 42 U.S.C. § 1396p(f).

go into a nursing home.

e. The individual and spouse (if any) may prepay funeral arrangements, provided that such funds are placed into an irrevocable pre-paid funeral trust.

5. Trusts.

a. Revocable trust.

(1) In the case of a revocable trust, the corpus of the trust and all payments made from the trust to or for the benefit of the individual are considered available assets for Medicaid eligibility purposes.[33]

(a) Any other payments from the trust are considered assets transferred by the individual for less than FMV and subject to the transfer of asset penalty period rules.[34]

b. Irrevocable trust.

(1) In the case of an irrevocable trust, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of the individual is considered to be an asset transferred for less than FMV for purposes of the transfer of asset penalty period rules.[35]

(2) Payments made from the trust to or for the benefit of the individual are considered income to the individual.[36]

(3) Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the individual, is considered an available resource. If the language of the trust specifies that money can be made available for a specific event, that amount shall be considered an available resource, whether or not that event has occurred.[37]

(4) Payments which are made from trust assets considered available to the applicant and which are not made to or for the benefit of the applicant are considered to be assets transferred for less than FMV for purposes of the transfer of asset penalty period rules.[38]

[33] 42 U.S.C. § 1396p(d)(3)(A)(i) and (ii).
[34] 42 U.S.C. § 1396p(d)(3)(A)(iii).
[35] 42 U.S.C. § 1396p(d)(3)(B)(ii).
[36] 42 U.S.C. § 1396p(d)(3)(B)(i)(I).
[37] CMS Transmittal No. 64 § 3259.6(B).
[38] 42 U.S.C. § 1396p(d)(3)(B)(i)(II).

(5) The foregoing trust provisions apply only to trusts which are established, other than by will;

(a) by the individual,

(b) by the individual's spouse,

(c) by a person, acting at the direction or request of the individual or his spouse; or

(d) by a court or administrative body with legal authority to act on behalf of the individual or his spouse.

(6) States have varying interpretations as to how third party inter-vivos or testamentary trusts are treated with respect to the Medicaid eligibility of an individual who is a beneficiary of such trust. Such trusts may give the trustee complete and unfettered discretion to distribute trust assets; whereas, others limit distributions to an ascertainable standard. The key is to avoid the trust being considered a support trust, in which case the assets would be considered available for Medicaid eligibility purposes. Ideally, the trust should be drafted as a third party supplemental needs trust to provide maximum preservation of trust assets in the event a beneficiary needs long-term care. Another option is to include language in the trust which triggers supplemental needs trust provisions in the event the beneficiary needs long-term care or applies for means-tested government benefits.

c. Exception Trusts.

(1) Exception trusts are trusts that are required to be disregarded as available income and resources for purposes of determining Medicaid eligibility.[39]

(2) The principal and accumulated income of exception trusts are disregarded in determining an individual's Medicaid eligibility. Any trust assets, however, that are actually distributed to the individual are counted as income in the month received and as a resource if retained into subsequent months.

(3) Types of exception trusts.

[39] CMS Transmittal No. 64 § 3259.7.

(a) Special needs trust.[40]

1. A trust containing the assets of an individual under age 65 who is disabled and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian or a court.

2. Upon the death of the individual, the state will receive all amounts remaining in the trust, up to the amount of Medicaid paid on behalf of the individual. States have varying interpretations of these rules. Some states require the payback of all Medicaid costs, even those incurred prior to the establishment of the special needs trust.

3. Once the trust is created, additional funds can be added to the trust until the person reaches age 65. Any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets subject to the applicable asset transfer rules.

4. Qualified income trust.[41]

   a. A trust established for the benefit of an individual in an "income cap" state if:

      1. Trust assets consist only of pension, Social Security, and other income; and

      2. The state receives all amounts remaining in the trust upon the death of such individual up to an amount equal to the total Medicaid paid on behalf of such individual.

5. Pooled trust.[42]

   a. Trust containing the assets of an individual who is disabled.

   b. Trust is established and managed by a non-

[40] 42 U.S.C. § 1396p(d)(4)(A).
[41] 42 U.S.C. § 1396p(d)(4)(B).
[42] 42 U.S.C. § 1396p(d)(4)(C).

profit association.

c. A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

d. Accounts in the trust are established solely for the benefit of individuals who are disabled by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

e. To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust must pay to the state from such remaining amounts in the account an amount equal to the total amount of Medicaid paid on behalf of the individual.

f. The assets of a pooled trust are be disregarded for Medicaid purposes regardless of the age of the individual when the pooled trust account is established, or when assets are added to the pooled trust account; however, some states treat a transfer of assets to a pooled trust by an individual age 65 and over as a transfer for less than FMV and subject to the Medicaid asset transfer rules.

6. Special considerations for spouses.

a. Community spouse protections.

(1) Rules regarding income.

(a) States are given discretion to establish an income allowance for the community spouse to be adjusted every year for inflation.[43]

1. The community spouse is allowed a MMMNA.[44] Depending on the particular state, the MMMNA

[43] 42 U.S.C. § 1396r-5(d)(3).
[44] 42 U.S.C. § 1396r-5(d)(2).

ranges from $2,030 to $3,090. If the community spouse's income falls below the MMMNA, the community spouse is entitled to a portion of the institutionalized spouse's income to bring the community spouse's income up to the MMMNA amount.[45]

2. The community spouse may be entitled to income above the MMMNA if a court has entered an order of support against the institutionalized spouse. In this case, the MMMNA will be increased up to the amount set by the court.[46]

3. Alternatively, the community spouse may request a fair hearing to revise the MMMNA based on exceptional circumstances resulting in significant financial duress.[47]

(b) Federal law provides certain rules to determine how income is apportioned between the community spouse and the institutionalized spouse.[48]

1. For non-trust property.

a. If income is paid solely in the name of the institutionalized spouse or solely in the name of the community spouse, the income is deemed available only to that particular spouse.[49] This is sometimes referred to as the "name on the check" rule.

b. If income is paid in the names of the institutionalized spouse and the community spouse, one-half of the income is deemed available to each of them.[50]

c. If income is paid or distributed in the names of the institutionalized spouse or the community spouse, or both, and to a third

[45] 42 U.S.C. § 1396r-5(d)(1)(B).
[46] 42 U.S.C. § 1396r-5(d)(5).
[47] 42 U.S.C. § 1396r-5(e)(2)(B).
[48] These rules apply except as otherwise provided in 42 U.S.C. § 1396r-5(b)(2)(A)(iii) and are applicable notwithstanding any state laws regarding community property or the division of marital property. 42 U.S.C. § 1396r-5(b)(2).
[49] 42 U.S.C. § 1396r-5(b)(2)(A)(i).
[50] 42 U.S.C. § 1396r-5(b)(2)(A)(ii).

party or parties, the income is deemed available to each spouse in proportion to the spouse's interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse).[51]

2. For trust property.

   a. Income is deemed available to each spouse as indicated in the trust agreement.[52]

   b. If there are no specific provisions in the trust agreement regarding allocation of income, the following rules apply:

      1. If income is paid solely to the institutionalized spouse or solely to the community spouse, the income shall be deemed available only to that respective spouse.[53]

      2. If income is paid to both the institutionalized spouse and the community spouse, one-half of the income shall be deemed available to each of them.[54]

      3. If income is paid to the institutionalized spouse or the community spouse, or both, and to a third party or parties, the income is deemed available to each spouse in proportion to the particular spouse's interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse.[55])

[51] 42 U.S.C. § 1396r-5(b)(2)(A)(iii).
[52] 42 U.S.C. § 1396r-5(b)(2)(B)(ii).
[53] 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(I).
[54] 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(II).
[55] 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(III).

c. In the case of income not from a trust in which there is no instrument establishing ownership, there is a rebuttable presumption that one-half of the income is deemed available to the institutionalized spouse and one-half to the community spouse.[56]

(2) Rules regarding resources.

(a) Community spouse resource allowance.

1. The community spouse is entitled to a CSRA set by the state and which is adjusted annually.[57] Depending on the particular state, the maximum CSRA ranges from $24,720 to $123,600.

2. The computation of the CSRA commences on the first day in which the institutionalized spouse begins a period of institutionalization that is likely to last for at least 30 consecutive days.[58] The computation will be made of:

a. The total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest;[59]and

b. A spousal share that is equal to one-half of the total value of the resources.[60]

3. Either the institutionalized spouse or the community spouse can request, at the commencement of the period of institutionalization of the institutionalized spouse that the state conduct an assessment of the total value of the resources based upon any relevant documentation provided to the state. The state is required to indicate on the assessment that the spouse is entitled to have a fair hearing under 42

[56] 42 U.S.C. § 1396r-5(b)(2)(C).
[57] 42 U.S.C. § 1396r-5(f)(2)(A).
[58] 42 U.S.C. § 1396r-5(c)(1).
[59] 42 U.S.C. § 1396r-5(c)(1)(A)(i).
[60] 42 U.S.C. § 1396r-5(c)(1)(A)(ii).

U.S.C. § 1396r-5(e)(2) and 42 U.S.C. § 1396r-5(c)(1)(B).

a. In attributing resources at the time of the initial Medicaid eligibility determination, all resources held by either the institutionalized spouse, community spouse, or both are deemed available to the institutionalized spouse to the extent that the value of the resources exceeds the maximum CSRA.

(b) Enhancing the CSRA.

1. 42 U.S.C. § 1396r-5(e)(2)(C) provides that if either spouse establishes that the CSRA (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the MMMNA, the CSRA is to be increased to an amount adequate to provide the MMMNA. For this purpose, all income of the institutionalized spouse that could be made available to the community spouse is considered to be available before the state will allocate to the community spouse an amount of resources adequate to provide the difference between the MMMNA and the amount of income available to the community spouse. This is known as the "income-first" rule.

a. Depending upon the amount of income of the spouses, this provision may translate into significant increases of the CSRA.

b. If the spousal share is deemed insufficient to raise the community spouse's income to the MMMNA, the community spouse may request a fair hearing[61] or seek a court order[62] aimed at obtaining a greater share of the institutionalized spouse's resources.

7. Liens and estate recovery.

a. Liens.

[61] 42 U.S.C. § 1396r-5(e)(2)(C).
[62] 42 U.S.C. § 1396r-5(f)(3).

(1) States may not impose a lien on a Medicaid recipient's property prior to death based on the individual's receipt of Medicaid institutional benefits except under the following circumstances:[63]

(a) When a court has found that an individual has incorrectly received Medicaid benefits, the state may place a lien on any real or personal property of the individual;[64]

(b) When an individual has correctly received Medicaid benefits, the state may place a lien on the person's real property[65] after notice and an opportunity for a hearing.

1. A lien many only be placed if the individual cannot reasonably be expected to be discharged from the facility and return home.[66]

2. No lien may be imposed on an individual's home if any of the following individuals lawfully reside in the home: (a) a spouse; (b) a child who is under age 21, blind, or disabled; or (c) a sibling who has an equity interest in the home and has been legally residing there for at least a year immediately before the person's admission to the nursing home.[67]

3. Any lien imposed is dissolved upon the individual's discharge from the nursing home and his return home.[68]

b. Estate recovery.

(1) States are mandated by federal law to have an estate recovery program. No adjustment or recovery of Medicaid correctly paid may be made, except that the state may seek recovery, in certain circumstances, upon sale of the property or from the individual's estate, or upon sale of property subject to a lien imposed on

[63] 42 U.S.C. § 1396p(a)(1).
[64] 42 U.S.C. § 1396p(a)(1)(A).
[65] 42 U.S.C. § 1396p(a)(1)(B)(i); 42 C.F.R. § 433.36(g)(2).
[66] 42 U.S.C. § 1396p(a)(1) (B) (ii); 42 C.F.R. § 433.36(d).
[67] 42 U.S.C. § 1396p(a)(2)(A)-(C); 42 C.F.R. §.433.36(g)(3)(i)-(iii).
[68] Congress wanted to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance the government's legitimate desire to recover its Medicaid costs against the individual's need to have the home available in the event discharge from the institution becomes feasible. *P.L. 97-248, 97th Congress, 2d Sess. (1982), reprinted in 1982 U.S.C.C.A.N. 814.*

account of Medicaid paid to such individual.

(a) In the case of an individual who was age 55 years or older at the time of receipt of Medicaid benefits, the state must seek recovery from the individual's estate for certain types of Medicaid, including nursing home and home care benefits.

(b) Any recovery against an individual's estate may only be made after death of the individual's surviving spouse and only when there is no surviving child who is under age 21, blind or disabled.[69]

(c) Any recovery sought pursuant to a properly imposed lien on an individual's real property may only be made after death of the individual's surviving spouse and only when there is no surviving (a) child who is under age 21, blind or disabled; (b) sibling who resided in the home for at least one year immediately prior to the individual's admission to a nursing home; or (c) son or daughter who resided in the home for at least two years immediately prior to the individual's admission to a nursing home and who provided care to such individual which permitted him to stay at home rather than an institution, who is lawfully residing in the home and has done so on a continuous basis since the individual's admission to the nursing home.[70]

(d) The term "estate" with respect to a deceased individual includes all real and personal property and other assets included within the individual's estate, as defined for purposes of state probate law.[71]

1. The term "estate" may include, at the option of the state, any other property in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.[72] Many states have expanded estate recovery statutes and some are more aggressive than others in their recovery efforts.

[69] 42 U.S.C. § 1396p(b)(2)(A).
[70] 42 U.S.C. § 1396p(b)(2)(B).
[71] 42 U.S.C. § 1396p(b)(4)(a).
[72] 42 U.S.C. § 1396p(b)(4)(b).

2. States are required to have procedures that waive the application of the estate recovery rules if such application would work an undue hardship.

3. Some states have attempted to recover against life estates by taking the position that the life estate has an actuarial value based on the age of the Medicaid recipient immediately prior to death. Moreover, at least one state has been successful in recovering against the entire value of the property upon the death of the life tenant, not just the value of the life estate the day before death.[73]

D. Long-term care insurance ("LTCI").

1. In General.

a. LTCI is insurance which is designed to cover the costs of long-term care. LTCI is regulated by the states. There is no federal law governing these policies.

2. Eligibility requirements.

a. Age.

(1) In most states, an individual over age 80 is not eligible to purchase LTCI.

(2) The age limit is due to the fact that the likelihood of needing long-term care services significantly increases after age 80.

b. Insurability.

