Stetson's National Conference on Special Needs Planning and Special Needs Trusts

The Changing Face of Public Benefits

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INTRODUCTION. Writing a paper on a broad topic proves dangerous when the author is focused on making a general point and the reader can't stop thinking "but not in my state…". This author is speaking generally about public benefits while knowing that there will be instances where an example is inapt or inapplicable. My advice is to jump up to the 30,000 feet level and enjoy the view. The remainder of the conference sessions will allow you to strap on the parachute and jump.

Merriam-Webster defines *special needs* as "any of various difficulties (such as a physical, emotional, behavioral, or learning disability or impairment) that causes an individual to require additional or specialized services or accommodations (such as in education or recreation)"[1]. The first known use of the term *special needs* was in 1899, and it was used with this same meaning[2]. What makes a trust a special needs trust is the fact that its primary purpose is to assist the trust beneficiary in meeting eligibility requirements for certain public benefit programs. The same trust may be irrevocable, spend-thrift, discretionary, or sole benefit, but the crux of the trust is its intent to benefit an individual who has special needs by allowing access to the specialized services and accommodations needed for health, safety and well-being. These services and accommodations are commonly offered through public benefits programs.

According to the Social Security Administration ("SSA"), the purpose of public assistance programs is to give a minimum degree of economic security to persons in need.[3] "Public assistance programs complement other programs for economic security by supplying basic maintenance to needy persons for whom benefits are not available or are insufficient." This statement is from a paper entitled "Public Assistance Goals: Recommendations of the Social Security Board"…[w]hether to volume of need is larger or smaller, public assistance should meet effectively whatever need exists." I was perusing this article when I noticed that it had been written in November, 1944 for the Social Security Bulletin. I commend it to you for reading because so many of the issues that faced the country in the post-WWII era remain unsolved, however the approach of SSA at that time was solution, rather than blame, oriented.

[1] https://www.merriam-webster.com/dictionary/special%20needs
[2] Id.
[3] https://www.ssa.gov › policy › docs › ssb; Social Security Bulletin, November 1944

There are a number of ways in which to identify public benefits – means-tested rather than entitlement; social welfare v. social insurance plans. The U.S. Census Bureau distinguishes social welfare and social insurance programs. Social welfare programs include:

- Supplemental Security Income (SSI)
- Supplemental Nutrition Assistance Program (SNAP, or food stamps)
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Temporary Assistance for Needy Families (TANF)
- General Assistance (GA)

The Census bureau goes on to define four social insurance programs: social security (whether for self or on behalf of a dependent child); VA benefits (except for pensions); Unemployment Insurance Compensation and Worker's Compensation.[4]

Social welfare plans are typically means-tested, meaning that applicants are required to meet certain income and/or asset limits to become eligible. Social insurance plan benefits are paid based upon the value of the applicant's contributions through payroll taxes, including Medicare and Social Security Disability Insurance.

For our purposes, I'll refer to social welfare programs as public benefits. The term welfare is prejudicial and stops any discussion of policy reform, moving the conversation to moral judgments about people who receive public benefits. Our focus is on those programs which keep our clients from impoverishment and provide the supports and services needed for their health and safety. Elder law and special needs practitioners are primarily focused upon protection of three public benefit programs: (1) Supplemental Security Income; (2) Medicaid; and (3) Housing assistance. This doesn't mean that we don't need to be aware of SNAP eligibility requirements and the rules for those who need TANF assistance or General Assistance. States offer additional benefit programs which can provide for specific needs either temporarily or in the long term. There is no consistency to the nature and services offered from state to state; offer a comparison to the client of supports and services offered in one state to those in another where a client may have family or other connections.

[4] https://www.census.gov/topics/income-poverty/public-assistance/about.html

I. GENERAL SSI AND MEDICAID BENEFIT ELIGIBILITY.

The federal statutes which spell out SSI[5] eligibility criteria also govern eligibility for Medicaid benefits.[6] Each program was initially constructed to serve low socio-economic populations and it makes sense that the eligibility criteria would be similar. In very few instances may a Medicaid program in any state have laws which are more restrictive than the federal law.[7] Recipients of public benefits must be aged, blind or disabled.[8] If the client is not sufficiently disabled to qualify for disability benefits, he or she may be entitled to SSI and Medicaid based upon age. Unfortunately, you may see more cases of clients who don't meet any of the age, blindness or disability requirements but still have insufficient means to get services and supports; there are limited options for these individuals. The lesser known programs and services referred to above which are available through state agencies might help. To assist the client, create a contact or referral sheet so that you can direct them to local resources who may provide direction. I once had a case where a 58-year old man was showing the initial signs of serious dementia. He sold the marital home in New York over his wife's objections, cashed in their savings and moved them to Florida. Within a few months, his disease had progressed so significantly that he needed assisted living or nursing home placement. He was inexplicably denied disability status and was too young for Medicaid benefits under the age-related classification. The response was to appeal the disability determination, but it took many months and by the time the appeal was won, most of their savings were gone and his wife had returned to her job as a hairdresser. She couldn't afford house payments and moved into an apartment. Had her husband been 65 at the time, a disability diagnosis wouldn't have mattered: he would have qualified by virtue of age alone.

The **age** of the beneficiary is crucial in public benefits planning; children can apply for SSI and Medicaid benefits upon reaching the age of 18, and as seen in the example, adults *under* 65 without medically determinable disabilities can be left out to dry. In the special needs' context, first party trusts are only available to persons whose disabilities began before age 65. In one case, an attorney/guardian contacted a special needs attorney four days before the Ward's 65th birthday because the Ward was disabled but had no special needs trust because he didn't have any money.

[5] 42 U.S.C. Subchapter XVI
[6] 42 U.S.C. Subchapter XIX
[7] 42 U.S.C. § 1396a(a)(C)(10)(i); see also 209b states
[8] 42 U.S.C. §1382c(A)

Suddenly, settlement of a probate litigation matter in which the Ward had an interest fell apart at the last minute and wasn't going to be resolved before the Ward's looming 65th birthday. A 1st party SNT was created and his interest in the lawsuit was assigned to the trust one day before his 65th birthday. Had the guardian waited a week, the proceeds of the suit would have been subject to spend down, leaving the disabled and dependent Ward with no funds for his long term needs.

