

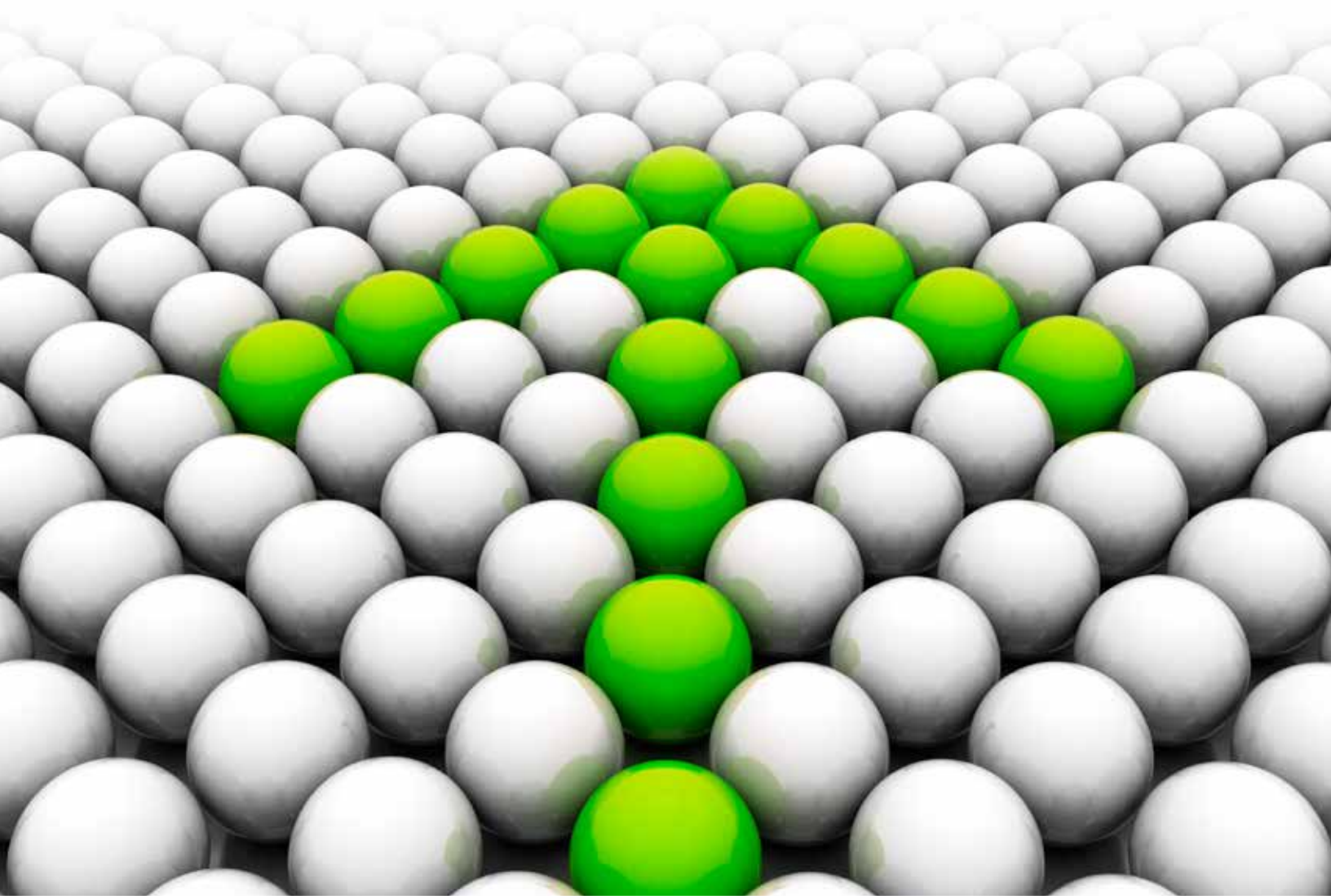
Excerpt

The CPA's Guide to

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Chapter 35

Social Security Benefits, Medicare, and Medicaid

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¶3501 Overview

This chapter addresses the benefits and rules of Social Security, Medicare, and Medicaid. As baby boomers retire and the overall population ages, financial planners will find an increasing portion of their practices addressing retirement, eldercare, and government entitlement program issues.

¶3505 Tax Planning for Social Security Benefits

Under complex Social Security income inclusion rules, some taxpayers must pay tax on 85 percent of their Social Security benefits.¹ Many benefit recipients, however, are able to exclude all their Social Security benefits from their gross income or pay tax on only half their benefits. These rules drastically increase the marriage penalty for retired couples who are both receiving Social Security benefits.

However, the rule including 85 percent of Social Security benefits applies only to those with provisional income in excess of \$44,000 for joint filers, \$0 for a married individual filing separately who does not live apart from his or her spouse for all of the tax year, or \$34,000 for all other filers.² For most people, provisional income is adjusted gross income (AGI) plus tax-exempt interest, plus one-half of Social Security benefits.³

Mechanically, the inclusion rules for Social Security benefits are built on two tiers. The following discussion explains how the rules work for taxpayers other than married persons filing separately who do not live apart from their spouses for the entire year.

.01 First Tier

The rules requiring 50 percent inclusion of Social Security benefits in gross income apply to those recipients whose provisional income bases are within the following dollar ranges: above \$25,000 but not above \$34,000 for unmarried taxpayers and above \$32,000 but not above \$44,000 for married persons

¹Internal Revenue Code (IRC) Section 86.