(1) Individuals typically must pass a physical and cognitive examination.

(2) Some companies may carve out a "pre-existing" condition for a certain period of time and issue the policy for a higher premium.

c. Coverage limits.

(1) Benefits are paid based on a daily benefit rate, such as $300/day, not to exceed actual cost of daily care. Some policies allow you to "bank" the difference to be used in the future. To determine

[73] *In the Matter of Melvin Peterson*, 340 P. 3d. 1143 (Idaho 2014).

the value of total available benefits, multiply the total maximum days permitted to be paid by the daily rate. Benefits are paid only when a valid and timely claim is made.

(2) Some policies contain inflation riders, which increase the daily benefit rate over time. There are different types of inflation riders, including simple inflation, CPI inflation, or compound inflation, among others. These policies are significantly more expensive than policies that do not contain an inflation rider.

(3) Time limit on daily benefits.

(a) Most policies limit the number of insured days (years). Previously, lifetime benefit policies were readily available which did not have a cap on the number of years or days for which benefits could be paid. In the current marketplace, lifetime benefit polices have become practically non-existent.

(b) Policies also contain an elimination period, typically 90-120 days, which is akin to a waiting period or deductible. The elimination period must be satisfied before any benefits are paid under the policy.

(4) Limits on the provider of care.

(a) Individuals need to make sure that the policy covers the type of care they are receiving and where they are receiving the care.

(b) Often, policies will not pay for care provided by an informal caregiver, such as a spouse or family member, even if the type of care is covered. The policy may require that care be provided by a licensed caregiver.

(5) Limits on coverage.

(a) Unlike Medicare and Medigap policies, LTCI does pay for custodial care, in addition to skilled nursing care.

(b) Typically, the individual must require assistance with at least two (sometimes three) activities of daily living in order to receive benefits from the policy. A cognitive impairment (such as dementia or Alzheimer's disease) also triggers the payment of benefits under most policies.

3. Premiums.

   a. The ideal age to consider purchasing LTCI has been long-debated by many in the field. The cost of the policy is a function, among other things, of the age of the insured at the time of purchase. The younger the individual, the lower the cost. While premiums don't rise during the term of the policy simply as a result of the individual aging, insurance companies are permitted (and often do) to raise rates to certain classes of policy holders by applying to the state for a rate increase. Some policies provide that if premiums are paid for a certain number of years (as opposed for the lifetime of the insured), then the policy is in effect "paid up" and not subject to future increases once the premiums have been paid for the initial agreed-upon term. The annual premiums on these types of policies are significantly higher than traditional LTCI polices where premiums are paid for life.

   b. Some policies may offer spouses a discount and allow them to "share" the benefits between themselves.

   c. In most states, LTCI policies cost more for women than men due to their longer life expectancy and increased likelihood of filing claims.

4. Tax qualified policies.

   a. Most policies are "tax qualified" under IRC Section 7702B(b), meaning that they meet certain minimum requirements set forth by the National Association of Insurance Commissioners and are eligible, subject to certain limitations in the IRC, for certain tax benefits.

   b. IRC Section 7702B(b) requires that the individual need substantial assistance with at least two activities of daily living for a period of 90 days due to a loss of functional capacity or require supervision to protect himself from threat to his health and safety due to severe cognitive impairment.

   c. Benefits received under a qualified LTCI policy are not considered taxable income and benefits received under an indemnity policy are tax-free up to a daily cap of $360.

   d. Premiums may be deductible under IRC section 213 for individuals who itemize their deductions. Medical expenses are deductible only to the extent they exceed 7.5% of the taxpayer's adjusted gross income. The deductibility of LTCI premiums are further limited annually as set forth below based on the individual's age:

      (1) Age 40 or less $420

(2)	More than 40 but not more than 50	$780
(3)	More than 50 but not more than 60	$1,560
(4)	More than 60 but not more than 70	$4,160
(5)	More than 70	$5,200

5. State partnership policies.

   a. Partnership policies combine private LTCI with Medicaid. Individuals who purchase a certain amount of private insurance are eligible to qualify for their state's Medicaid program even though their assets exceed the state's Medicaid limits. In most states, the individual is allowed to exclude as exempt resources an amount of assets equivalent to the amount of insurance purchased. In other cases, there is total asset protection so long as a minimum amount of insurance is purchased. In either case, states are not permitted to seek recovery against assets excluded for Medicaid eligibility purposes pursuant to the provisions of a state's partnership plan.

   b. Partnership policies are portable among states that have chosen to participate in the program. This should allow an individual to move to another state and receive Medicaid benefits in that state even though the policy was purchased in another state.

6. Short-term care insurance.

   a. A relatively new product that provides insurance for the costs of long-term care for a shorter period of time than LTCI. Unlike LTCI, there is no gender-based pricing in short-term care insurance.

      (1) This product could be useful to the following individuals:

         (a) Those who were declined for LTCI, either because of age or a medical condition; or those who didn't buy LTCI because they felt it was too expensive. The underwriting process for short-term care insurance is not as arduous as it is for LTCI.

         (b) Those who want insurance to cover the elimination period associated with LTCI policies.

V. <u>Conclusion.</u>

A. With the enhanced federal (and many states') estate tax exemption, clients are

increasingly concerned about non-tax issues, including how to plan and pay for long-term care.

B. While it is never too late to plan, the options available to those who plan ahead far exceed the choices available to those who wait. Individuals who address these issues early on, will have greater control over their long-term care decisions, including where they receive care, the quality of such care, and how it is paid for.

This outline is based on an outline prepared by Bernard A. Krooks for his presentation at the 52nd Annual Heckerling Institute on Estate Planning

1. Special Needs Planning.

Special needs planning is a niche practice area within the estate planning field that requires a working knowledge of many different areas of the law, including tax, public benefits, trusts and estates, among many others. The experienced special needs planning practitioner will not only know the law, but will also be in a position to offer practical advice to his clients that will improve the lives of individuals with disabilities and their families. It is also very important to be familiar with local practice as this often differs from state to state or even from county to county. One aspect of special needs planning is special needs trusts ("SNTs"). This outline will explore the different types of special needs trusts that are available and when it is appropriate to consider them. The outline will also address certain drafting and administration issues. ABLE accounts, a relatively new tool in the toolbox of special needs practitioners, will also be discussed.

One of the goals of special needs planning is to allow the individual with disabilities to qualify for government benefits while also having a source of funds that can be used to pay for things that government programs will not pay for. By doing so, the quality of life of the individual with special needs is improved. As a practical matter, special needs planning may be appropriate for someone who is already on government benefits or for someone who may potentially need government benefits in the future.

The primary government benefit available for many individuals with special needs is Medicaid. If you are eligible, Medicaid will generally pay for medical expenses, including the costs of long-term care and other chronic illnesses. For many individuals with special needs, this is critically important since the benefits available under private insurance, even those policies offered under the Affordable Care Act, are extremely limited in this regard. Medicaid is a jointly funded, federal/state program in which the federal government pays a percentage of the cost, and the state(s) the remaining percentage, which varies by state. Medicaid is the payer of last resort. Thus, in order to become eligible for Medicaid, an individual must meet strict income and asset requirements which are set forth by each state.

Another important government benefit available for individuals with special needs is Supplemental Security Income (SSI). SSI is a federal program which pays a monthly stipend to those who qualify. For 2018, the maximum monthly benefit is $750, plus a $20 per month income disregard. SSI may also cover the cost of group homes or other residences for individuals with special needs. Both SSI and Medicaid are "means-tested," which means that, to qualify, the individual has to meet the requirements of each program. To qualify for SSI, an individual can have no more than $2,000 of non-exempt assets in his name. Moreover, both Medicaid and SSI have rules restricting transfers of assets to others, including transfers to trusts, in order to qualify. In addition to federal statutes and regulations, the Social Security Administration ("SSA") has issued the Programs Operations Manual System, commonly referred to as the "POMS."[1] Although the POMS should not have the same weight as federal regulations, they are often given great deference by the courts and are very relevant in a special needs planning practice since

[1] https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView

they represent the SSA's views on a variety of issues pertaining to SSI. SSI recipients who receive payments, from a trust or otherwise, for food or shelter, will have their SSI benefits reduced by either one-third[2] or by the presumed maximum value ("PMV")[3] of the third party's contribution. However, in many cases, it may be appropriate to allow for these types of distributions from an SNT under the proper circumstances, especially if they will improve the quality of life of the beneficiary.

1.1 Types of Special Needs Trusts.

There are generally two different types of SNTs: First party SNTs and third party SNTs. The primary difference being that in first party SNTs the assets used to fund the trust belong to the individual with disabilities; whereas, in third party SNTs, the assets used to fund the trust belong to someone other than the individual with disabilities. Under the umbrella of first party SNTs are pooled trusts. These types of SNTs are funded with assets of the individual with disabilities, but unlike other first party SNTs, they are managed and operated by a not-for-profit organization. By way of nomenclature, some practitioners refer to SNTs as "supplemental needs trusts" instead of "special needs trusts." The name is not important. What is important is the source of funds used to fund the trust.

1.2 First Party Special Needs Trusts.

Other names for a first party SNT include a "(d)(4)(A)" (referring to the federal statute 42 U.S.C. Sec. 1396p(d)(4)(A) which authorizes these types of trusts), "self-settled", or "payback" trust. The assets used to fund these types of trusts typically, but not always, come from medical malpractice or personal injury lawsuits, accumulated assets through work, improper estate planning by family members (including outright inheritance), or child support. One of the key characteristics of a first party SNT is that upon death, or early termination, of the trust, Medicaid, but not SSI, must be repaid for the cost of services provided. The states have varying interpretations of how to calculate this payback.

First party SNTs first came into existence in 1993 with the enactment of "OBRA '93"- the Omnibus Budget Reconciliation Act of 1993. Basically, the law provides an exception to the Medicaid and SSI transfer of asset provisions if assets are transferred to a properly executed first party SNT. In addition, those assets held by the trust do not count towards the asset limits allowed by SSI and Medicaid. In exchange for these two benefits (no penalty period and not counting the assets), the law requires those assets remaining in the first party SNT to be first used to repay the Medicaid program for benefits paid upon death of the beneficiary or other early termination of the trust. To be a valid first party SNT, the trust must (1) contain the assets of an individual under age 65, (2) the individual must be "disabled," as defined by 42 U.S.C. Sec. 1382c(a)(3), (3) the trust must be established for the sole benefit of such individual by the individual, a parent,

[2] POMS HI 03020.045.

[3] POMS SI 00835.300.

grandparent, court or legal guardian, and (4) the trust must contain a Medicaid payback provision.

As noted, pooled trusts are a type of first party SNT managed and operated by a not-for-profit organization. While each beneficiary of a pooled trust has a separate sub-account identifying his share of the total assets in the trust, the assets in the trust are pooled for purposes of investment and management. Moreover, an individual need not be under age 65 to join a pooled trust, although states have different rules on whether transfers of assets to a pooled trust by an individual who is age 65 or older are subject to the Medicaid transfer of asset provisions. Finally, these types of trusts have a modified payback meaning that, depending on state law, all or a portion of the assets remaining in the trust upon the death of the beneficiary may be retained in the trust to benefit other beneficiaries of the pooled trust instead of being repaid to Medicaid. Pooled trusts are a good option for an individual who is not going to be transferring a significant sum to an SNT. Most banks are reluctant to serve as trustee of an SNT or have very high minimum balance requirements. A pooled trust might also be a good option for someone who doesn't have a capable trustee to appoint or for someone age 65 or older who cannot set up a first party SNT. Pooled trusts have trustees who offer professional management and investment of funds and should be considered in appropriate cases. To join a pooled trust, an individual must sign a "joinder agreement."

1.3 Third Party Special Needs Trusts.

A third party SNT is a trust which is created by and funded with assets belonging to someone other than the individual with a disability. A typical example is parents creating a third party SNT for the benefit of their child with a disability. The parents' estate plan would typically provide that, upon their deaths, the assets that are to be allocated for the benefit of the child with a disability are to be placed in the third party SNT created for the child's benefit. The purpose of a third party SNT is to permit a parent, grandparent or other person to provide for the needs of a person with disabilities which are not being met by public benefits. If the funds were left outright to the individual with disabilities, he would be disqualified for Medicaid and SSI. Even "wealthy" families may benefit from special needs planning depending on a number of factors, including the anticipated cost of care, the age of the person with special needs, the type of disability he has, and the community where he resides, among others. Moreover, there can be no assurance that a family's wealth will continue to the next generation(s), potentially increasing the need to rely on government benefits to pay for, at least part, of the care of the individual with disabilities.

Third party SNTs are not governed by federal law, although some states have statutes which address them.[4] Third parties can generally include anyone other than the person with disabilities, although there may be other issues to address if the beneficiary is a minor child or spouse or someone else who the creator of the trust has an obligation to support. Prior to drafting a third party SNT, it is important to determine which public benefits the beneficiary is receiving or may receive in the future. Whether the funds in a

[4] Among them are Minnesota, New York, Arizona, California, New Hampshire, Maryland, New Jersey, Illinois, Indiana, Kentucky, South Carolina, Tennessee, Wisconsin, and Pennsylvania.

third party SNT are considered a resource will often depend upon the terms of the trust, including the existence of a support standard, the extent of discretion given to the trustee and whether the beneficiary can compel a distribution. The settlor's intent to create an SNT should also be clearly stated in the trust instrument. Use of the words "supplement, rather than supplant government benefits" are typically good indicators of the settlor's intent. In determining whether the assets of a third party SNT have any effect on the beneficiary's eligibility for SSI, it is important to review the POMS to ensure that all requisite criteria are met so that trust assets do not disqualify the beneficiary for benefits.[5]

A third party SNT can be created by a revocable inter-vivos trust, an irrevocable inter-vivos trust, or a will. One of the benefits of creating a third party SNT during lifetime is that other relatives can leave assets to this trust if they so desire. Thus, it can serve as a vehicle to receive potential bequests from others thereby ensuring that the beneficiary's government benefits are protected. If the SNT is irrevocable, the settlor can engage in his own estate tax planning through the use of lifetime gifts to the trust. The draftsperson of the trust should be careful not to give Crummey rights of withdrawal to the beneficiary with disabilities as this may result in trust assets being considered an available resource of said beneficiary for SSI and Medicaid purposes. Moreover, the failure to exercise the right of withdrawal may be considered an uncompensated transfer resulting in a penalty period with respect to the beneficiary's eligibility for those benefits. If the SNT is revocable, it is imperative that there be a provision to convert it to an irrevocable trust upon the receipt of funds from persons other than the settlor. Without such a provision, it is unlikely that others would contribute assets to the SNT for fear that the trust could be revoked and the funds not used to enhance the quality of life of the beneficiary with disabilities. When drafting an SNT for a surviving spouse who is receiving, or expected to receive Medicaid benefits in the future, the SNT must be a testamentary trust created in a will. Assets contained in an inter-vivos trust created by a spouse will be considered an available resource of the surviving spouse for public benefits purposes.[6]

A third party SNT does not have to be for the sole benefit of the individual with disabilities; whereas, a first party SNT must be. Thus, it is permissible to have beneficiaries of a third party SNT who are not disabled. For families with more than one child, the assets can either be left to one "pot" trust which has sprinkling provisions or to separate trusts set up for each child. There are conflicting views as to which is the best approach. The benefit of a pot trust is that the trustee can use the money where it is determined to be most appropriate among all the children. However, this can lead to an unfair (in someone's eyes) allocation of resources depending on the circumstances. By leaving the assets in separate trusts and having one of them be a third party SNT, it is clear from the beginning the amount of funds each beneficiary was intended to receive. However, this approach will not afford the trustee the flexibility, if needed, to spend additional funds (beyond what is in that person's SNT) to enhance the quality of life of the individual with disabilities.