Clients with **blindness** don't make up a large percentage of special needs clientele. An individual is considered to be blind if he or she has central visual acuity of 20/200 or less in the better eye with the use of a corrective lens.[9]

In special needs planning, **disability** is a term of art.[10] It is the predicate for almost every type of benefit our clients might seek – if there has been no determination of disability by the Social Security Administration, (or in some instances, by the designated agency in the state where an individual resides[11]), then an individual will not qualify for a public benefit regardless of their income or assets. A disability can be a (1) physical, or a (2) mental impairment that prevents him or her from engaging in substantial gainful activity ("SGA")[12]. The impairment must be expected to last for a continuous period of not less than twelve months, or to result in death.[13]

Substantial gainful activity roughly translates into the ability to work a sufficient amount of time to earn a basic living. The formal definition is that the impairment is so severe that he or she can't do the work previously done, but also cannot, considering age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy regardless of whether such work exists in the immediate area in which the individual lives or whether a specific job vacancy exists, or whether he or she would be hired if a job application was made.[14] Whew.

A determination of disability must be made regardless of whether the applicant is seeking SSI or Social Security Disability Insurance (SSDI) benefits. SSA keeps records of how often an individual has worked, the amount of the wages and the amount paid into the social security

[9] 42 U.S.C. §1382c(a)(2)
[10] 42 U.S.C. § 1382c(3)
[11] http://www.floridahealth.gov/programs-and-services/people-with-disabilities/index.html
[12] 42 U.S.C. § 1382c(a)(3)(B)
[13] Id.
[14] 42 U.S.C. § 1382c(a)(3)(B)

system. An applicant who has never worked will have a lot of blank spaces on his or her social security statement and will only qualify for SSI. An applicant who has worked may qualify for SSDI if he or she has earned enough quarters of credit during the working years by paying into the FICA system. SSDI is actually an insurance program which is funded through FICA and provides a source of monthly income. In many instances, the SSDI monthly benefit will exceed the SSI maximum, although it is possible for individuals to have both SSI and SSDI. A very basic example would be an SSDI recipient whose monthly benefit was only $550 per month; if the SSI monthly benefit was $783 in 2020, SSI would pay an additional $233 ($550 + $233 = $783) to bring the recipient to the minimum income benefit.

A quarter of credit ("QC") is the basic unit for determining whether a worker is insured under the Social Security rules.[15] The maximum number of quarters which can be earned by an individual each year is four, no matter how much money the individual earns in that year. SSA sets a minimum annual amount of earnings each year to earn a QC; in 2020 the amount of earnings required for a QC is $1410[16]. To obtain disability insured status, the applicant must have earned at least 20 QC during the last ten years and be fully insured. Fully insured status is achieved when an individual has earned 40 QC. Prior to 1978, employers calculated wages on a quarterly basis, not an annual basis. Individuals were credited with one QC if they earned $50 or more for the quarter. After 1978, employers began reporting wages on an annual basis and SSA began determining the amount of earnings needed for one QC by typing it to the national average wage index.[17] The amount of earnings needed for one QC has varied by zero to fifty dollars per quarter since 1978.[18]

To be eligible for an SSDI benefit, the claimant must have paid into Social Security for a sufficient period based on his or her age. If the claimant became disabled before age 24, he or she generally needs six credits in the three year period before becoming disabled.[19] If the claimant is between the age of 24 and 30, he or she generally need credits for half of the time between age 21

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[15] "Quarter of Coverage." *Social Security Administration.* www.ssa.gov/oact/cola/QC.html
[16] https://www.ssa.gov/OACT/COLA/QC.html
[17] "National Average Wage Indexing Series", *Social Security Administration.* www.ssa.gov/oact/cola/AWI.html#Series
[18] "Id."
[19] 42 U.S.C. § 423(c)(1); 20 C.F.R. § 404.130; "Social Security Credits." *Social Security Administration*. https://www.ssa.gov/planners/credits.html.

and the time he or she became disabled.[20] If the claimant is age 31 or older, he or she need at least 20 credits *in the 10 years immediately before* becoming disabled.[21] It can be difficult to establish that the credits needed were earned in the ten years immediately before becoming disabled, especially if an individual is self-employed. It's critical for individuals with disabilities to apply for SSDI benefits before the 10-year limit has passed. Unlike Supplemental Security Income (SSI), there are no asset or unearned income restrictions for SSDI benefits.

Disability determinations for children under the age of 18 are necessarily different, because children aren't held to the same SGA standard. *It's important to know that there is a difference between the medical criteria for children's disability and adult disability standards.* The first part of the statute is the same: having a medically determinable physical or mental impairment[22] which results in "marked and severe" functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.[23]

Medicaid for children is confusing. Some programs are geared toward children with disabilities. Others are provided by virtue of the economic status of parents. Some Medicaid programs are specifically designed for those with these marked and severe functional limitations,[24] and the parents income doesn't matter regarding whether services exist (availability of services is different than whether services exist because many states have very long waiting lists for services). Other times, the income of the parents or parent living in the household is "deemed" (I find it easier to translate the term in my mind to "attributed" rather than deemed, because it seems clearer to my particular brain). In those cases, the child will only receive services if the parents' income is low enough.

II. UNDERSTANDING MEANS-TESTING.

The foundation of special needs planning is gaining access to or maintaining either cash assistance (e.g. Supplemental Security Income a/k/a "SSI"), or in kind-benefits (e.g. Medicaid,

[20] *Id*.

[21] *Id*.

[22] 42 U.S.C. § 1382c(A)(3)(C)(i)

[23] Id.

[24] E.g. Medically Dependent Children's Program, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/medically-dependent-children-program-mdcp

housing, food stamps) available from a government agency. When the programs offering cash or in-kind services are available and funded, the next hoop to jump through is "means-testing". A benefit is "means-tested" when it has income and/or asset thresholds. The thresholds are a maximum amount of income or assets, but vary widely by size of household, relationship of household members to one another, source of income, types of assets, and dozens of other parameters.

The most common benefits needed by individuals with disabilities, and the caregivers who assist them are SSI, Medicaid, housing and food stamps. As noted above, SSI provides a monthly cash income benefit. Medicaid provides a myriad of programs which run the gamut from direct medical care, to supports and services such as companions, adaptive aids, respite, nursing, case management, behavioral support, home therapies, supportive living coaches, dental, transportation and employment assistance. Without meeting the financial requirements, individuals with disabilities live without the ability to gain and maintain maximum health and safety through the use of these programs.