[5] POMS SI 01120.200.

[6] 42 U.S.C. Sec. 1396p(d)(2)(A).

Unlike a first party SNT, any funds remaining in the third party SNT at the time of the death of the beneficiary are not subject to Medicaid payback. This makes sense since the creator of the trust would otherwise have no legal obligation to use those funds to pay for the expenses of the beneficiary. Thus, they should not be subject to a Medicaid payback. A third party SNT often resembles a traditional discretionary spendthrift trust drafted to protect the trust assets for the benefit of a person who is vulnerable to exploitation or who does not manage money well. In order for a discretionary trust to meet the criteria of a special needs trust, and thus be exempt from consideration when determining financial eligibility for public benefits, the trust must limit the powers of the beneficiary, the authority of the trustee, and the trust must include a spendthrift clause.[7]

An alternative to a third party SNT is to disinherit the person with disabilities. While this will accomplish the goal of not disqualifying the individual for government benefits, it will not further the goal of enhancing his quality of life. Alternatively, some families consider leaving the assets to a third party (perhaps a sibling) who makes a verbal commitment to assist the person with a disability. Unfortunately, this type of arrangement puts the person with disabilities at risk. The person who is entrusted with the funds could pass away prior to the death of the individual with disabilities, get divorced, get married, become disabled himself, get sued, etc. For the foregoing reasons, this option does not work for most families since it does not ensure that there will be available funds to enhance the quality of life of the individual with disabilities.

1.4 ABLE Accounts.

ABLE accounts are modeled after Internal Revenue Code ("IRC") section 529 Plans and are tax-advantaged accounts that grow tax-free and receive favorable treatment for certain means-tested government benefit programs so long as program requirements are fulfilled. The envisioned purpose of ABLE accounts was to provide secure funding for disability-related expenses on behalf of designated beneficiaries with disabilities that will supplement, but not supplant, benefits otherwise available to those individuals, whether through private sources, the government, or otherwise. The goal was to create a vehicle that was simpler than an SNT, and did not require professionals such as lawyers and trustees, or court involvement.

Although the ABLE Act is federal law, each state can choose whether to have an ABLE program and must enact its own state law before establishing ABLE accounts. States have the option to participate. Several states have declared their intention to not participate due to reasons such as the cost of administering the program. When first enacted, only residents of the state could participate in the ABLE program for that state; however, the law was subsequently amended to allow non-residents to create ABLE accounts in a state other than their home state. Some states have ABLE programs for residents only. Oregon currently runs two programs, one for residents and one for non-residents.

[7] POMS SI 01120.200.

In order to be eligible for an ABLE account, the onset of the individual's disability must have occurred prior to age 26. Each calendar year, the individual with disabilities, or another person for their benefit, can make a contribution in any amount up to the federal annual gift tax exclusion amount, presently $15,000, into an account in the name of the individual with disabilities. Contributions must be made in cash. Aggregate annual contributions from all sources cannot exceed $15,000. There is no federal income tax deduction for contributions made to an ABLE account. However, some states have passed legislation providing for a state income tax deduction or tax credit for ABLE account contributions.

Total contributions into the ABLE account are capped at each state's limitations for 529 accounts and the first $100,000 in an ABLE account will not adversely affect the individual's eligibility for SSI. So long as the funds in that account are used for permitted government-approved disability-related expenditures, the account will be permitted to accrue value income tax-free. An individual can have only one ABLE account. While contributions are completed gifts for tax purposes, there is no five-year up-front funding as there is for 529 accounts.

Funds in an ABLE account must be used for "qualified disability expenses." Non-qualifying distributions are subject to a 10% penalty. This term is broadly construed and is not limited to expenses for items for which there is a medical necessity or which provide no benefit to others in addition to the benefit to the designated beneficiary. This is in stark contrast to a first party SNT which must be established and administered for the "sole benefit" of the individual with disabilities.

Upon the death of the designated beneficiary, the balance of the ABLE account is subject to recovery by the state's Medicaid agency, which provided benefits to the beneficiary during his life. The payback is limited to the account balance of the ABLE account. Neither the designated beneficiary nor his family is personally responsible. Thus, if the money contributed each year is spent in a short period of time, this can minimize the payback. However, for some beneficiaries this may be inconsistent with a desire to save money for a large purchase in the future. The payback applies to all funds in the ABLE account, even those funds contributed by third parties. This is a major distinction between an ABLE account and a third party SNT, where there is no Medicaid payback. The Medicaid recovery is limited to the period in which the ABLE account was in existence. This is a significant difference from first party SNTs in some states, which seek recovery for all Medicaid ever paid on behalf of the beneficiary, since birth. Some states have recently indicated that they do not intend to pursue the ABLE Medicaid payback.

The Tax Cuts and Jobs Act of 2017 made two significant changes to ABLE accounts. First, rollovers from 529 accounts are now permitted up to the $15,000 annual limit. Rollovers may be made from the 529 account of the ABLE designated beneficiary or certain family members. Second, the designated beneficiary may now contribute annually an amount capped at the lesser of (1) the federal poverty level for a one-person household (approximately $12,000) or (2) his compensation for the year. This

contribution is in addition to the $15,000 annual limit. Additionally, the designated beneficiary may claim a saver's credit up to $2,000 for that year if he qualifies. No additional contribution may be made if a contribution was made to the designated beneficiary's retirement plan that year. These two provisions sunset on December 31, 2025.

2. Taxation of Special Needs Trusts.

2.1 First Party Trusts.

All first party SNTs are irrevocable. Irrevocable trusts are generally taxed at a much higher rate than individuals. Due to the compressed income tax rates for trusts, if the taxable income of the trust exceeds $12,500 the trust income will be taxed at the highest federal marginal income tax rate of 37 percent (plus the Medicare and net investment income surtax). Whereas, an individual is not taxed at the 37 percent marginal rate until income exceeds $500,000. This can be a significant issue for SNTs since not all income is typically distributed. To address this concern, the trustee can invest trust assets in items which do not generate taxable income subject to the highest rates. Alternatively, the draftsperson can include provisions in the trust which cause it to be treated as a grantor trust for income tax purposes under IRC sections 671 through 677. One of the benefits of grantor trust status is that all trust income flows through to the grantor and is taxed at the individual income tax rates and not the trust tax rates. In a first party SNT, the grantor is typically the individual with disabilities who would be in a much lower tax bracket than the trust. The practitioner needs to exercise caution when drafting a first party SNT since some of the grantor trust provisions are not well-understood by local Medicaid agencies and may cause issues in having the trust qualify as an exempt trust for SSI and Medicaid purposes. For example, Medicaid might take the position that if the grantor has a power of appointment or the power to substitute property of equivalent value, that these powers could violate the "sole benefit" rule or otherwise give the grantor/beneficiary too much control over the trust to allow it to be an exempt resource.

Contributions to a first party SNT are generally not subject to gift tax for a number of reasons. Unless the trust is set up in one of the asset protection states, the assets held by a first party SNT are subject to the claims of the grantor's creditors. The IRS has ruled that this makes the gift to the trust an incomplete gift for tax purposes.[8] In addition, the assets held by a first party SNT must be used for the sole benefit of the grantor/beneficiary during lifetime and be payable to his estate on death. Thus, it is unlikely that transfers of assets to a first party SNT would be considered a completed gift for tax purposes. If permitted by the local Medicaid agency, you may consider having the grantor reserve a testamentary limited power of appointment in the trust assets. This would ensure that there would be no completed gift.

First party SNT assets are generally included in the grantor's estate for estate tax purposes. Administration expenses, including attorney's fees, and the payback to

[8] See Rev. Rul. 76-103.

Medicaid are allowable deductions on an estate tax return. For 2018, the federal estate exemption is $11,200,000.

2.2 Third Party Trusts.

If a third party SNT is revocable, then all income tax is reported on the settlor's personal income tax return. If the trust is funded, it will not be a completed gift for gift tax purposes and the trust corpus will be includable in the settlor's gross estate upon his death. Upon the settlor's death, the trust becomes irrevocable. Be careful if this type of trust is to be funded from sources other than the settlor as there may be unintended estate tax consequences.

Generally, the same grantor trust rules that apply to first party SNTs also apply to third party SNTs. The primary difference is that, in a third party trust, the settlor is not the beneficiary with special needs. Also, testamentary supplemental needs trusts cannot be considered grantor trusts as the settlor is no longer alive. A third party trust can retain its grantor trust status so long as the grantor is alive. Giving an irrevocable inter-vivos third party trust grantor trust status can be an important estate planning tool for families who want to preserve trust assets and decrease their net worth by paying income taxes.

A qualified disability trust ("QDT") can claim an exemption in the amount of $4,150.[9] In order for a third party SNT to qualify as a QDT, the trust must not be a grantor trust and it must be established for the sole benefit of an individual under age 65 who is disabled. Thus, a first party SNT would not typically qualify as a QDT because it is usually a grantor trust.

Inter-vivos third party SNTs will generally not be included in the settlor's estate so long as the settlor retains no dominion or control over the trust. Thus, any contributions to the third party SNT during the settlor's life will not be included in the settlor's gross estate. If estate taxes are a concern for the settlor, Crummey powers may be utilized in a third party SNT to allow contributions to the trust to qualify for the annual gift tax exclusion. Caveat: you should not provide for Crummey rights of withdrawal powers to a beneficiary who is disabled. It is possible that the SSA or Medicaid could take the position that a disabled beneficiary's Crummey right of withdrawal could cause the assets of the trust to be available to that beneficiary. Further, the lapse of the power could be considered a gift as well.

3. Drafting Considerations.

3.1.1 Trustee Selection.

The selection of the trustee is one of the most, if not the most, important decisions in determining whether the special needs plan you have created will ultimately work for your client and his family. The perfect trustee should be knowledgeable in many areas, including trust law, tax law, public benefits law, investments, medical issues, education

[9] IRC § 642(b)(2)(C)(iii).

issues and advocacy issues. Obviously finding the perfect trustee is not always possible. This is an area where the input of an experienced special needs trust practitioner can be extremely useful to the client.

The trustee may be a family member, professional colleague or a corporate fiduciary. It is not recommended that the beneficiary himself serve as trustee. The government would likely argue that this would give the beneficiary too much control over the trust property, and it could cause the trust assets to be considered an "available" resource for Medicaid and SSI purposes. It makes sense for many clients to consider appointing co-trustees: a family member and a professional trustee. The family member trustee can deal with the advocacy and care issues, while the professional trustee can take care of the investment and compliance issues.

An SNT differs from a more traditional trust since the beneficiary may be on government benefits and there may be accounting or other requirements that cause the government to be an interested party. In addition, for a first party SNT, the government receives the payback on the death of the beneficiary or early termination of the trust. Thus, there may not be the same desire to maximize total overall return since there will be immediate needs of the beneficiary that must be met. In any event, the trustee must keep accurate records and make sure that distributions do not inadvertently violate the Medicaid or SSI rules.

3.1.1 Professional Trustee.

In many cases, the client will be well-served by having a professional serve as trustee of an SNT. Of course, this will likely mean increased expense compared to a family member; however, in most cases this will be well worthwhile. Most family members have never served as trustee of any kind of trust, much less an SNT. There could be a tendency to treat the trust money as their own or comingle the funds with their own. This is especially troublesome when the beneficiary with special needs is not capable of monitoring the trustee's actions. It is important to have a trustee who will take the time to get to know the beneficiary and who will investigate and understand his needs. In a first party SNT, the trustee must have the backbone to refuse to make inappropriate distributions that are not for the sole benefit of the beneficiary and also be flexible enough to make distributions that will enhance the quality of life of the beneficiary. Be careful, as not all professional trustees will take the time to do the job properly. Increasingly, courts are becoming less tolerant of SNT trustees who simply invest the money, take their fees and do nothing much else to benefit the beneficiary. Courts are holding trustees of an SNT to a higher standard, often requiring them to apply for public benefits on behalf of the trustee or make distributions that improve the quality of life of the beneficiary. For this reason, among others, many banks and trust companies will not serve as a trustee of an SNT. It is important to work with a trust company that seeks out this type of business and will do a good job.

When utilizing a corporate trustee, make sure you incorporate their fee schedule into the trust document. Most banks and trust companies have a minimum annual fee or

may have a minimum corpus requirement. In many cases, this will be an impediment to appointing a corporate trustee. It is important for you to establish relationships with professional trustees who seek out this type of business and who are flexible when it comes to minimum corpus requirements.

3.1.2 Trust Protector.

It is often appropriate to appoint someone or entity as trust protector to have the authority or duty to oversee the trustee in an SNT since the beneficiary often cannot serve this role. For example, a beneficiary with cognitive impairment would not be able to review the accountings of the trustee. A trust protector can have a number of roles, depending on state law and the trust instrument itself. It is important to carefully think through which powers you give to a trust protector, as these can vary widely. They can be merely administrative in nature or can be substantive. You must decide whether the trustee has to follow the direction of the trust protector or whether the trust protector is merely acting in an advisory capacity. Depending on the powers given to the trust protector, fiduciary responsibility may attach thereto.