Consider this scenario: Julia, who is 54 and divorced, suffered a severe stroke four months ago. Her left side is weak, and her speech is garbled. Only immediate family members can understand what she is saying. She is unable to walk without the assistance of a walker and a wheelchair. She needs help getting on and off the toilet, and with bathing. She isn't able to use a microwave oven and it's unsafe for her to use a stove or oven. Julia was being treated for periodontal disease before the stroke. Julia worked part-time as a hair stylist but had never had full-time employment as an adult because she was a stay-at-home mom to her twin sons, who are now 24 years old. She currently lives with her parents in their two-story home. They have set up a bed for her in the living room until she can negotiate the stairs again. Her father and mother are 78 and 76, respectively. They live off of social security and a modest pension. Her mother has cardiac problems and a bad back. The situation is very stressful for everyone, and Julia occasionally lashes out and tries to hit others when she gets frustrated. Julia is being treated by an internist, a neurologist, a psychologist, a physical therapist, a speech therapist and a massage therapist. She is covered by medical insurance through her former husband, but those benefits will terminate in eight months. She has maxed out most of the services which the insurance covers.

What does Julia need in order to begin the long recovery from the stroke? She needs to be able to move around the house (ambulate), especially up and down the stairs, with minimal risk of falling. Adaptive aids including a walker, wheelchair, stairlift, and balance bars can ease ambulation problems and reduce the risk of falls. A physical therapist can provide other supports for her rehabilitation. Julia needs to be able to toilet and bathe. Bathroom rails, a tub chair, non-slip mats, grab bars and a raised toilet seat can address those needs. A companion or aide can manage the tasks of bathing and general hygiene that her mother has been struggling to do.

Julia has no income. She does not own a home. She has $60,000 in a bank account in her name alone, which is what remains of the assets she was awarded in the divorce. She can apply for SSI, which would provide her with monthly income. And she can apply for Medicaid, hoping that Medicaid programs can provide many of the supports and services listed above. To be successful, she will need a first-party special needs payback trust and will need to fund the trust with the money in her bank account.

III. SUPPLEMENTAL SECURITY INCOME (SSI)

Eligibility. Persons with disabilities need a source of monthly income. Some of them paid into the social security system prior to the onset of the disability and have paid enough quarters to receive a Social Security Disability Insurance ("SSDI") benefit. While the local SSA agency will tell an applicant whether he or she qualifies for SSDI, the individual can also find out for him or herself by going online and looking for their personal Social Security Statement.[25] Individuals with a disability may not qualify for SSDI either because they did not contribute enough into the social security system through withholding, or have never contributed to Social Security. When this occurs, the back-up source of income is Supplemental Security Income (SSI).

SSI is a cash assistance program administered by the Social Security Administration, which provides a monthly benefit to individuals that have low income and resources and are either (1) over the age of 65, (2) blind, or (3) disabled as defined by the Social Security Administration.[26]

To qualify for SSI, an individual must have no source of income, or a limited income. The amount of an individual's monthly SSI benefit depends on how much income he or she already

[25] https://www.ssa.gov/myaccount/statement.html

[26] "Supplemental Security Income (SSI)." *Social Security Administration*. https://www.ssa.gov/pubs/EN-05-11000.pdf.

receives and how much in-kind support and maintenance ("ISM") is being provided by a third party. An applicant may have earned income –a disability does not keep him or her from doing a few hours work per month (there is a formula for determining what the SSI benefit will be). In 2020, the maximum benefit will not exceed $783; some states also provide a supplemental income benefit, so at times you'll see from the income records that total income does exceed $783. Money not counted as earned or unearned income is sometimes known as a "disregard" (turning a verb into a noun). When a couple both meets the aged, blind or disabled criteria, the total SSI benefit for the two of them will be lower. In 2020, the monthly maximum SSI benefit for couples is $1,175. States have the option of providing an SSI recipient with an optional supplementation to the SSI payment.

When an individual is working, the calculation for determining how much SSI will be paid each month begins with applying exclusions: the first $20 of most income received; the first $65 of earned income and half the amount over $65; and Supplemental Nutrition Assistance Program (SNAP) benefits.[27] If you are married, your spouse's income and resources are considered; and if you are under the age of 18, your parents' income and resources are counted.[28] There will be an example below. The SSI payment amount increases with the annual cost-of-living adjustment (COLA).[29]

When working on income eligibility, knowing exclusions or disregards is essential because certain assistance provided by a third party to an SSI claimant is considered as income, primarily food and shelter. This is known as "in-kind maintenance and support".[30] SSI will reduce a claimant's monthly benefit up to 1/3 if he or she receives in-kind income in the form of food and shelter from a third party. This is known as the value of the one-third reduction rule (VTR). When the SSI recipient receives either food or shelter from the house in which he or she lives, the VTR doesn't apply; instead, a different calculation, known as "presumed maximum value" (PMV) is used. The PMV is equal to one-third of the federal benefit rate (which is the same as the SSI payment), plus $20[31]. Deductions from SSI for receiving in-kind maintenance and support from

[27] POMS SI 00815.000.
[28] POMS SI 01320.500; SI 01320.620.
[29] *Id.*
[30] POMS SI 00835.200.
[31] POMS SI 00835.300

a household that does not belong to the SSI recipient cannot exceed one-third plus $20, even regardless of the value of the house or the food provided.[32]

As for assets, a single individual cannot own more than $2,000 in countable assets,[33] and a married individual cannot own more than $3,000 in countable assets.[34] Some assets are excluded from consideration, including a home and one car (two in some states), certain face values of life insurance, burial and funeral plans, and personal items.

Some people will be dually eligible for Social Security retirement or disability benefits *and* SSI benefits. This usually occurs when the person entitled to the retirement or disability benefit has a low monthly benefit due to having little work history. Since SSI is needs based program, with eligibility based on income and asset limits; the Social Security disability or retirement recipient must meet those criteria. Other income, earned or unearned, will affect the amount of SSI the dually eligible individual may receive.

IV. SOCIAL SECURITY DISABILITY INSURANCE

When the Social Security Act was first passed, disability insurance was not included as a benefit. In 1956, a disability insurance program was added to the Social Security Act for disabled workers between the ages of 50 and 65 who met certain requirements. Since 1956, Social Security Disability Insurance has expanded to provide coverage to a broader range of people. SSDI is <u>not</u> a means-tested benefit, it's a monthly income alternative for disabled applicants who have sufficient work history. Unlike Supplemental Security Income (SSI), there are no asset or unearned income restrictions for SSDI benefits. It's covered under public benefits planning because individuals who qualify for SSDI may choose not to pursue SSI or Medicaid. From the practitioner's perspective, knowing whether an individual is receiving, or is eligible for Social Security Disability Insurance (SSDI) is very important. With no income or asset restrictions, a special needs trust may not be necessary.