3.1.3 Trustee Discretion.

SNT practitioners frequently debate whether an SNT should include very specific distribution standards or standards which are broad in nature. The theory behind specific standards is the hope that it will provide clear guidance to trustees (and beneficiaries and family members) as to what is intended with respect to permissible distributions. The thought is that this will reduce any potential litigation risk or the need to seek court approval for distributions. However, by being specific, you may run into problems getting your trust approved by SSA since they change their policies and the POMs from time to time. One of your provisions may run afoul of a new POMS provision which changes SSA policy on a particular issue. Conversely, it is thought that broad standards allow the trustee to exercise its unfettered discretion to make a distribution to improve the quality of life of the beneficiary in accordance with the trust instrument. In fact, many corporate trustees actually prefer this to a specific standard. After all, it is very hard to anticipate at the time of drafting all the future possible needs of the beneficiary. One of the drawbacks of a broad standard is that the trustee often feels the need to seek court approval for certain distributions since they are not specifically stated in the trust. With respect to this issue, there is no “one size fits all” approach that can be applied to all trusts. Each case must be thought through and discussed with the relevant parties prior to drafting the trust.

One drafting issue with respect to trustee discretion that deserves some thought is whether the trustee should be permitted to make a distribution even if it reduces or eliminates the beneficiary’s entitlement to government benefits. If this type of distribution would improve the quality of life of the beneficiary, then perhaps it makes sense to make the distribution even if it has a negative impact on government benefits.

3.1.4 Trustee Powers.

In an SNT it is important for the trustee to have the power to invest trust assets in non-income producing assets, such as a car or a house. Also, in an SNT, preservation of principal may not be paramount since the intent is to improve the quality of life of the beneficiary with special needs and the interests of the remaindermen typically fall behind the lifetime beneficiary.

3.1.5 Trust Amendment.

Due to a rapidly changing regulatory and legal landscape, it is possible that an SNT will need to be amended after it is executed. For example, if the beneficiary moves to another state and the new state's Medicaid agency doesn't agree with certain trust provisions and requires that they be removed or amended before Medicaid will be granted in that state. Another example is that the POMS are constantly changing and may cause the exempt trust to no longer be exempt. This is a major reason why the draftsperson needs to incorporate flexibility into the trust so that it may be amended when necessary. Even though decanting or reformation may be available, it is almost always more cost effective and practical to amend the trust if the power to do so is included in the trust document. If the original trust is a first party SNT which was approved by a court, it is quite possible that the court will insist on approving any modifications to the trust.

3.1.6 Other Provisions.

The trust should also give the trustee the power to hire other professionals, including lawyers, accountants, and care managers. Be mindful that in first party SNTs, professional fees may be subject to court approval.

4. Trust Administration Considerations.

4.1.1 Family Member as Caregiver.

Frequently, parents of children with disabilities need to stay at home and care for their child and cannot be out in the regular workforce causing some parents to give up successful careers. Other times, parents cannot rely on the Medicaid system to provide appropriate aides for their child. Questions often arise regarding whether the trust should pay for private aides, or pay the parent as a caregiver. A third party SNT can provide for this type of compensation. However, when dealing with first party SNTs, even if the trust grants this authority, a corporate trustee may still wish to notify Medicaid and seek court approval. A few years ago, the POMS actually had a provision that would have prohibited first party SNTs from paying family members as caregivers unless the family member was certified. Interestingly, the POMS did not define who was a family member or how one would become certified. The provision was purportedly put in place because SSA was concerned about alleged abuses of certain family members who were taking advantage of the trust beneficiary who had disabilities. Under recent revisions to the POMS, third-party caregivers are treated the same regardless of whether they are family members,

non-family members, or a professional entity. There is no need for medical training or certification for a caregiver to be paid. Companion care is considered a valid expense of the trust and may even include incidental expenses such as admission tickets to events that the beneficiary can only attend with assistance.

4.1.2 Travel Expenses.

Another POMS provision which was also subsequently withdrawn would have treated a trust provision which allowed the first party SNT to pay for the travel of someone else as a violation of the "sole benefit" rule resulting in trust assets being considered an available resource. This POMS provision has since been revised to permit payment by first party SNTs of travel expenses of non-beneficiaries in limited circumstances. The revised rule provides that payments to third parties do not violate the sole benefit rule if they are for goods and services received by the beneficiary or payments for travel expenses of third parties which are necessary for the trust beneficiary to obtain medical treatment or payments that allow a third party to visit a beneficiary who resides in an institution, nursing home, or other long-term care facility (i.e., group homes and assisted living facilities), or other supported living arrangement in which a non-family member or entity is being paid to provide or oversee the individual's living arrangement. However, the travel must be for the purpose of ensuring the safety and/or medical well-being of the individual.[10] It is important to note that these provisions are limited solely to those beneficiaries receiving SSI and also do not apply to third party trusts. Thus, payment from third party SNTs to reimburse travel expenses of family members is permissible so long as the trust provides for such reimbursement.

4.1.3 Housing Options.

The purchase of a home for someone with disabilities is something that can improve his quality of life for a long time. However, a home purchase often presents a number of complex issues at the time of purchase and during the time period that the beneficiary resides in the house. For this reason, many practitioners suggest that a beneficiary rent instead of owning a home. If the decision is made to purchase a home, a threshold question is whether the purchaser of the home should be the trust, the beneficiary, or some other third party. If a first party SNT owns the home, then the value of the home will be subject to the Medicaid payback upon the death of the beneficiary. If the beneficiary owns the home, the Medicaid payback will not apply; however, Medicaid may, under certain circumstances, place a lien on the home, or, the value of the home may be subject to Medicaid estate recovery upon the death of the beneficiary. Pursuant to 42 U.S.C. Sec. 1396p(b)(1)(B), Medicaid may have the right to recover for certain long-term care benefits paid after the beneficiary attained the age of 55. With respect to third party SNTs, it often makes sense for the SNT to own the home since there is no Medicaid payback in those types of trusts.

When purchasing a home, the question invariably arises as to whether the purchase should be financed. The proceeds of a mortgage will not be considered income

[10] POMS SI 01120.201 F.2.b.

for SSI or Medicaid purposes so long as they are used to purchase the home in the same month in which they are received. If the trust owns the home, it may be difficult for the trustee to qualify for a mortgage. Of course, this situation can be ameliorated if the trust company and the mortgage company are owned by the same entity. If the home purchase transaction is structured so that the beneficiary owns the home, it may also be difficult to obtain a mortgage since many beneficiaries do not work or have poor credit. For this reason, it is common for home purchases to be all cash transactions.

If a house is owned individually by a first party SNT beneficiary, it may not make sense for the ownership to be transferred to the SNT if the beneficiary is under age 55 since Medicaid does not have a right of recovery for benefits paid to an individual prior to age 55. If ownership of the house is transferred to the first party SNT and other family members are living in the house owned by the trust, the trustee should consider contributions from those family members. This is especially true in first party SNTs since you want to make sure that the trust does not violate the sole-benefit rule by allowing others to live in the house rent-free. In these situations, it is often necessary to charge the other family members rent. If the other family members provide care to the beneficiary that allows him to stay at home, that can be a mitigating factor.

4.1.4 Purchase of a Vehicle.

A trust can purchase a vehicle for the benefit of a beneficiary. It is important to consider who should be the owner of the vehicle. In some cases it makes sense to title the vehicle in the name of the beneficiary or family member. This way, if a car accident occurs in which the beneficiary or family member was responsible, it will minimize the exposure of trust assets in any subsequent litigation. It is suggested that the trust hold a lien on the title of the car so the beneficiary or family member cannot sell the vehicle.

4.1.5 Payback Provision.

As previously noted, all first party SNTs must include a "payback" provision at the death of the beneficiary or early termination of the trust. It is important to remember that the payback is only for Medicaid expenditures and not SSI. Be mindful that beneficiaries sometimes move during lifetime and thus receive Medicaid benefits from more than one state. Upon death, the respective states will be entitled to a pro-rata allocation of whatever remains in the trust on death. Also, different states may have different rules regarding how far back the payback must go. In many states, the payback includes Medicaid expenditures incurred prior to the creation of the trust.

Some, but not many, expenses receive priority over the Medicaid payback. For example, trust administration expenses and federal and state estate taxes may be paid prior to repaying Medicaid. Debts due third parties, funeral expenses and payments to residual beneficiaries cannot be paid until the state is reimbursed for Medicaid paid. For this reason, it is critically important that burial and funeral expenses be prepaid by using a Medicaid-exempt, irrevocable prepaid funeral contract prior to the beneficiary's death. In fact, the properly drafted first party SNT should include a provision authorizing the

trustee to spend trust assets for this purpose. When determining the amount to be paid back to Medicaid, it is important to review a report provided by Medicaid which details each and every expenditure made by Medicaid on the beneficiary's behalf. Frequently, there are errors, including care provided to other individuals and payment for special education and related services, which are not subject to payback.

5. Common Errors.

Set forth below are some common errors practitioners make when representing clients in the special needs planning and SNT area. These are by no means exhaustive, but merely a sampling of some of the things that can go wrong if careful attention is not paid to detail and all scenarios are not thought out properly. Each client situation must be evaluated on its own as one size does not fit all in this area.

5.1 Not being flexible in drafting. You must carefully consider the needs of the trust beneficiary and circumstances of the particular matter. The trust should not be "cookie cutter," but rather an instrument that will provide flexibility to meet the beneficiary's needs for years to come. The goal of most clients is to improve the quality of life of the individual with special needs. They are relying on the trust draftsperson to draft a document and put in place a plan that will adapt to the changing needs of the trust beneficiary and the ever-changing status of the law.

5.2 Not creating a third party SNT for someone over 65. There is no law prohibiting the creation and funding of a third party trust for individuals with disabilities who are age 65 or older. This limitation applies only to first party SNTs. Third party SNTs also are a very effective planning too for married seniors when one of the spouses may be facing a long-term care situation.

5.3 Create first party SNT for someone over age 65. Federal law expressly prohibits the creation and funding of first party, self-settled trusts for individuals age 65 or older. If this type of trust was created, the beneficiary would be subject to transfer penalties and potential disqualification of public benefits. Moreover, since the trust must be irrevocable, it may be extremely difficult to undo this mistake and engage in proper planning.

5.4 Requiring mandatory distributions of income or principal. SNTs must be purely discretionary trusts. If the draftsperson puts in a standard pursuant to which the beneficiary can demand distributions from the trust then that could frustrate the entire purpose of the trust. Ideally, the trust should be designed to supplement, not supplant, government benefits. By requiring the trustee to make distributions, the beneficiary's right to certain government benefits could be compromised.

5.5 Spending third party trust assets prior to first party trust assets. Often, individuals with special needs are beneficiaries of both a first party SNT and a third party SNT. For example, they might have received a lawsuit settlement which was placed into a first party SNT and the parents might have funded a third party SNT. Since the third

party SNT does not have a Medicaid payback provision, it is essential that assets of the first party SNT be spent first prior to expending any third party SNT assets.

5.6 Gifts to first party trust made by third parties. While this may seem obvious, unfortunately, it does happen. Since the first party SNT must have a payback provision, it is imperative that any planning done by third parties include a third party SNT and that contributions by third parties go into the third party SNT and not the first party SNT.

5.7 Failure to coordinate with other relatives' planning. It is important to discuss with your client whether other family members are intending to leave assets to a child with a disability. After a client completes his estate planning, he should write a "Dear Family" letter to family members and inform them of the trust that has been put into place and how they can contribute to it if they wish to leave anything to the individual. This is one of the benefits of utilizing an inter-vivos third party SNT.

5.8 Failure to review and coordinate all beneficiary designations. In any estate plan, but especially in a special needs situation, it is important to review and coordinate beneficiary designations. You will be frustrating the intent and purposes of a third party SNT if the beneficiary designations of life insurance, retirement accounts, etc. leave assets outright to a person with special needs.

5.9 Not preparing a letter of intent. While not a legally binding document, a letter of intent is a critical component of a special needs plan. It provides a roadmap for future caregivers so that they can do the best job possible.

5.10 Failure to appropriately consider proper trustee. Too often, not enough time is spent discussing this very important decision. In many cases, the proper trustee is the key to the successful implementation of the plan and administration of the trust. Clients often wish to appoint a family member. However, family members often have a conflict of interest and have no experience serving as trustee. Serving as trustee of an SNT is even more complicated than serving as a trustee of a more traditional trust since the trustee must also be familiar with public benefit rules. In fact, some banks and trust companies refuse to serve as trustee of an SNT. Oftentimes, it makes sense to have co-trustees where the individual trustee can address the beneficiary's personal needs and the corporate trustee can handle the investment and compliance issues.

5.11 Failure to consider a trust protector. While a relatively new concept in the United States, the concept of appointing a trust protector is gaining traction, especially in SNTs. In an SNT, the beneficiary is often not able to monitor the actions of the trustee due to cognitive issues. Thus, a trust protector can serve a very useful oversight role in these cases. The trust protector can have a number of powers, including the power to make certain changes to the trust, the power to approve distributions, the power to change the trustee, among others. One issue you will want to consider is whether the trust protector will be a fiduciary. There are several states which have trust protector statutes and these must be reviewed if your trust is governed by the laws of one of those states.

5.12 Having remainder beneficiaries who are adverse to the beneficiary with disabilities. Too often, families lose sight of the fact that the SNT was set up primarily for the benefit of the person with disabilities. Practitioners need to be mindful of potential conflicting and hostile family relationships which may impact the administration of the SNT. For example, if the sibling is a trustee and also a remainder beneficiary, the sibling may be hesitant to spend necessary money on the beneficiary for fear that their remainder interest will be diminished.

5.13 Failure to include a contingent SNT in Will. Many practitioners will not include an SNT in an estate plan because the family is not sure that the individual with special needs will ever need government benefits. In these situations, a contingent SNT works very well. The practitioner can draft the will leaving the assets either outright or in a non-SNT. If, at the time that the beneficiary becomes entitled to receive the assets, it is possible that government benefits may be in his future, then the SNT provisions can be triggered. This approach allows the decision on whether to utilize an SNT to be deferred, thereby giving all parties more time and information to make the proper decision.

5.14 Prohibiting disqualifying distributions. The goal of special needs planning is to improve the quality of life of the individual with special needs. In certain circumstances, the beneficiary may be better off if services or items are paid for by the trust even if this will have the effect of reducing or eliminating benefits. It is important that the trust allow for the trustee to exercise its discretion in this regard.