Charlotte, age 43, comes to you because she has recently been determined by SSA to be disabled. Prior to her disability, she had been a successful real estate agent. She is divorced and has a 17-year-old son. She has an IRA worth $17,000; savings of $362,000 in an investment account and has just inherited a home from her father, free and clear. Its fair market value is

[32] 20 CFR 416. 1102
[33] This number was set by Congress in January 1989 and has not been increased since that time.
[34] POMS SI 01110.003.

$360,000. She has also inherited $150,000 in cash. Her disability is due to mental illness and she is now stable on medications. She's unable to hold a job but may be able to do so in the future. She has been told by her investment advisor that she needs to talk with you about a special needs trust so that she can get help through Medicaid. She is paying health insurance premiums through COBRA (Consolidated Omnibus Reconciliation Act) to her former employer for 18 months. She is unfamiliar with special needs planning. Charlotte needs monthly income and health care coverage.

Charlotte has been told by social security that she is entitled to SSDI. Her monthly benefit will be $1790. Charlotte feels that she will be able to work again, despite the current severity of her illness. There are a number of Medicaid funded programs for individuals with mental health disabilities, including both in-patient and outpatient treatments, and medications. In order to access those benefits, Charlotte would need to establish a 1st party, Medicaid payback trust, with the additional provision that if the trust terminates early, she will need to re-pay Medicaid, and have the Trustee pay the remaining balance directly to her ("early termination")[35]. She would also lose control over her assets. Because her parents are deceased and her assets are below most bank limits for serving as Trustee, either her brother or sister would serve as Trustee.

You advise Charlotte to take the SSDI benefit because she has earned it by paying into FICA for many years. SSA has already decided that Charlotte meets the medical determination for disability. She has not had to prove-up financial eligibility <u>because SSDI is not means-tested</u>. But what about her medical care? The law provides that Charlotte will begin to receive Medicare coverage <u>24 months</u> from the month she receives her first SSDI check. This concept is very confusing because it is also known as the <u>29-month</u> rule. So, here's how it goes – Medicare benefits begin 29 months after the month in which the SSDI award was approved; the first SSDI payment is not issued for five months after the award is approved. If you count the Medicare eligibility from the date the disability was approved, it's 29 months. If you count the Medicare eligibility from the date the first check is received, it's 24 months. Both statements are correct – I choose to use the 24-month explanation because it is clearer to me. Others choose differently, of course.

OK, if Charlotte receives her first check on January 1, 2020 (meaning she was approved for disability in August, 2019), she will be eligible for Medicare coverage on January 1, 2022.

[35] POMS SI 00120.199

What will she do about medical coverage after COBRA ends? In certain circumstances, if a disabled individual and non-disabled family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA continuation coverage, for a total of 29 months.[36] If she can afford the COBRA payments, she can continue her insurance until her Medicare benefits are awarded, as long as her current insurance coverage is good under her personal circumstances. You tell Charlotte that the public benefit system is very confusing and difficult, and that avoiding benefits might be a good choice. You tell her that it would be okay for her to wait and see; she'll have a better sense about her ability to improve her health in a year, perhaps.

You also explain to Charlotte that if she is concerned about her current insurance coverage, she can create a special needs trust (because the individual with a disability can be the trust establisher according to the Special Needs Fairness Act)[37]. All of her money, except the IRA, can be placed into the trust. Only inherited IRAs can be transferred into a trust, not the Beneficiary's own IRA. Her brother or sister will control the trust money, and she will be unable to demand a particular item or treatment. However, she will be able to access all of the Medicaid benefits and may be more financially secure in the future. The Trust can be terminated early, if the Trustee consents.

All situations are fact-specific, and Charlotte has many things to consider before making her decision. She can avoid all means-tested programs and have greater control over her life; or she can decide that she feels more secure, personally and financially, if someone else manages her money.

V. MEDICAID

Medicaid is a federal health care and services program created under Lyndon Johnson's Great Society[38]. About 75 million individuals in the U.S. are enrolled in a Medicaid program.[39] Through the joint contributions of federal and state governments[40], it provides a funding stream

[36]https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna
[37] 42 U.S.C. § 1396p(d)(4)(A)
[38] Title XIX, Social Security Act; 42 CFR 435 et. Seq.
[39]https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
[40] 42 USC §1396a; Two alternative funding methods are currently under consideration by Congress. The Medicaid program has become so costly and bogged down by administrative requirements that (1) block granting; and (2) per capita caps, are under serious consideration. Both proposals threaten to create an even more significant paucity of programs in those states where provision of care has not been a priority of legislators and/or voters. For now, federal and state contribution formulas (Federal Medical Assistance Percentages or "FMAP") remains the law of the land.

for medical services offered in the United States, the District of Columbia, Puerto Rico, the Mariana Islands and Guam (US territories). The contributions of federal and state monies to Medicaid are specified percentage of program expenses based on per capita state income, called the Federal Medical Assistance Percentage (FMAP).[41] Originally intended to provide medical care for certain low-income populations, over time it has become the only program which assists aged, blind and disabled persons in the middle and sometimes upper-middle classes with the skyrocketing costs of long-term care services. Medicaid became law after decades of debate about national health care. The Affordable Care Act expanded health care coverage to additional populations since that time, and it's likely that the costs of long-term care supports and services will eventually be addressed either in Congress or the individual states.[42]

Prior to 1965, the medical coverage that existed in the United States to injured or disabled individuals was delivered in a piece-meal fashion by industries, states and some private organizations. The enactment of Medicare and Medicaid addressed concerns regarding services to populations otherwise unable to access medical care. Medicare, health insurance for individuals ages 65 and older, and part of the same Great Society legislative package, was directed at people who were likely to have retired and who no longer had health care through employment. In the late 1970's, the Medicare benefit was extended to cover persons with disabilities. Medicaid is an entirely separate program with different goals, funding sources and eligibility requirements.[43] Medicaid is a means-based (income and asset tested) program while Medicare is an entitlement for those persons who have paid into the Medicare Trust Fund; who purchased coverage because

[41] See https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[42] For an interesting history of the advent of government's role in health care, see Corning, Peter, *The History of Medicare*; www.ssa.gov/history/corning

[43] Social Security Act Title XVIII (Medicare) and Social Security Act Title XIX (Medicaid)

their employment did not participate in federal tax and benefit contributions; or had an insufficient work history to qualify. It is not an automatic benefit for persons reaching age 65, but if the person didn't pay into the Trust Fund he or she may be able to purchase Medicare coverage.