5.15 No provision to terminate third party trust if treated as available asset. Medicaid agencies are becoming increasingly aggressive in their treatment of trusts, including third party SNTs. For that reason it is important that the trustee (or someone else such as a trust protector) have the power to terminate the trust if Medicaid takes the position that the trust is an available resource. In that case, it may be important to remove the assets from the trust so that other planning may be implemented.

5.16 Include payback in third party trust. This is one surefire way to have an unhappy client and a malpractice case on your hands. Many practitioners don't understand the difference between a third party and a first party SNT and they think that all SNTs must have a Medicaid payback. That is simply not the case.

5.17 Give SNT beneficiary with disabilities Crummey powers. For tax planning purposes, it is often desirable for trust beneficiaries to have a Crummey right of withdrawal so that contributions to the trust qualify for the annual gift tax exclusion. If the trust beneficiary is receiving government benefits, however, it is possible that SSA or Medicaid could take the position that a disabled beneficiary's Crummey right of withdrawal could cause the assets of the trust to be available to that beneficiary. Further, the lapse of the power could be considered a gift as well. If estate and gift tax planning is important to the client, perhaps there are others, including contingent remaindermen, who you could give the Crummey power to.

5.18 Make first party trust revocable. First party SNTs must be irrevocable trusts. If the beneficiary has the power to revoke the trust, then the trust assets will be considered available for Medicaid and SSI purposes.

5.19 Include sprinkling provisions in first party SNT. A first party SNT must be for the sole benefit of the beneficiary with disabilities. Thus, first party SNTS may not contain a provision which gives the trustee the power to distribute or sprinkle trust assets to other individuals. With respect to third party SNTs, sprinkling provisions are permitted although many practitioners prefer to set up separate trusts.

5.20 Not reviewing public benefits. Clients frequently do not know the exact benefits they are receiving. Always review written documentation of benefits eligibility. For example, if a beneficiary is receiving only SSDI and Medicare and it is never anticipated that he will be receiving any means-tested benefits, perhaps an SNT is not necessary.

5.21 Retirement benefits. If substantial retirement benefits are being funded into an SNT, the practitioner should consider whether it makes sense to use an accumulation trust as opposed to a conduit trust. While this might accelerate the payment of certain income taxes, it may preserve more of the trust corpus for the beneficiary when needed.

5.22 Knee-jerk SNT. In many cases, practitioners assume that an SNT is the best option, when in fact, that might not always be the case. In a third party SNT situation this can be addressed by using a contingent SNT. This allows for the creation of an SNT in the future if necessary. In a first party SNT situation, the amount of funds might be so substantial that it might not make sense to apply for means-tested government benefits. The beneficiary may be better off not being on Medicaid or SSI. Of course, each case must be evaluated on its own circumstances and merits.

Update on ABLE Accounts: What Trust and Estate Lawyers Need to Know

By Bernard A. Krooks and Benjamin A. Rubin

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ABLE (Achieving a Better Life Experience) accounts, first discussed in an article published in this magazine last spring, have already undergone significant changes since the original enactment of the law in 2014. Prob & Prop., May/June 2017, at 40. Most recently, the Tax Cuts and Jobs Act of 2017 (2017 Tax Act) made two significant changes that will be discussed below.

ABLE accounts are tax-advantaged savings accounts that can be established for certain persons with disabilities and used for qualified disability-related expenses. Annual contributions to ABLE accounts are limited to an amount not to exceed the federal annual gift tax exclusion. This annual contribution limit is from all sources, and individuals can have only one ABLE account. As a result of an increase in the annual gift tax exclusion amount in 2018, the cap on annual contributions to an ABLE account has been increased from $14,000 to $15,000.

The 2017 Tax Act modifies ABLE accounts to permit the beneficiary of the account to make additional contributions to the beneficiary's own ABLE account above and beyond the $15,000 limitation. Additional contributions are permitted in an amount up to the lesser of (1) the federal poverty line for a one-person household (currently, $12,060) or (2) the individual's compensation for the year. No additional contribution, however, may be made if a contribution, on behalf of the individual, was made for the taxable year to (1) a defined contribution plan under IRC § 414(i), (2) an annuity contract described in IRC § 403(b), or (3) an eligible deferred compensation plan described in IRC § 457(b). This provision is effective for tax years commencing in 2018 and sunsets on December 31, 2025.

In addition, the beneficiary may now be eligible to claim a nonrefundable saver's tax credit for contributions to an ABLE account up to $2,000. Because the credit is nonrefundable, from a practical perspective it may not help many ABLE account owners, who often have very low or no individual tax liability.

The other significant change made by the 2017 Tax Act permits rollovers from 529 accounts to an ABLE account of the individual or certain family members. The rollover amount counts toward the $15,000 annual contribution limitation. Thus, if other contributions have been made that year they must be taken into account in determining whether the annual limit has been reached. Caution should be exer-

cised before making the rollover, however, because ABLE accounts are subject to the Medicaid payback upon death of the beneficiary, but 529 accounts are not. The new rollover provisions apply to distributions from 529 accounts commencing in 2018 and ending on December 31, 2025.

The changes to ABLE accounts that went into effect on January 1, 2018, create new opportunities for individuals with disabilities and their families. However, like all aspects of special needs planning, the issues are complex. Practitioners should recommend taking advantage of these opportunities only after examining the individual circumstances of each particular family. n

Administering a Special Needs Trust

A Handbook For Trustees

(2018 Edition)

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Introduction and Definition of Terms

"Special Needs" trusts are complicated and can be hard to understand and administer. They are like other trusts in many respects—the general rules of trust accounting, law and taxation apply—but unlike more familiar trusts in other respects. The very notion of "more familiar" types of trusts will, for many, be amusing—most people have no particular experience dealing with formal trust arrangements, and special needs trusts are often established for the benefit of individuals who would not otherwise expect to have experience with trust concepts.

The essential purpose of a special needs trust is usually to improve the quality of an individual's life without disqualifying him or her from eligibility for public benefits. Therefore, one of the central duties of the trustee of a special needs trust is to understand what public benefits programs might be available to the beneficiary and how receipt of income, or provision of food or shelter, might affect eligibility. Because there are numerous programs, competing (and sometimes even conflicting) eligibility rules, and at least two different types of special needs trusts to contend with, the entire area is fraught with opportunities to make mistakes. Because the stakes are often so high—the public benefits programs may well be providing all the necessities of life to the beneficiary—a good understanding of the rules and programs is critically important.

The essential purpose of a special needs trust is usually to improve the quality of an individual's life without disqualifying him or her from eligibility to receive public benefits.

Before delving into a detailed discussion of special needs trust principles, it might be useful to define a few terms:

GRANTOR (sometimes "Settlor" or "Trustor")—the person who establishes the trust and generally the person whose assets fund the trust. There might be more than one grantor for a given trust. The tax agency may define the term differently than the public benefits agency. Special needs trusts can make this term more confusing than other types of trusts, since the true grantor for some purposes may not be the same as the person signing the trust instrument. If, for example, a parent creates a trust for the benefit of a child with a disability, and the parent's own money funds the trust, the parent is the grantor. In another case, where a parent has established a special needs trust to handle settlement proceeds from a personal injury lawsuit or improperly directed inheritance, the minor child (through a guardian) or an adult child will be the grantor, even though he or she did not decide to establish the trust or sign any trust documents.

TRUSTEE—the person who manages trust assets and administers the trust provisions. Once again, there may be two (or more) trustees acting at the same time. The grantor(s) may also be the trustee(s) in some cases. The trustee may be a professional trustee (such as a bank trust department or a lawyer), or may be a family member or trusted adviser—though it may be difficult to qualify a non-professional to serve as trustee.

BENEFICIARY—the person for whose benefit the trust is established. The beneficiary of a special needs trust will usually (but not always) be disabled. While a beneficiary may also act as trustee in some types of trusts, a special needs trust beneficiary will almost never be able to act as trustee.

DISABILITY—for most purposes involving special needs trusts, "disability" refers to the standard used to determine eligibility for Social Security Disability Insurance or Supplemental Security Income benefits: the inability to perform any substantial gainful employment.

INCAPACITY (sometimes Incompetence)—although "incapacity" and "incompetence" are not interchangeable, for our purposes they may both refer to the inability of a trustee to manage the trust, usually because of mental limitations. Incapacity is usually important when applied to the trustee (rather than the beneficiary), since the trust will ordinarily provide a mechanism for transition of power to a successor trustee if the original trustee becomes unable to manage the trust. Incapacity of a beneficiary may sometimes be important as well. Not every disability will result in a finding of incapacity; it is possible for a special needs trust beneficiary to be disabled, but not mentally incapacitated. Minors are considered to be incapacitated as a matter of law. The age of majority differs slightly from state to state, though it is 18 in all but a handful of states.

REVOCABLE TRUST—refers to any trust which is, by its own terms, revocable and/or amendable, meaning able to be undone, or changed. Many trusts in common use today are revocable, but special needs trusts are usually irrevocable, meaning permanent or irreversible.

IRREVOCABLE TRUST—means any trust which was established as irrevocable (that is, no one reserved the power to revoke the trust) or which has become irrevocable (for example, because of the death of the original grantor).

SOCIAL SECURITY DISABILITY INSURANCE—sometimes referred to as SSDI or SSD, this benefit program is available to individuals with a disability who either have sufficient work history prior to becoming disabled or are entitled to receive benefits by virtue of being a dependent or survivor of a disabled, retired, or deceased insured worker. There is no "means" test for SSDI eligibility, and so special needs trusts may not be necessary for some beneficiaries—they can qualify for entitlements like SSD and Medicare even though they receive income or have available resources. SSDI beneficiaries may also, however, qualify for SSI (see below) and/or Medicaid benefits, requiring protection of their assets and income to maintain eligibility. Of course, just because a beneficiary's benefits are not means-tested, it does not follow that the beneficiary will not benefit from the protection of a trust for other reasons.

SUPPLEMENTAL SECURITY INCOME—better known by the initials "SSI," this benefit program is available to low-income individuals who are disabled, blind or elderly and have limited income and few assets. SSI eligibility rules form the basis for most other government program rules, and so they become the central focus for much special needs trust planning and administration.

MEDICARE—one of the two principal health care programs operated and funded by government—in this case, the federal government. Medicare benefits are available to all those age 65 and over (provided only that they would be entitled to receive Social Security benefits if they chose to retire, whether or not they actually are retired) and those under 65 who have been receiving SSDI for at least two years. Medicare eligibility may forestall the need for or usefulness of a special needs trust. Medicare recipients without substantial assets or income may find that they have a difficult time paying for medications (which historically have not been covered by Medicare but began to be partially covered in 2004) or long-term care (which remains largely outside Medicare's list of benefits).

MEDICAID—the second major government-run health care program. Medicaid differs from Medicare in three important ways: it is run by state governments (though partially funded by federal payments), it is available to those who meet financial eligibility requirements rather than being based on the age of the recipient, and it covers all necessary medical care (though it is easy to argue that Medicaid's definition of "necessary" care is too narrow). Because it is a "means-tested" health care program, its continued availability is often the central focus of special needs trust administration. Because Medicare covers such a small portion of long-term care costs, Medicaid eligibility becomes centrally important for many persons with disabilities.

The Most Important Distinction

Two entirely different types of trusts are usually lumped together as "special needs" trusts. The two trust types will be treated differently for tax purposes, for benefit determinations, and for court involvement. For most of the discussion that follows, it will be necessary to first distinguish between the two types of trusts. The distinction is further complicated by the fact that the grantor (the person establishing the trust, and the easiest way to distinguish between the two trust types) is not always the person who actually signs the trust document.

"Self-Settled" Special Needs Trusts

Some trusts are established by the beneficiary (or by someone acting on his or her behalf) with the beneficiary's funds for the purpose of retaining or obtaining eligibility for public benefits—such a trust is usually referred to as a "self-settled" special needs trust. The beneficiary might, for example, have received an outright inheritance, or won a lottery. By far the most common source of funds for "self-settled" special needs trusts, however, is proceeds from a lawsuit—often (but not always) a lawsuit over the injury that resulted in the disability. Another common scenario requiring a person with a disability to establish a self-settled trust is when they receive a direct inheritance from a well-intentioned, but ill-advised relative.

A given trust may be treated as having been "established" by the beneficiary even if the beneficiary is completely unable to execute documents, and even if a court, family member, or lawyer representing the beneficiary actually signed the trust documents. The key test in determining whether a trust is self-settled is to determine whether the beneficiary had the right to outright possession of the proceeds prior to the act establishing the trust. If so, public benefits eligibility rules will treat the beneficiary as having set up the trust even though the actual implementation may have been undertaken by someone else acting on their behalf. Virtually all special needs trusts established with funds recovered in litigation or through a direct inheritance will be "self-settled" trusts.

Self-settled special needs trusts are different from third-party trusts in two important ways. First, self-settled trusts must include a provision directing the trustee, if the trust contains any funds upon the death of the beneficiary, to pay back anything the state Medicaid program has paid for the beneficiary. Second, in many states, the rules governing permissible distributions for self-settled special needs trusts are significantly more restrictive than those controlling third-party special needs trusts.

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Because Social Security law specifically describes self-settled special needs trusts, these instruments are sometimes referred to by the statutory section authorizing transfers to such trusts and directing that trust assets will not be treated as available and countable for SSI purposes. That statutory section is 42 U.S.C. §1396p(d)(4)(A), and so self-settled special needs trusts are sometimes called, simply, "d4A" trusts.

"Third-party" Special Needs Trusts

The second type of special needs trust is one established by someone other than the person with disabilities (usually, but not always, a parent) with assets that never belonged to the beneficiary. It is often used, when proper planning is done for a disabled person's family, to hold an inheritance or gift. Without planning, a well-meaning family member might simply leave an inheritance to an individual with a disability. Even though it may be possible to set up a trust after the fact, the funds will have been legally available to the beneficiary. That means that any trust will probably be a "self-settled" special needs trust, even though the funds came from a third party.

Parents, grandparents and others with the foresight to leave funds in a third party special needs trust will provide significantly better benefits to the beneficiary who has a disability. This type of trust will not need to include a "payback" provision for Medicaid benefits upon the beneficiary's death. During the beneficiary's life, the kinds of payments the trust can make will usually be more generous and flexible.