Medicaid is not a single program; it is an umbrella reference for funding many different populations and services. Laws and regulations governing Medicaid are promulgated by the federal government. When Medicaid passed in 1965, a pre-requisite to joining this federal program was the submission of a proposed "State Plan"[44] to the federal Department of Health and Human Services.[45] The plans are dizzying but the concept is clear. Each state chose the services it would provide to persons who met the program's general, medical and financial eligibility criteria. The first group to be served would be those whose needs were the greatest. These individuals were known as "mandatory populations".[46] In general, the mandatory populations for long term care supports and services are persons who are aged (over age 65)[47], blind or disabled.[48]

Unable to foresee the future financial melee which would occur as the population aged and more persons needed more expensive services, states also included "optional populations".[49] Optional populations are persons who don't meet the mandatory eligibility criteria but are still in need of Medicaid program services. Optional populations are just that – the services available to them can be cut or modified if state budgets don't allow for more spending.

State Plans then outlined their goals for service provisions. For the mandatory populations, there were "mandatory services". Mandatory services vary significantly from state to state: the

[44] 42 CFR §430.10 et. seq
[45] 42 USC §1396a(a); 42 CFR 430.10
[46] 42 CFR Part 435, Subpart B
[47] 42 CFR §435.520
[48] 42 U.S.C. §1382c(a)
[49] 42 CFR Part 435, Subpart C

prevalence of the elderly population in Florida is different from a more sparsely populated state like Montana. Some states can offer more mandatory services; others are less generous. Nursing home care is a mandatory service in most states because at the time the program was adopted, nursing homes (sometimes called "sanitoriums") were the most common place in which long term care services were provided. Many nursing homes were operated by churches or not-for-profit entities with restricted budgets and the Medicaid funds were welcomed. Unlike other programs, nursing home benefits cover almost every need that a resident has, including medication, supplies, and room and board.

If the states were to write new plans in 2020, there's no doubt that mandatory populations and services would differ from the goals and projections in 1972. With the growth in population, the sophistication of medical care and the inability to predict how many individuals would be eligible for nursing home care annually, the federal government and states have become frustrated with the lack of budget predictability. A mandatory population or service cannot be changed without great upheaval.

Optional populations are offered services which are often badly needed by the optional populations, but which are not mandated. If money remains in a Medicaid budget after the mandatory services and populations are provided, states can fund these optional services, which might include assistance to individuals via assisted living benefits, respite care, home-and-community based services, directed services for persons with certain individuals (e.g. HIV/AIDS) and hospice. (Some states include these types of care within their mandatory service provisions in their state plans).

Waivers. Over time, the states began to recognize that the needs of their eligible populations were changing, and/or that there might be a more cost-efficient way to provide services

than those identified in their state plans. To amend a state plan, the state Medicaid agency[50] may submit a "waiver" proposal to the Centers for Medicare and Medicaid Services ("CMS"), the regulating agency under the federal Department of Health and Human Services.[51] The waiver programs [the most common being permitted under Sections 1115[52] and 1915(b) and (c)][53] of the Social Security Act), sought to keep up with the new realities of LTC through demonstration projects and changes in service provision by allowing provision of home-and-community based services ("HCBS"). Waivers are not precluded from having waiting lists, while mandatory populations and services may not have waiting lists. Over the past two decades, a wave of requests to offer services through HMOs rather than a series of private providers. The HMOs are private corporations which argue that they can provide more targeted services for less money. While some waivers have had satisfactory budget outcomes for states, (Arizona's Medicaid delivery system has always been through HMOs), many serve to reduce services and shift costs back to financially strapped individuals and families. The government is better able to predict costs when certain waivers are put into place, but applicants and beneficiaries may be losing important LTC benefits. The Centers of Medicare and Medicaid keeps a list of states and their current approved Medicaid waivers.[54]

General Eligibility Requirements. The Medicaid program has defined citizenship and legal aliens, age, blind, disabled and residence requirements as a pre-requisite for all its benefits.[55] Once those requirements are met, individual Medicaid programs have additional criteria.

[50] 42 USC §1396a(a)(5)
[51] 42 CFR §430.25
[52] 42 USC §1315(a); 42 CFR Part 431, Subpart G
[53] 42 USC §1396n(b) – (c)
[54] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[55] 42 CFR 435.400 et. Seq.

Residence requirement questions arise when a family member moves an ill parent/sibling or other family member to be closer to them geographically, - when does an individual become a resident of a state to which he or she moved to get Medicaid benefits? Except for an institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence for an institutionalized individual is the state in which the individual is living and intends to reside.[56] A state Medicaid agency may not deny eligibility because an individual has not resided in the State for a specified period.[57] Additionally, the agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.[58]

Long-Term Care Eligibility Requirements. In additional to meeting the general eligibility requirements, applicants for long term care services have additional hoops to jump. Three specific conditions of eligibility are (1) medical necessity (sometimes known as "level of care"); (2) resource requirements; and (3) income restrictions.

Medical necessity. Whether or not an individual is eligible for LTC services depends upon his or her medical needs. The medical necessity decision governs if, and what, services are needed. Without a finding of medical necessity, there's no need to move to financial eligibility. The medical decision is made by the domicile state's designated agency, with input from the individual's physician and medical records. Common conditions which prompt the need for services are outlined by reviewing a person's ability to complete "Activities of Daily Living" or "ADLs". Different states and providers break down the ADL list in different ways, but ADLs

[56] 42 CFR 435.403(h)(4)-(5)
[57] 42 CFR 435.403(j)(1)
[58] 42 CFR 435.403(j)(2)

will include (1) the ability to take medication; (2) the ability to get dressed in an appropriate manner; (3) the ability to bathe independently – and thoroughly, with the use of soap and shampoo; (4) ambulation, or the ability to walk without the assistance of another person; (5) toileting without assistance; and continence issues; (6) transferring – getting from bed to chair, chair to toilet, chair to bed, etc.; and (7) the ability to eat without having to be fed by someone else. These capabilities have a profound effect on overall health, safety and dignity of daily life.

Income. Income for Medicaid eligibility purposes is well defined in the POMS. There are categories for earned income and unearned income, and for income exclusions.[59] Income comes into play in several places in the eligibility and financial responsibility process. (1) Is the applicant's monthly income within the income limits (if any)? (2) Will the Medicaid recipient have to use his/her income to pay a share of the cost of the program services? (3) Is there a spouse who may be entitled to some or all the Medicaid beneficiary's income to avoid spousal impoverishment? (4) Do these income numbers change, and if so, when?

Income cap states. Coping with the income cap affects both you and your clients. Presently, income is an eligibility criterion in 24 states which place a "cap" on monthly income to determine eligibility for Medicaid LTC benefits.[60] The annual cap is equal to 300% of that year's federal benefit rate (FBR).[61] If *gross* income of only the applicant exceeds 300% of the FBR, the applicant is ineligible for program benefits. Period. The income of a spouse is *not* included in determining the eligibility of the applicant but will be considered in the later phases of entitlement to a spousal allowance. For now, only the applicant's gross income is in play.

[59] POMS SI 00800.000 et Seq.
[60] Alabama, Arizona, Alaska, 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.
[61] POMS SI 00810.001

In the seminal case of *Miller v. Ibarra*, 746 F.Supp. 19 (1990) a Colorado guardianship court held (among other things – it's a broadly written opinion addressing many eligibility and transfer issues) that a guardian could create a trust and place income into that trust in a manner that would allow the applicant to be Medicaid eligible for income purposes. After *Miller,* states which imposed a cap on income for eligibility purposes were required to give the applicant a way around the cap in order to avoid complete dissipation of assets while barring access to LTC. States adopt an income cap to reduce the number of individuals who successfully apply for benefits (because they are unaware of the income cap restriction), or at the very least reduce the amount of benefits which are eventually paid out. Assume Mrs. Capone approaches the state Medicaid agency to get nursing home benefits for her husband, Al. She reports that Al has unearned income which exceeds the income cap. The caseworker tells Mrs. Capone that Al is over the income cap and therefore doesn't qualify for Medicaid. Mrs. Capone goes away, but three months later someone tells her that she can get around the income cap problem with an income trust. She re-applies and Al is approved for benefits. The state has saved three months of paying Medicaid benefits for Al's care. If the state has enough Al's who apply in a given year, there can be substantial savings.

The result of *Miller v. Ibarra* was the "Miller Trust", also known as a "Qualified Income Trust" (QIT). A QIT provides that an amount which would reduce the applicant's monthly income below the monthly cap be transferred from the checking account where the income is typically deposited, and deposited into a new bank account set up in the name of the QIT. Money deposited into a trust bank account is not counted for purposes of determining income eligibility in an income cap state. Example: Joe has $4000 in gross monthly income. The income cap (for 2020) is $2349 per month and his wife is told that he cannot qualify for nursing home, or home and community-based services because his income is over the cap. Her lawyer creates a QIT and names Joe's wife

as the Trustee. After the QIT is executed, a trust bank account is opened, and evidence of such is provided to the Medicaid agency. Each month, $2000 is transferred from his checking account into his QIT account. The transferred funds are not attributed as income to Joe for Medicaid eligibility purposes. Instead, Joe's countable monthly income is $2000 ($4,000 - $2,000 = $2,000); and because his countable income is now lower than the income cap of $2349, Joe meets his state's income requirement.

Although Joe's countable income is $2,000 for eligibility purposes, his countable income reverts to its true amount of $4,000 for the process of determining his patient responsibility/share of the cost. To calculate the amount that Joe must pay to the nursing home, there may be deductions for personal needs, spousal diversion and defined medical expenses. The language of a QIT must include a Medicaid payback provision as well. If the applicant is incapacitated, the person accessing his or her income must have the legal authority – either through a joint account, as an agent under a valid Durable Power of Attorney, or as a court-appointed guardian to access and transfer the income.

An application for benefits cannot be approved for three months retroactive approval unless the QIT is signed and funded in each month in which benefits are being sought.[62] Telling the client that they will be retroactively eligible without understanding or realizing the income situation can cost the client a considerable sum. On an unfortunate note, a few states, including Florida, were granted waivers eliminating retroactive eligibility; eligibility is only available from the month in which the application is made and the applicant meets all eligibility requirements.[63]

[63] https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf?eType=EmailBlastContent&eId=a7bb9cdd-1ce1-4012-b154-7981533a4875

Resources. The resource allocation for individuals attempting to qualify for LTCSS requires divestment of assets to a level which deeply worries clients. Applicants who are over resource limits won't qualify for benefits, even though cashing in or selling assets can result in loss of equity or significant tax consequences. Nor, despite our clients' wishes to the contrary, can we simply hand our money to someone else and claim to meet eligibility requirements. Asset rules create both short and long-term economic and emotional consequences for clients. To assist our clients in receiving Medicaid benefits with the least "pain" as possible, we must know the resource requirements, including countable assets, excluded assets, exempt assets and the regulations which our own states may have adopted which provide direction to us on how to move forward with planning options.

Return to the understanding that Medicaid LTC follows SSI financial eligibility criteria. The resource limit for SSI-related Medicaid is $2,000 for a single individual. The resource limit for SSI-related Medicaid for a couple is $3,000.

Attribution of marital asset ownership is done by using the "name on the check" rule.[64] All of the resources of the couple are considered available to the applicant.[65] Ownership of income can be rebutted by the applicant.[66]

Countable assets are outlined in federal law and regulation, including the U.S. Code, C.F.R., state laws, administrative codes and state Medicaid manuals. Liquid assets are those which can be cashed in within 20 days. The general rule is that liquid assets are countable toward the

[64] 42 USC 1396r-5(b)(2)(A) (i-iii)
[65] 42 USC 1396r-5(c)(2) (A, B)
[66] 42 USC 1396r-5(b)(2)(D)

resource limits imposed on single and married persons. As with all general rules, there are exclusions and exemptions. The most prominent exemptions are:

1. Homestead property with equity value permitted in your state[67]. The home must be the principal place of residence of the applicant, and a single individual must evidence an intent to return to the home. Intent to return is not required if a spouse or dependent relative of the applicant continues to live in the home. Some states are no longer allowing a homestead exclusion if the homes have been transferred into a revocable living trust.[68]

2. One automobile.

3. Irrevocable burial and funeral expenses of certain value or a burial fund account of $1500 held in a separate bank account.