Some trusts are established by the beneficiary for the purpose of retaining or obtaining eligibility for public benefits with the beneficiary's funds. By far the most common source of funds for "self-settled" special needs trusts is proceeds from a lawsuit—often (but not always) a lawsuit over the injury that resulted in the disability.

The "Sole Benefit" Trust

Although there are two primary types of special needs trusts, there is actually a third type that might be appropriate under certain unusual circumstances. Because Medicaid rules permit applicants to make unlimited gifts to or "for the sole benefit of" disabled children or spouses, some individuals with assets may choose to establish a special needs trust for a child or grandchild with disabilities in hopes of securing eligibility for Medicaid for both themselves as grantor and for the disabled beneficiary. A number of states are very restrictive in their interpretation of the "sole benefit" requirement, so that such trusts are rarely seen. In many ways they look like a hybrid of the two other trust types; they may be taxed and treated as third-party trusts, but require a payback provision like a self-settled trust (at least in some states).

The Second Most Important Distinction

Once the type of trust is determined, the next important issue is discerning the type of government program providing benefits. Some programs (like SSDI and Medicare) do not impose financial eligibility requirements; a beneficiary receiving income and all his or her medical care from those two programs might not need a special needs trust at all, or might benefit from more flexibility given to the trustee. A recipient of SSI and/or Medicaid, however, may need more restrictive language in the trust document and closer attention on the part of the trustee.

SSDI/Medicare Recipients

Neither Social Security Disability Insurance benefits nor Medicare are "means-tested." Consequently, it may be unnecessary to create a special needs trust for someone who receives benefits only from those two programs. After 24 months of SSDI eligibility, the beneficiary will qualify for Medicare benefits as well, so it may be appropriate to provide special needs provisions to get the SSDI recipient through that two-year period, during which he or she may rely on Medicaid for medical care. Restrictive special needs trust language may actually work against an SSDI beneficiary if it prevents distribution of cash to the beneficiary in all circumstances; an SSDI recipient will almost always benefit from broad language giving more discretion to the trustee.

Some SSDI/Medicare recipients may also receive SSI and/or Medicaid benefits. It may be critically important for those individuals to have strict special needs language controlling use of any assets or income that would otherwise be available. As the Medicare prescription drug benefit evolves over the next few years, this concern may be somewhat lessened—but for the moment, it remains true that availability of the drug coverage provided by Medicaid is critically important to many Medicare recipients.

Even an SSDI/Medicare beneficiary who does not receive any SSI or Medicaid benefits may be a good candidate for special needs trust planning. Future developments in public benefits programs, including housing, are uncertain, but constant budget pressure may well make benefits now taken for granted completely or partially indexed to income and/or assets in the future. Medical conditions also change, of course, and some persons with disabilities living in the community who presently receive adequate support from Medicare may one day become dependent on Medicaid for services not available under Medicare-like long term care.

SSI/Medicaid Recipients

Most special needs trust beneficiaries are eligible for (or seeking eligibility for) Supplemental Security Income payments. In many states, receipt of SSI payments automatically qualifies one for Medicaid eligibility. Many other government programs explicitly rely on SSI eligibility rules as well, so that SSI eligibility rules become the central concern for those charged with administering special needs trusts.

Veterans' Benefits

"Veterans' benefits" is the term used to describe the benefits available to veterans, the surviving spouses, children or parents of a deceased veteran, dependents of disabled veterans, active duty military service members, and members of the Reserves or National Guard. These benefits are administered by the U.S. Department of Veterans Affairs ("VA").

> Parents, grandparents and others with the foresight to leave funds in a third-party special needs trust will provide significantly better benefits to a beneficiary with disabilities.

The benefits available to veterans include monetary compensation (based on individual unemployability or at least ten-percent disability from a service-connected condition), pension (if permanently and totally disabled or over the age of 65 and have limited income and net worth), health care, vocational rehabilitation and employment, education and training, home loans and life insurance. Although the pension is available to low-income veterans, it is important to note that some income, such as child's SSI or wages earned by dependent children, is excluded when determining the veteran's annual income. Also keep in mind that a service-connected disability payment will not offset SSDI, but any VA disability payment will offset SSI.

The benefits available to dependents and survivors of the veteran include Dependency and Indemnity Compensation ("DIC") and, in certain circumstances, home loans.

Transferring a VA recipient's assets into a special needs trust may not be fully effective. According to VA interpretation, the assets of such a trust will be counted as part of the claimant's net worth when calculating an improved pension. It is important to remember that the VA may place a "freeze" on new enrollees in order to manage the rapid influx of new veterans or older veterans who did not previously enroll for services. Therefore, it is important to evaluate current and future need for VA services in order to anticipate and plan for a situation where a person is otherwise eligible for VA benefits but, due to a freeze, cannot receive services. Under a new law, attorneys must become accredited with the VA to advise clients in this area.

Subsidized Housing

FEDERAL SUBSIDIZED HOUSING

The U.S. Department of Housing and Urban Development ("HUD") provides opportunities to low-income individuals and families to rent property at a cost that is lower than the open market. This is especially important to those people who are expected to pay for their shelter costs (rent or mortgage, plus utilities) with their insufficient SSI income. There are two issues to consider when evaluating the role of special needs trusts and subsidized housing: the initial eligibility for subsidized housing and the rent determination.

Eligibility for subsidized housing depends on the family's annual income. Annual income includes earned income, SSI, SSDI, pension, unemployment compensation, alimony, and child support, among other items. Annual income also includes unearned income, which is comprised, in part, of interest generated by assets. If the family has net family assets in excess of $5,000, the annual income includes the greater of the actual income derived from all net family assets or a percentage of the value of such assets based on the current passbook savings rate, as determined by HUD.

Assets that are not included as income upon receipt are lump sums, such as inheritances and insurance settlements for losses (although the income they generate will be countable), reimbursement for medical expenses, PASS set-asides, work training programs funded by HUD and the income of a live-in aide.

In general, to qualify for federal subsidized housing, an individual's countable income may not exceed eighty percent of the median income in the area to be considered "low income", and the individual's income may not exceed fifty percent of the median income to be considered "very low income". The result is a disparity in eligibility depending on where the person resides within the county, state, and region of the country.

There is no asset limit to be eligible for federal subsidized housing, although as described above, if countable assets are greater than $5,000, the interest income generated will be counted towards eligibility. If a person transfers an asset for less than its fair market value, then HUD will treat the asset as if it were still owned by the individual for two years after the transfer. HUD will assume that the asset generates

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income at the passbook rate and will include that income in calculating the individual's rent. Therefore, it is very likely that HUD will treat transfers to a special needs trust as a transfer for less than fair market value and, for the next two years, will include the interest generated by the special needs trust as income to the individual, either at the passbook rate or the actual earnings, whichever is greater.

Special Needs Trusts are excluded from family assets and the income generated by the trust assets is not included once the two-year penalty period has expired. It is important to note that, similar to other programs such as Medicaid and SSI, "regular" distributions from a special needs trust, even if made to a third-party provider, will be treated as countable income, even if used for non-food and shelter items.

> In many states, receipt of SSI payments automatically qualifies one for Medicaid eligibility. Many other government programs explicitly rely on SSI eligibility rules as well, so that SSI eligibility rules become the central concern for those charged with administering special needs trusts.

The second issue relating to subsidized housing and a special needs trust is determining the monthly rent. Generally, an individual/family's rent will be thirty percent of their adjusted gross income. Similar to treatment under the threshold eligibility rules, the special needs trust and the income generated by trust assets are excluded, but "regular" distributions made directly to the beneficiary (as opposed to a third-party provider of goods or services) will be considered as income.

SECTION 8

Section 8 is a voucher program that is administered by HUD but managed by local public housing authorities ("PHA") or metropolitan housing authorities ("MHA"). The tenant pays their rent, typically thirty percent of their net adjusted income, to the landlord. The PHA pays the remaining balance due, which is called the voucher, to the landlord. The rent is based on the market value for the area and established by the PHA according to payment standards issued by HUD.

While a family member generally cannot serve as a Section 8 landlord, it is possible for a special needs trust to do so, even if the trustee is a family member. Although there are special rules applicable to a Section 8 landlord, it can be a beneficial relationship. The trust beneficiary would pay rent to the trustee (using the thirty percent of income rule) and the PHA would pay the remainder to the trustee.

It is important to investigate how your local housing authority's rules differ from the general rules listed above.

Temporary Assistance for Needy Families ("TANF")

TANF provides assistance and work opportunities to needy families. TANF is administered locally by the states, but is overseen by The Office of Family Assistance ("OFA"), which is located in the United States Department of Health and Human Services, Administration for Children and Families. TANF is a result of combining two other programs: Aid to Families with Dependent Children ("AFDC") and Job Opportunities and Basic Skills Training ("JOBS"). Because TANF is administered on a local level, the program and eligibility rules vary greatly from state to state. However, it is safe to assume that distributions directly made to the beneficiary of a special needs trust, or to the beneficiary's family if a minor, may be considered income and will impact eligibility for TANF.

Other Means-Tested Benefits Programs

State supplements to SSI and other government benefit programs, like vocational rehabilitation services, also play important roles in the lives of many individuals with disabilities. Because the welter of eligibility programs is confusing and the reach of most other programs is not as broad as those described in detail here, those other programs are not described in any depth. In analyzing the proper approach to establishment or administration of a special needs trust, however, care should be taken to consider all the available program resources and restrictions on use of trust funds mandated by those programs.

Eligibility Rules for Means- Tested Programs

As previously noted, the primary program with financial eligibility restrictions is SSI, the Supplemental Security Income program. Because the concepts are central to an understanding of other eligibility rules, and because many other programs explicitly utilize SSI standards, the SSI rules become the most important ones to grasp. They are described here in a general way, with a few notations where other programs (particularly long-term care Medicaid) differ from the SSI rules.

Income

SSI eligibility requires limited income and assets. SSI rules have a simple way of distinguishing between income and assets: Money received in a given month is income in that month, and any portion of that income remaining

on the first day of the next month becomes an asset. SSI rules also distinguish between what is "countable" or "excluded," "regular" or "irregular," and "unearned" or "earned" income. "Countable" income means that it is used to compute eligibility and benefit amount. "Excluded" means that it is not counted. "Regular" means that it is received on a periodic basis, at least two or more times per quarter or in consecutive months, and "irregular" or "infrequent" means that it is not periodic or predictable. "Unearned" means that it is passively received, such as SSDI benefits or bank account interest. "Earned" means that work is performed in exchange for the income. An SSI recipient is permitted to receive a small amount of any kind of income ($20 per month) without reducing benefits. That amount is sometimes referred to as the SSI "disregard" amount.

Each classification or grouping has a somewhat different rule, and it is an understatement to call these income rules "confusing." Any unearned income reduces the SSI benefit by the amount of the income, so investment income or gifted money simply reduces the benefit dollar for dollar, less the disregard. Earned income is treated more favorably, only reducing benefits by about half of the earnings. This is designed to encourage SSI recipients to return to the workforce. Keeping in mind that disability is defined as "unable to perform any substantial gainful activity," it is easy to see that any significant amount of earned income will eventually imperil SSI eligibility and, since trust administration does not usually involve earned income in any event, we will not attempt to deal with those issues here.

SSI also has a concept of "in-kind support and maintenance" (ISM) that is central to much understanding of special needs trust administration. Any payment from a third party (including a trust) for necessities of life—food or shelter (note that the federal government deleted "clothing" from the list of necessities in March 2005) to a third party provider of goods or services—will be treated as countable income, albeit subject to special rules for calculating its effect.

The effect of receiving ISM on SSI benefits is different from the receipt of cash distributions. Where as cash payments reduce the SSI payment dollar for dollar, ISM reduces the benefit by the lesser of the presumed maximum value of the items provided or an amount calculated by dividing the maximum SSI benefit by three and adding the $20 disregard amount.

For 2018 the maximum federal SSI benefit for a single person is $750. One-third of that amount is $250, and so the maximum reduction in benefits caused by ISM (no matter how high the value) is $270 per month. The meaning of that confusing collection of information is best illustrated using an example (CAUTION: some states provide SSI supplemental payments that affect this calculation).

Consider John, who is disabled as a result of his serious mental illness. He has no work history, and he does not qualify for SSDI. He is an adult, living on his own. He qualifies for the maximum federal SSI benefit of $750; he lives in a state which does not provide an SSI supplement.

If John's mother gives him $100 cash per month (for food and cigarettes), he is required to report that as countable unearned income each month. Although SSI may take two or three months to accomplish the adjustment, the program will eventually withhold $80 ($100 minus the $20 disregard) from his benefit for each month in which his mother makes a cash gift to him. The same result will obtain if John's mother is trustee of a special needs trust for John and the cash comes from that trust.

If, however, John's mother does not give him the $100 directly, but instead purchases $70 worth of food and $30 worth of cigarettes each month, only the food will affect his SSI payment—reducing it by $50 ($70 minus the $20 disregard). If she purchases $20 worth of food and $80 worth of cigarettes, there will be no effect at all—the food purchase is within the $20 monthly disregard amount. Similarly, if she purchases $20 worth of cigarettes and $30 worth of movie tickets, there will be no effect—provided that the movie tickets cannot be turned in for cash (because if the movie tickets can be converted to cash, John could—even if he does not—convert the movie tickets into payment for food or shelter).

In other words, the effect of John's mother's payments to him or for his benefit changes with the nature of her payments. Any cash she provides to him (over the $20 monthly amount ignored by SSI) reduces his SSI payment directly. Direct purchase of items other than food or shelter does not affect his SSI, so long as the purchased items cannot be converted to food or shelter. Finally, any payment she makes for food or shelter reduces his SSI check as well, but not as harshly as cash payments directly to John.

Now suppose that John's mother decides to give up on trying to work around the strictures of SSI rules, and she simply pays his rent at an adult care facility that provides his meals. Assume that the facility costs her $1500 per month, which she pays from her own pocket. Because of the ISM rules, John's SSI benefit will be reduced by only $270 per month, and so his SSI check will be $480. Critically important, however, John will still qualify for Medicaid benefits in most states because he receives some amount of SSI. If the adult care home payment comes from a special needs trust for John's benefit, the same result will occur, assuming that the room and board portion of the payment exceeds $270. Incidentally, the same result will also obtain if John's mother simply takes him in and allows him to live and eat with her without charging him rent.

Now assume that John does have a work history before becoming disabled, and that he qualifies to receive $520 per month from SSDI. Because he has been receiving SSDI for more than two years, he also qualifies for Medicare.

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Because his countable income is less than $750, he continues to receive $250 in SSI benefits ($20 of the SSD is disregarded), and qualifies for Medicaid as well (we will ignore the effect of the QMB and SLMB programs for qualified, special low-income Medicare beneficiaries, and the Medicare Part B premium which would ordinarily be withheld from his SSDI check). Now if John's mother pays his rent at the adult care home, or takes him into her own home, he will lose his SSI altogether—since he is receiving less than $270 per month from SSI, the effect of the ISM rules will be to knock him off the program. Unless he separately qualifies for Medicaid, he will also lose his coverage under that program. The income strictures are the same or similar for other programs, with one important exception. In some states, but not all, eligibility for community or long-term care Medicaid is also dependent on countable income. The income tests vary. In some, you can "spend down" excess income over the limit to become eligible. In others, if countable income exceeds the benefit "cap" (like SSI), you cannot become eligible at all.

Some states also attempt to limit expenditures from self-settled (and even third-party) special needs trusts, and can require amendments to the language of those trusts in order to allow eligibility. While a good argument can be made that the Medicaid program does not have that ability, as a practical matter, the trustee of the special needs trust will have to either litigate that issue or acquiesce in the Medicaid agency's demands.

Assets

The limitation on assets for SSI eligibility may be somewhat easier to master, or at least to describe. A single person must have no more than $2,000 in available resources in order to qualify for SSI. Some types of assets are not counted as available (called "non-countable"), including the beneficiary's home, one automobile, household furnishings, prepaid burial amounts plus up to $1500 set aside for funeral expenses (or life insurance in that amount), tools of the beneficiary's trade, and a handful of other, less important items. Each of these categories of assets is subject to special rules and exceptions, so it is easy to become tangled in the asset eligibility structure.

Deeming

The SSI program considers portions of the income and assets of non-disabled, ineligible parents of minor disabled children and of an ineligible spouse living with the SSI recipient as available, and countable for eligibility purposes. This is called "deeming". A certain portion of the ineligible person's income and assets is considered as necessary for his or her own living expenses, and therefore is excluded.

As soon as a child reaches age 18, parental deeming no longer occurs, even if the child continues to live in the household. If spouses voluntarily separate and live in different households, then deeming from the separate spouse or parent also ends. However, in both instances, if the separate person continues to provide support or maintenance to the SSI eligible individual, it will still count as income as described above unless a Court orders it to be deposited directly into the trust. There is also a limited exception to all parental deeming for a severely disabled minor child returning home from an institution or whose condition would otherwise qualify them for institutionalization, which is called a waiver.

"I Want to Buy a..." or "I Want to Pay for..."

What do these complicated rules mean for expenditures from a special needs trust? In-kind purchases, meaning purchase of goods or services for the benefit of the beneficiary, only potentially affect the SSI benefit amount, and not Medicaid benefits, although the Medicaid agency may restrict expenditures for approved things. There are a number of specific purchases that frequently recur:

Home, Upkeep and Utilities

Keep in mind that SSI's in-kind support and maintenance (ISM) rules deal specifically with payments for "food and shelter." The Social Security Administration includes only these items as food and shelter:

1. Food
2. Mortgage (including property insurance required by the mortgage holder)
3. Real property taxes (less any tax rebate/credit)
4. Rent
5. Heating fuel
6. Gas
7. Electricity
8. Water
9. Sewer
10. Garbage removal

The rules make special note of the fact that condominium assessments may in some cases be at least partial payments for water, sewer, garbage removal and the like.

In other words, a payment for rent will implicate the ISM rules, as will monthly mortgage payments. The outright purchase of a home, whether in the name of the beneficiary or the trust, will not cause loss of SSI (although it may reduce the beneficiary's SSI benefit for the single month in which the home is purchased). This brings up

another consideration. Purchase of a home in the trust's name will subject it to a Medicaid "payback" requirement on the death of the beneficiary, whereas purchase in the name of the beneficiary may allow other planning that will avoid the home becoming part of the payback. This complicated interplay of trust rules, ISM definition, estate-recovery rules, and home ownership makes this area of special needs trust administration particularly fraught with difficulty.

However, the Medicaid state agency's treatment of distributions from special needs trusts may differ from the Social Security interpretation—especially when the beneficiary of a self-settled trust is eligible for Medicaid benefits. For example, contrary to putting the house in the individual's name, a state may require that any purchase of a home by such a trust would result in title being held in the trust's name, thereby ensuring that the state will at least receive the proceeds from the sale of the residence upon the death of the beneficiary.

Clothing

Until March 7, 2005, purchase of clothing by a trust was considered as ISM for SSI, similar to shelter and food. Since then, a clothing purchase for the beneficiary will not affect the benefit amount or eligibility, whether the clothing in question is special garments related to the disability or just ordinary street clothes and shoes. Not all state Medicaid regulations reflect this change.

> As soon as a child reaches age 18, parental deeming no longer occurs even if the child continues to live in the household.

Phone, Cable, and Internet Services

Other than those utilities listed above, there is no federal limitation on utility payments. In other words, the trust can pay for cable, telephone, high-speed internet connection, newspaper, and other "utilities" not on the list.

Vehicle, Insurance, Maintenance, Gas

Purchase of a vehicle and maintenance (including gas and insurance) is permitted under federal law. Note that there is a mechanical difficulty in providing gasoline without providing cash that could be converted to food or shelter. One technique which has worked well has been to arrange for the beneficiary to have a gas-company credit card. Because eligibility for such cards is easier to meet, and because the cards cannot be used to purchase groceries, administration of the credit account is easier to set up and monitor, and the card can then be billed directly to the trust.

Some state Medicaid agencies put limitations on the value, type, and title ownership of vehicles, such as only allowing a vehicle valued at up to $5,000, handicapped-equipped, or requiring a lien in favor of the payback trust on the title. The SSI program does not specifically require or monitor such limitations.

Pre-paid Burial/Funeral Arrangements

Nothing in federal law prohibits or restricts use of special needs trust funds for purchase of burial and funeral arrangements during the beneficiary's lifetime— except to the extent that the beneficiary has access to the funds used to pay for the arrangements, and thereby subject to the asset limitations affecting SSI recipients. State Medicaid agencies may limit the value of the burial contract. It is important to ask for an "irrevocable, pre-paid" funeral plan.

Tuition, Books, Tutoring

No limit under either federal or state law. This is an excellent use of special needs trust funds.

Travel and Entertainment

Once again, no limit except that there may be some concern about payment for hotels. When the beneficiary still maintains a residence at home, the hotel stay and restaurant may be considered "shelter" and "food" expenses. Some states may impose limitations on companion travel not found in federal law. These might include not allowing recipients to have the special needs trust pay for more than one traveling companion, the companion must be necessary to provide care, and the companion may not be a person obligated to support the beneficiary such as a minor beneficiary's parent. Note that foreign travel can have two other adverse effects: (1) airline tickets to foreign destinations, if refundable, will be treated as being convertible into food and shelter, and (2) if an SSI recipient is out of the country for more than a month, he or she may lose eligibility until return. For those reasons, foreign travel, unlike domestic travel, usually must be limited in time.

Household Furnishings and Furniture

The trust can be used to purchase appliances, furniture, fixtures and the like. Before March 2005, there was a theoretical concern in the SSI program that the value of household furnishings might exceed an arbitrary limit and affect the beneficiary's eligibility; that value limit has now been removed.

Television, Computers and Electronics

There is no specific limitation on purchase of household televisions or other electronic devices, although under SSI rules the individual is only allowed to own "ordinary household goods" that are not kept for collectible value and are used on a regular basis. The trust can also provide a computer for the beneficiary, plus software and upgrades.

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Durable Medical Equipment

There is no federal limitation on any medical related equipment, but individual states may limit purchase of some equipment as not being "necessary." Problem areas could be if the equipment could also be considered as recreational, such as a heated swimming pool needed for arthritic or other joint conditions.

Care Management

No federal limitation, but many states attempt to limit payments for care or management if made to a family member or other relative, especially if there is an obligation of support (e.g., parents of minor children).

Therapy, Medications, Alternative Treatments

Same principle as durable medical equipment, above, so long as the state does not regulate the treatment, there is no federal limitation.

Taxes

No federal limitation, but states may attempt to direct trust language on what taxes can be paid for, such as taxes incurred as a result of trust assets or at the death of the beneficiary. Since it is difficult to imagine an SSI or Medicaid beneficiary having significant non-trust income, it is hard to see how this limitation is so much troublesome as it is quarrelsome.

It is generally beneficial for a self-settled special needs trust to be a grantor trust. This is true because the tax rates for non-grantor trusts are tightly compressed, and the highest marginal tax rate on income is reached very quickly for trusts.

Legal, Guardianship and Trustee Fees

At least some states allow legal, guardianship, and trustee fees to be paid from the trust, although some federal law indicates that payment of guardian's fees or guardian's attorney fees may really benefit the guardian and not the beneficiary. Payments for trust administration expenses, including the trust's attorney's fees, are clearly permissible under both federal and state law, and are rarely limited beyond reasonableness standards.

Loans, Credit, Debit and Gift Cards

Receipt of a "loan" will not count as income for the SSI or Medicaid programs, which means that a trust can make a loan of cash directly to a beneficiary. There are rules that must be followed for loans to be valid and non-countable. There must be an enforceable agreement at the time that the loan is made that the loan will be paid back at some point, which usually means that it should be in writing. The agreement to pay back cannot be based on a future contingency such as, "I only have to pay it back if I win the lottery..." Finally, the loan must be considered as "feasible," meaning that there is a reasonable expectation that the beneficiary will have the means at some point to pay back the loan.

If a loan is forgiven, then it would count as income at that time. Also, if the beneficiary still has the loaned amount in the following month, it will then count as a resource. However, school loans are not countable as income or as a resource so long as the funds are spent for tuition, room and board, and other education-related expenses within nine months of receipt.

Since goods or services purchased with a credit card are actually a "loan" that must be paid back to the credit card company, they are also not considered as income to the beneficiary at time of purchase. As long as the beneficiary doesn't sell the goods for cash, there is also the added advantage that the trust can pay back the credit card company without the payment counting as income, except for purchases that are considered as food or shelter. Food and shelter related purchases use the same ISM countable income rules (and particularly the countable income limits) described above.

Use of a debit card by a beneficiary when purchases are made for payment through a trust-funded bank account is income to the beneficiary for the amount accessed. The total amount in the account available to be accessed could possibly be a countable resource. Is a gift card purchased by a trust and provided to a beneficiary considered to be a distribution of income, a line of credit to a vendor (similar to a credit card), or just access for in-kind purchase of goods or services on behalf of a beneficiary by the trust? SSI rules are not yet clear on this point, and it is probable that different Social Security and Medicaid offices will treat the use of debit and gift cards differently until precise guidelines are provided by the agencies. The safe approach is to use them in a very limited way; if they are to be used at all, keep receipts for all special needs items, and be prepared for adverse treatment.

Trust Administration and Accounting

Actual administration of a special needs trust is in most respects similar to administration of any other trust. A trustee has a general obligation to account to beneficiaries and other interested parties. Tax returns may need to be filed (though not always), and tax filing requirements will be based on the tax rules, not special needs trust rules. Some special needs trusts, but by no means all, will be subject to court supervision and control.

Trustee's Duties

As with general trust law requirements, the trustee of a special needs trust has an obligation not to self-deal, not to delegate the trustee's duties impermissibly, not to favor either income or remainder beneficiaries over one another, and to invest trust assets prudently. The obligations of a trustee are well-discussed in several centuries of legal precedent, and cannot be taken lightly. Legal counsel (and professional investment, tax and accounting assistance) will be required in administration of almost every special needs trust.

A few cardinal trust rules bear special mention:

NO SELF-DEALING

As with other trusts, the trustee of a special needs trust is prohibited from self-dealing. That means no investment of trust assets in the trustee's business or assets, no mingling of trust and personal assets, no borrowing from the trust, no purchase of goods or services (by the trust) from the trustee (other than, of course, trust administration services), and no sale of trust assets to the trustee. The same strictures also apply to the trustee's immediate family members, and the existence of an appraisal, or the favorable terms of a transaction, do not change these rules.

> A trustee has a general obligation to account to beneficiaries and other interested parties. Tax returns may need to be filed (though not always), and tax filing requirements will be based on the tax rules, not special needs trust rules.

IMPARTIALITY

Because the trust has both an "income" beneficiary (the person with disabilities) and a "remainder" beneficiary (the state, in the case of a Medicaid payback trust, or the individuals who will receive assets when the income beneficiary dies), the trustee has a necessarily divided loyalty. It is important to remain impartial as between the trust's beneficiaries. Thus, investment in assets exclusively designed to maximize income at the expense of growth, or vice versa, may violate the trustee's duty to the negatively affected class of beneficiaries. Note that a trust may, by its terms, make clear that the interests of one or the other class of beneficiaries should be paramount—though such language will probably earn the disapproval of the Medicaid agency in any self-settled trust which must be submitted to Medicaid for approval.

DELEGATION

Generally speaking, a trustee may delegate functions but may not avoid liability by doing so. In other words, while the trustee may hire investment advisers, tax preparers and the like, he or she will remain liable for any failures by such professionals.

Some states do limit the trustee's liability. For example, in states which have adopted the Uniform Prudent Investor Act, delegating investment authority pursuant to the Act will limit the trustee's liability so that he or she will only be required to carefully select and monitor the investment adviser.

INVESTMENT

Any trustee should be familiar with the principles of Modern Portfolio Theory, with its emphasis on risk tolerance and asset diversification. A trustee who holds himself, herself, or itself out as having special expertise in investments or asset management will be held to a higher standard, but any trustee will be required to understand and implement prudent investment practices. Some courts will institute an investment policy that requires a percentage of assets to be held in fixed income investments and the remainder in securities (e.g., a 60/40 split is common).

Bond

A trustee, especially one who administers a special needs trust supervised by a probate court, may need to be bonded. Bond is a type of insurance arrangement whereby the trustee pays a premium in order to guarantee that the trustee manages the trust and carries out his or her fiduciary duties correctly. The bond premium is an acceptable expense of the trust, and need not come out of the trustee's own pocket. If the trustee fails to exercise his or her fiduciary duty and the trust loses money as a result, the insurance company that issued the bond will compensate the trust and take action to collect from the trustee.