4. Cash value of life insurance policies the aggregate face value of which does not exceed $1,500.

5. Household goods and personal effects.

States maintain their own Medicaid procedures in manuals which must be consulted as a practical path for making Medicaid applications, and to determine the State rules governing some planning options. Note that while federal laws govern, the States can choose to be more generous in their eligibility criteria than the federal law.[69] As an example, in determining financial eligibility for Medicaid long term care, federal law does not include the cash value of life insurance policies

[67] 42 USC 1396p(f); 2020 minimum = $595,000; maximum $893,000
[68] For example, *see* Texas Medicaid Manual Section F-3210
[69] 42 USC 1396a(a)(C)(10)(i)

having an aggregate face value equal to or less than $1,500. If Joe has three $500 insurance policies which have a cash value of $2700, the cash value is excluded because the face value of the three policies does not exceed $1500. A State may choose to increase that face value exclusion to policies with an aggregate face value of $2,500 but may not reduce the face value exclusion to $1,000 – an amount which is lower than that permitted under federal law.

Certain assets will be excluded if they meet criteria set forth under federal law. Again, the POMS, CFR, your state Medicaid manual and a couple of good treatises and/or textbooks are essential to have at your side. Planning options have often included the purchase of single premium annuities, the use of promissory notes, annuitization or other delineation of retirement accounts, long term care insurance partnership programs/policies. These issues were targeted in the Deficit Reduction Act of 2005, which became effective on February 8, 2006. The new laws included:

1. Long Term Care Insurance Partnership Plans – defines a "qualified" long term care insurance policy and provides a list of requirements for policies to become qualified. To the extent that the benefits of a policy are used prior to the Medicaid application is made, the amount of benefits paid under the policy is added to the $2,000 asset limit for resource eligibility purposes. For example, if the applicant used the $180,000 available under the LTCI qualified policy, the asset limit would be $182,000. The extra asset allocation is not subject to estate recovery.[70]
2. Transfer of assets changes – Prior to the implementation of the Deficit Reduction Act of 2005 (effective February 8, 2006), the penalty period for transfers began from the

[70] 42 USC 1396p(c)

month in which the transfer was made. After DRA, the penalty for a transfer of assets begins the first month in which the applicant otherwise meets all eligibility criteria for long term care. States have interpreted this differently; the exact wording for post February 8, 2006 transfer penalty calculations is:

> …the state specified date is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid assistance under the State Plan and would otherwise be receiving institutional level care based on an approved application for such care but for the implementation of the penalty period, whichever is later, and which does not otherwise occur during any other period of ineligibility under this subsection…[71]

Transfer of assets rules which were haphazard before DRA were clarified and certain basic criteria are now in place, which avoids having the implementation of annuity planning, promissory notes, some retirement accounts, personal service contracts, etc., result in the imposition of a disqualifying transfer penalty. Those criteria include that these instruments and investments be (1) irrevocable and non-assignable; (2) actuarily sound; (3) provide for payments equal amounts for the term of the annuity with deferrals or balloons.[72]

The entrance value of a Continuing Care Retirement Community will be considered a resource under certain circumstances.[73]

[71] 42 USC 1396p(c)(1)(D)(A)
[72] 42 USC 1396p(c)(1)(G)
[73] 42 USC 1396p(g)

Assets include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year.[74]

These provisions of the law which outline the changes since DRA and prior laws are found in 42 U.S.C. 1396p; it's essential to slog your way through and read this provision (as well as 42 U.S.C. 1396r-5 for Community Spouses and other sections of the Social Security laws) to understand the *federal* laws; you need to know your state's specific application for your practice.

Spousal Impoverishment. In the early days of Medicaid, the applicant spouse's financial state was largely ignored. In 1988, Congress passed the Medicare Catastrophic Care Act (MCCA) which despite the Medicare moniker, also addressed the spousal impoverishment problems of Medicaid long term care recipients. The result was the creation of the Community Spouse Resource Allowance (CSRA) – other names are used in some states – an amount of resources that the health spouse (a/k/the Community Spouse) is permitted to retain when an ill-spouse applies for Medicaid long-term care services. The CSRA is defined as an amount, if any, by which the greater of the computed resources exceeds the amount of resources otherwise available to the CS.[75] At this same time, the Minimum Monthly Maintenance Needs Allowance (a/k/a Minimum Monthly Maintenance Income Allowance) was created to ensure that the CS has adequate monthly income. Calculating the CSRA and MMMNA are some of the first steps taken when looking at Medicaid long-term care eligibility. Long term financial security for the CS becomes the most critical issue once it becomes apparent that options exist which will allow the ill spouse to qualify for benefits.

[74] 42 USC 1396p(c)(1)(J)

[75] 42 USC 1396r-5(f)(2)(A); (f)(2)(B)

Monthly Minimum Maintenance Needs Allowance (MMMNA). When a Medicaid recipient receiving LTC benefits is validly married, the institutional spouse ("IS") is entitled to a minimum amount of *monthly income* on which to live.[76] This spouse is known as the Community Spouse ("CS")[77]. The MMMNA is a number issued by SSA each July 1 (most benefit changes are announced January 1). For 2020, that figure is $2,155. The maximum MMMNA for 2020 is $3,216. If the CS receives earned and/or unearned income each month more than the MMMNA, the CS is not entitled to have any portion of the IS income "diverted" to the CS. If the CS' income is less than the MMMNA, he or she is entitled to have an amount of income equal to the difference between the CS income and the MMMNA diverted from the IS spouse to the CS. For example: Teresa is the CS. Joe is the IS. Joe's gross monthly income from social security and his pension is $2600.00. Teresa's monthly income consists only of social security. Her gross social security is $1450. Teresa is entitled to $705.00 of Joe's income ($1450 + $705.00 = $2155.00), which gives her total monthly gross income equal to the MMMNA.

Given the cost of food and shelter, the MMMNA can be increased if the CS has "excess shelter" costs. Excess shelter expenses include food, mortgage, rent, real estate taxes, heating fuel, gas, electricity, water, sewer and garbage removal, condominium fees (to the extent that they include coverage for the other listed expenses) and utilities. As noted above, there is a maximum amount of income which a CS can receiving excess shelter diversion ($3216). When the numbers are calculated, Teresa is likely to have to cut expenses to stay solvent. The MMMNA can be overridden in some states if the CS applies for spousal support in a family law court. If the numbers work, the CS can receive diversion of income well in excess of the maximum MMMNA in order

[76] 42 USC 1396r-5
[77] 42 USC 1396r-5(h)

to maintain his or her existing costs of living. Medicaid is required to honor the court order even if the award of income is over the MMMNA.[78]

Asset limits. The terms assets and resources are used interchangeably unless specifically noted. Each year the Social Security Administration issues a number which tells us that maximum amount of *resources* which a CS can retain while married to an IS. The current figure is $128,640. The minimum amount which the CS can retain in 2020 is $25,728. In states which follow the minimum CSRA (sometimes known as the SPRA), the CSRA is ½ of the couple's countable resources, not to exceed the year's resource CSRA; or the minimum set by federal law.[79] The amount by which the couple's countable resources exceeds the resource limit must be spent down or transferred or made ineligible – the crux of Medicaid planning. The CS allowance is always going to be the annual maximum resource limit, however, it's possible for the CS to end up with much less than the CSRA if the couple has [80]minimal assets. For instance, CS Joe has $55,000 in investments, and IS Teresa has $25,000 in cash savings. For the resource eligibility calculation, the couple's total assets are $80,000. Joe and Teresa's resource allocation is $40,000 each. Joe's excess assets are transferred to Teresa. There is no transfer penalty between spouses.[81] IS Joe must spend down to the asset limit of $2,000. CS Teresa must spend down to $40,000.