The bond premium depends on multiple factors, including the credit history of the trustee and the value of the trust. Most corporate trustees are exempt from posting bond. Individual trustees must "post bond"; that is, provide written documentation to the probate court that the individual is bonded. The bond is typically issued for a set period of time, for example one year, and at the expiration of the time period, the trustee must pay an additional premium or show the bond issuer that bond is no longer required by the probate court.

It is possible in most states, at least when the trust is supervised by a court, to ask the court for permission to deposit the assets in a restricted or "blocked" account with a financial institution rather than posting bond. While this circumvents the issue of being bonded, the financial institution should require a certified copy of the court's order authorizing the expenditure of funds prior to making a distribution from the special needs trust. This can result in frequent in-person trips to the bank by the trustee, although it avoids the sometimes costly bond premium.

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Titling Assets

The trust assets should not be titled in the beneficiary's name except in limited circumstances, such as when it is advantageous to title the home in the individual's name. Typically, the trust assets should be titled in the name of the trustee. For example, if James Jones is the trustee of the Lisa Martin Special Needs Trust, and that trust was signed on March 15, 2007, then the trust assets should be titled as follows: "James Jones, Trustee of the Lisa Martin Special Needs Trust u/a/d March 15, 2007" ("u/a/d" means "under agreement dated").

It is important that most assets not be held in James Jones's or Lisa Martin's name individually. If the assets are not titled properly, then the assets may be counted as a resource, or the interest earned counted as income, by the agencies that administer means-tested government benefits, which will frustrate the purpose of the special needs trust, as well as contribute to confusion during tax preparation. Additionally, as discussed in further detail below, it may also be important to request a separate Tax ID number for the trust as well as properly title the assets.

Accounting Requirements

A trustee is required to provide adequate accounting information to beneficiaries of the trust. That requirement generally means annual accountings. While there is no specific form required for accountings if the trust is not under court supervision, it is important to provide enough information that a reader could determine the nature and amount of any payment or investment. For some trusts, a simple "check register" accounting may be sufficient, showing interest income and the names of payees, with dates and amounts. Any trust with significant assets or diverse investments, however, should provide a thorough accounting.

Regular, complete accountings are critical. A beneficiary is generally foreclosed from later raising objections to investments or expenditures if he or she received adequate disclosure in the annual accounting at the time. In other words, thorough accounting can limit the trustee's later exposure to claims by beneficiaries, and therefore benefits the trustee.

In addition to the accounting requirements to the beneficiary, the trustee may be required to provide an annual or biennial accounting to the probate court. The trustee should use the county-specific forms available upon request from the court, and may also be required to provide the court with copies of bank statements and cancelled checks or receipts as evidence of trust distributions and deposits. This requires the trustee to be organized or be prepared to pay potentially substantial bank fees for duplicate account statements or cancelled checks.

> The trustee of a special needs trust is prohibited from self-dealing. That means no investment of trust assets in the trustee's business or assets, no mingling of trust and personal assets, no borrowing from the trust, no purchase of goods or services (by the trust) from the trustee (other than, of course, trust administration services), and no sale of trust assets to the trustee.

Reporting to Social Security

The simple term "income" has different meanings in trust accounting, tax preparation, and public benefits eligibility determinations. Trustees sometimes raise concerns that thorough trust accountings (to SSI, especially) may result in suspension of benefits, or that tax return information may be used to terminate SSI or other benefits. While such things undoubtedly do occur, Social Security workers are increasingly likely to be relatively sophisticated about such distinctions, and willing to work through any problems. In a general way, then, it is better to disclose more fully to Social Security rather than withhold any information. Annual accountings of any self-settled trust naming an SSI recipient as beneficiary should be provided to Social Security. Any third-party trust which makes significant distributions for the benefit of an SSI recipient should probably be provided to Social Security, just to prevent later problems that could have been headed off. If distributions disrupt eligibility, the problem is with the distribution, not with the accounting.

If the beneficiary receives only SSDI and not any concurrent SSI, there is no point in providing accounting information to Social Security, because SSDI benefits are not means-tested. If the trust is a third-party trust, the trustee may not have any obligation to provide accounting information, though the beneficiary may (if the beneficiary receives SSI and trust distributions invoke the ISM rules) be required to do so.

Although it no longer occurs as regularly, some Social Security eligibility workers may misunderstand the effect of special needs trust expenditures or terms and reduce or eliminate benefits improperly. When this does occur, it should be possible to remedy the error, but the beneficiary may suffer for months (or years) while the system works out the problem. Far better to head off problems in advance, rather than have to spend substantial resources and time resolving them after the fact. Be aware that fees for a trustee's time spent directly dealing with Social Security on the beneficiary's behalf may be subject to approval by SSA.

Reporting to Medicaid

If the beneficiary resides in a state where the receipt of SSI results in the beneficiary also being automatically enrolled in Medicaid, then no separate accounting requirement need be made to the Medicaid agency. However, if the individual is in a state where SSI and Medicaid are not interrelated, then it may be necessary to account to both agencies. The Medicaid consumer (or their guardian) is required to notify Medicaid of a change in resources or income within a set period of time, usually as short as ten days. This includes situations where the Medicaid consumer receives an inheritance or settlement and immediately transfers the funds to a special needs trust.

The trustee of a third-party special needs trust may not have the same duty to account, but may choose to provide accounting information to Medicaid rather than risk later disqualification of the beneficiary, even though Medicaid's power to consider trust expenditures may be subject to challenge.

Reporting to the Court

Many self-settled special needs trusts will be treated in essentially the same fashion as a conservatorship or guardianship of the estate. This is so because, typically, the court was initially asked to authorize establishment of the trust. Most courts expect any trust established by the court to remain under court supervision, including bonding, seeking authority to expend funds, and filing periodic accountings.

Even if the trust does not require court accounting, some consideration should be given to seeking court involvement. One great advantage of court supervision of the trust is that each year's accounting is then final as to all items described in that accounting (provided, of course, that the appropriate notice has been given to beneficiaries who might otherwise complain about the trust's administration and other court procedural requirements are followed).

The Court may also have a set fee schedule that governs the amount the trustee can be compensated for providing trust administration services.

Modification of Trust

As explained above, a special needs trust must be irrevocable in order for the trust to be considered an exempt resource. However, that does not preclude the trust itself from permitting the trustee to amend or modify the trust in limited ways, particularly as it relates to program eligibility for the beneficiary. This is particularly important since we cannot predict future changes to the laws governing means-tested benefits. The courts may also be willing to modify or terminate a trust whose purpose has been frustrated by law changes or other factors, such as the trust assets being valued at a nominal amount.

Wrapping up the Trust

If the special needs trust is a self-settled trust with a provision requiring repayment of Medicaid expenses, it will obviously be necessary to determine the "payback" amount upon the death of the beneficiary or termination of the trust. Because Medicaid's historical experience with these trusts is still slight, state agencies may have difficulty providing a reliable and final figure. The prudent trustee will request a written statement of the amount due, including evidence showing how it was calculated and a statement of authority to make the final determination. Once any payback issues have been addressed (and remember that most third-party special needs trusts will have no requirement of repayment to the state), then termination of the trust will follow the usual requirements of tax preparation and filing, final accounting and distribution according to the trust instrument. Remember, because Social Security requires that Medicaid reimbursement and certain tax liabilities must be squared away before the trustee may even pay for the beneficiary's funeral, purchase during the beneficiary's lifetime of an irrevocable pre-paid funeral is critical.

Income Taxation of Special Needs Trusts

Special needs trusts, like other types of trusts, can complicate income tax preparation. The first question to be addressed is whether—for income tax purposes-the trust is a "grantor" trust or not. Tax rules defining "grantor" trusts are neither simple nor intuitive, but fortunately there are some easy rules of thumb to apply, and they will work for most special needs trusts.

"Grantor" Trusts

A "grantor" trust is treated for tax purposes as a transparent entity. In other words, the grantor of a "grantor" trust is treated as having received the income directly, even though the accounts are titled to the trust and all income shows up in the name of the trust.

Generally speaking, a self-settled special needs trust will be a grantor trust if a family member is the trustee. If the trust names an independent trustee it may still be a grantor trust if one of several specific provisions exists in the trust. A qualified accountant or lawyer should be able to tell whether a given trust is a grantor trust at a glance. If it is, it remains a grantor trust for its entire life—or at least until the death of the grantor (when the trust may either terminate or convert into a non-grantor trust as to its new beneficiaries). Until the trust has been reviewed by an expert, assume that it is probably a grantor trust.

It is generally beneficial for a self-settled special needs trust to be a grantor trust. This is true because the tax rates for non-grantor trusts are tightly compressed, and the highest marginal tax rate on income is reached very quickly for trusts. The practical difference will be small

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if the trust actually makes distributions for the benefit of the beneficiary in excess of its annual taxable income, but the proper tax reporting approach should still be followed.

TAX ID NUMBERS

A grantor trust may, but need not, obtain an Employer Identification Number (an EIN). Some attorneys and accountants choose to secure an EIN in each case, while others resist doing so—either approach is defensible. Although banks, brokerage houses and other financial institutions may insist that the trust requires its own EIN, they are simply wrong. There is widespread confusion about the necessity for an EIN for irrevocable trusts, but a confident and well-informed trustee, attorney or accountant should be able to convince the financial institution that no separate EIN is required. Instead, the trustee can simply provide the financial institution with the grantor's Social Security number.

FILING TAX RETURNS

A grantor trust ordinarily will not file a separate tax return. If a grantor trust has been assigned an EIN, it may file an "informational" return. The return can include a paragraph indicating that the trust is a grantor trust, that all income is being reported on the beneficiary's individual return, and that no substantive information will be included in the fiduciary income tax return. Actually, completing the fiduciary income tax return is not an option for a grantor trust, although again there is much confusion on this point, even among some professionals.

Non-Grantor Trusts

Virtually all third-party, and some self-settled, special needs trusts will be non-grantor trusts. Because income will not be treated as having been earned by the beneficiary, a fiduciary income tax return (IRS form 1041) will be required.

TAX ID NUMBERS

A non-grantor trust will need to obtain its own EIN by filing a federal form SS-4. Nearly all third-party special needs trusts will be "complex" trusts—this designation simply means that the trust is not required to distribute all its income to the income beneficiary each year. Although the trust will be listed as "complex" on the SS-4, it may in fact alternate between "complex" and "simple" on each year's 1041.

FILING TAX RETURNS

The non-grantor trust must file a 1041 each year. All distributions for the benefit of the beneficiary are conclusively presumed to be of income first, so any trust expenditures in excess of deductions will result in a Form K-1 showing income imputed to the beneficiary. This should not cause particular concern, since Social Security (and even Medicaid) eligibility workers are increasingly likely to understand that "income" for tax purposes is different from "income" for public benefits eligibility purposes. Any tax liability incurred by the individual beneficiary as a result of this imputation can be paid by the trust, though the trustee may not have the authority to prepare and sign the individual's tax return.

Administrative and other deductible expenses on an individual tax return must reach 2% of the taxpayer's income before being deducted at all. The same is not true of a trust tax return, leading to a modest benefit to treatment as a non-grantor trust in some cases. This benefit may not offset the compressed income tax rates levied against non-grantor trusts, but each case will be different. The difficulty in determining the proper—and the best—income tax treatment is made worse when one adds the confusing option of treatment as a "Qualified Disability Trust."

Qualified Disability Trust

Beginning in 2002, Congress allowed some non-grantor special needs trusts to receive a modest income tax benefit. Trusts qualifying under Internal Revenue Code Section 642(b)(2)(C) receive a special benefit—they are granted a larger and special deduction on their federal income taxes. In tax year 2018, for example, the personal exemption will be $4,150, which means that income up to that amount will not generate any tax liability at all. In fact, once the trust uses its exemption and calculates the remaining taxable income, it is usually passed through to the beneficiary—who then gets to use the usual standard deduction and pay taxes at his or her lower tax rate.

Coupled with the greater flexibility available to non-grantor trusts in deducting administrative expenses, Qualified Disability Trust treatment may be advantageous in some cases. Typically, the Qualified Disability Trust election will be attractive when there is a fair amount of income on trust assets, and relatively few medical or other expenses incurred on behalf of the beneficiary. Careful review with a qualified income tax professional is usually necessary to determine whether to pursue Qualified Disability Trust treatment.

Seeking Professional Tax Advice

It should be apparent from this brief discussion of taxation of special needs trusts that professional tax preparation and advice are essential. Although most accountants are qualified to prepare fiduciary (trust) income tax returns, most do not have much experience in the field. A first question to ask a prospective accountant might be "How many 1041s do you typically prepare in a year?" Follow that with "Could you please explain the concept of Qualified Disability Trusts to me?" and you will quickly locate any truly proficient practitioner. You probably will not want to automatically reject an

accountant who cannot tell you about Qualified Disability Trusts immediately, unless you are prepared to deal with an accountant in another city—there are simply not very many accountants or tax preparers who have ever had occasion to claim that status on any fiduciary income tax return. As always, you can get some assistance in complicated special needs trust issues from the attorney who prepared the document, or the attorney who advises you as trustee. Members of the Special Needs Alliance® are usually among the very few who are familiar with these concepts, and your attorney may have worked with an accountant in your area who is familiar with the special tax treatment of these trusts.

For Further Reading

There are a handful of books and articles, and a growing number of websites, available to aid trustees of special needs trusts. Among our favorites:

Special Needs Trust Administration Manual: A Guide for Trustees, by Jackins, Blank, Macy and Shulman—this guide is among the best available. It was written by four Massachusetts lawyers, and is frankly focused on Massachusetts law and practice. Much of what the authors have to say, however, is applicable to special needs trusts in every state.

Special People, Special Planning: Creating a Safe Legal Haven for Families with Special Needs, by Hoyt and Pollock—provides some general advice and direction, but is more conversational than detailed. This volume also tends to focus on the "why" more than the "how", which is an important message but not as useful to someone who is already administering a special needs trust.

Special Needs Trusts: Protect Your Child's Financial Future, by Elias—this recent addition to the literature comes from Nolo Press, an organization that many lawyers find annoying at best. We disagree. This is a plain-language, straightforward explanation of special needs trusts from a lawyer who doesn't even practice in the area (his previous books for Nolo Press include explanations of bankruptcy, trademark and other areas of law).

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