If the CS will not have enough income, even with total spousal diversion, to reach the MMMNA, the institutionalized spouse's income (above the allowances specified in the statute) is allocated to the community spouse for purposes of determining the extent to which the community spouse has sufficient income to meet the MMMNA. Using the "income-first" method, the CSRA is increased only if the community spouse's income will not reach his or her minimum

[78] 42 USC 1396p(f)(3)
[79] 42 USC 1396r-5(f)(2)(A)
[80] 42 U.S.C. §1396r-5(e)(2)(A)
[81] 42 U.S.C. §1396r-5(f)

monthly maintenance needs allowance *after* considering any non-protected income that is available or potentially available from the institutionalized spouse. To increase the CSRA through the income-first rule, failure to apply the rule must result in significant financial duress to the CS.[82] Prior to the Deficit Reduction Act ("DRA"), there was confusion about the process of increasing the CSRA.[83] The expanded CSRA is the lesser of (1) $250,300; or (2) the value of the couple's combined total combined countable resources as of the first month of entry to a medical care facility for a continuous stay. Review your Medicaid manual for a step-by-step analysis of the process.

While the application will be denied at the local level, the attorney can take the matter to a fair hearing and assuming all other eligibility criteria are met, the hearing officer can agree to allow the CS retain assets which yield monthly income, reducing the amount of any diversion to the spouse (and thereby reducing the amount Medicaid has to pay), while allowing the CS to avoid adverse tax consequences of cashing in certain assets and to maintain an opportunity for growth.

Medically Needy. States have the option to establish a "medically needy program" for individuals with significant health needs whose incomes are too high to otherwise qualify for Medicaid under other eligibility groups. The Medically Needy population falls under the "categorically eligible" standard; these individuals are not entitled to mandatory coverage absent a state waiver. Medically needy individuals can still become eligible by using medical expenses incurred to reduce or spend down their amount of income in order to qualify for Medicaid coverage. Once an individual's incurred expenses exceed the difference between the individual's income and the state's medically needy income level (the "spend down" amount), the person can

[82] 42 U.S.C. §1396r-5(e)(2)(B)
[83] 42 U.S.C. §1396r-5(d)(6)

be eligible for Medicaid. The Medicaid program then pays the cost of services that exceed what the individual had to incur.

Medicare Savings Programs. Medicare Savings Programs are *Medicaid* benefits offered to low-income Medicare recipients. These programs help pay the costs of Medicare Part A and B premiums, co-payments, coinsurance, and deductibles. The programs include the Qualified Medicare Beneficiary (QMB) program; Specified Low Income Medicare Beneficiaries (SLMB) program; and the Qualified Individual (QI) Program. Many people need Medicaid eligibility just to have the advantage of these savings programs; cost savings can be as much as $20,000 or more per year. Each program has an income limit: in 2020 for QMB, an individual's income is limited to $1084; a couple may have income up to $1457. For SLMB, the individual limit is $1296; a couple may have income up to $1744. For the QI program, the individual limit is $1456; a couple may have income up to $1960. A single resource limit applies to all three savings programs - $7860 per individual and $11800 per couple.[84]

VI. APPLYING FOR BENEFITS

Applying for any social security benefit is typically done online , at the local social security branch, or over the phone. Special needs planners vary in their approach to involvement in the initial application process. In many instances, the disability is apparent, and once the financial eligibility requirements are satisfied, the attorney is comfortable having the client (or his or her family) make the application personally. If the family is uncomfortable, the attorney can become involved at the initial stage of the process. When issues about the medical determination of disability are expected, I recommend that the applicant retain a Social Security Disability attorney from the start. The SSA publishes a "Social Security Disability Starter Kit" which is informative for both attorneys and clients.[85]

[84] https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs
[85] https://www.ssa.gov/disability/disability_starter_kits.htm

A successful appeal from an initial denial of disability will result in an award of back benefits. Benefits are paid back to the date that the applicant would have been eligible for benefits. For example, Carlotta applies for Social Security Disability Insurance (SSDI) benefits in December 2018. Her application was denied. She appealed the denial which took two years. Her appeal was favorably decided on September 1, 2020. Persons approved for disability receive their first check five months after the month in which the application is made. In Carlotta's case, had her initial application been approved, her first check would have arrived (December - April) May 1, 2019. When she won the appeal, the agency owed her 17 months of back benefits.

VII. CONCLUSION

A few of our valued colleagues began their careers working within the SSA or state Medicaid system, and have a depth of knowledge and insight which the rest of us spend years learning. Fortunately, they are giving of both their time and knowledge. New clients often assume that because you are a "special needs lawyer", you know everything about every aspect of eligibility, regulations, protocols and the application process. They have no way of knowing that you might not work in the area of medical determination of disability – this is a separate and special area of disability practice. They may not realize that you are an estate planning attorney who understands the special needs trust requirements, but have never been involved in implementation or administration of a SNT. You may never have made a disability application yourself, but you know what the clients must know in order to have the application approved. Over the years, I've touched each part of an SSA application from initial determination to appeal, simply to have the experience of knowing what to expect. Medicaid applications and counseling are far more hands on and if you cover this area of practice you undoubtably know your local and state Medicaid folks. HUD, food stamps, state supplementation – you may have more or less familiarity with these processes. In this practice area, there is never a day when you can't learn something new, and all of it benefits the clients you see. I continue to hold my non-legal colleagues in great esteem because the many facets of public benefits laws are too great for anyone to know in full (or at least, for me), so together we provide our clients with the information we believe will be most helpful and walk with them in their journey to get food, housing, health care, supports, services and other available benefits that are basic necessities in their own journeys.