²IRC Sections 86(c)(1)(C) and 86(c)(2).

³IRC Section 86(b).

filing jointly.⁴ For such taxpayers, the maximum amount of Social Security benefits included in gross income is the lesser of (1) 50 percent of the benefits or (2) 50 percent of the excess of the provisional income base over the applicable threshold amount (\$25,000 or \$32,000).

.02 Second Tier

For those who have provisional income bases above \$34,000 or \$44,000 (as appropriate), gross income includes the following:

- The smaller of
 - the amount of benefits included in the first tier, or
 - \$6,000 for married persons filing jointly or \$4,500 for other taxpayers, plus
- 85 percent of the excess of the taxpayer's provisional income base over \$44,000 for married persons filing jointly or \$34,000 for other taxpayers.

However, for recipients who fall in the second tier, the amount subject to tax is capped at 85 percent of the Social Security benefits. Note that the amounts of the provisional income bases are not indexed for inflation.

.03 Married Persons Filing Separately

Taxpayers receiving Social Security who are married at the close of a tax year, file separate returns, and did not live apart from their spouses for the entire year pay tax on 85 percent of each and every Social Security benefit dollar (or 85 percent of provisional income, if that is less). In *T.W. McAdams*,⁵ the U.S. Tax Court ruled in a case of first impression that living apart means living in separate residences, not merely in separate bedrooms.

.04 Higher Inclusion Has Variable Effect

Social Security recipients with provisional income in excess of \$44,000 or \$34,000 (as appropriate) include more than 50 percent of their Social Security benefits in gross income. Depending on income and benefit levels, some pay tax on more than 50 percent but less than 85 percent of their benefits. Others pay tax on a full 85 percent of their benefits.

Example 35.1. Each year, Mr. and Mrs. David English have \$40,000 of income from pensions, dividends, and tax-exempt securities and receive \$12,000 of Social Security benefits, producing a provisional income base of \$46,000 (\$40,000 + \$6,000).

As a result, \$7,700 of their benefits is taxed (roughly 64-percent). The couple's income is not high enough for the 85 percent-of-benefits cap to come into play.

Example 35.2. Each year, Mr. and Mrs. John Bates have \$50,000 of income from pensions, dividends, and tax-exempt bonds and receive \$14,000 of Social Security benefits. They have provisional income of \$57,000 (\$50,000 + \$7,000).

As a result, \$11,900 of their Social Security income is taxed, which is a full 85 percent of their benefits.

.05 Marriage Penalty Impact

Some Social Security recipients will pay a very high price if they marry instead of simply living together.

⁴IRC Section 86(c).

⁵118 T.C. 373 (2002).

Example 35.3. Assume the same facts as in example 35.2, except that Mr. John Bates and Ms. Rose Piccoli live together, instead of being married, and each has exactly half their combined income. Thus, each has \$25,000 of income from pensions, dividends, and tax-exempt bonds and \$7,000 of Social Security income.

As a result, the amount of Social Security income subjected to tax is \$1,750 for each person and a total of \$3,500 for both. This amount is roughly 70 percent less than the \$11,900 of Social Security benefits that would be subject to tax if they were married.

Note that married persons of the same sex will now be required to file federal income tax returns as either married filing jointly or married filing separately—no longer as single taxpayers.

.06 Social Security Recipients Who Work Part-Time

For Social Security recipients under normal retirement age (age 62 to age 67 depending on date of birth), part-time, supplemental earnings may reduce benefit levels and cause more of what is left to be exposed to tax. For example, under the Social Security earnings test that applies to retirees under normal retirement age, a person can earn \$15,720 in 2015 without having benefits reduced. Beyond that dollar level, however, one dollar is deducted from benefits for every two dollars earned over the exempt amount (see [§3530](#) for further details). Taking into consideration reduced benefits, a higher income inclusion on Social Security benefits that are paid, FICA taxes, and income taxes, a part-time earner who takes on more work could wind up losing a significant portion of his or her pay increase.

Example 35.4. Jeff Solomon is a single 63-year-old who has \$10,000 of salary from a part-time job, \$16,940 of income from pensions and investments, and \$7,000 of Social Security benefits. Jeff has been asked to work more hours at his part-time job in exchange for \$7,000 more in pay. The year is 2016.

If Jeff declines the offer from his employer, he will have provisional income of \$30,440 (\$10,000 + \$16,940 + 50% of \$7,000). He will include \$3,500 of his Social Security benefits in income. Assuming Jeff is in the 15-percent tax bracket, he will pay \$525 in tax on his benefits.

If Jeff works more hours at his part-time job and is paid an additional \$7,000, about 31 percent ($7,000 - 4,822.50 = 2,177.50 / 7,000$) of the extra pay will be lost to taxes and benefit reductions.

Gross pay boost	\$7,000.00
Reduction in benefits $(\$17,000 - \$15,720) \times 50\%$	(640)
FICA on \$7,000 extra (7.65%)	(535.50)
Income tax on \$7,000 of earnings (at 15%)	(1,050.00)
Income tax saved on reduced benefits $(\$640 \times 50\% \times 15\%)$	48.00
Net	<u>\$4,822.50</u>

.07 Practice Aid for Calculating the Taxable Portion of Social Security Benefits

The following worksheet shows how taxpayers other than married persons filing separately will compute the taxable portion of their Social Security benefits.⁶

⁶Married persons filing separate returns who did not live apart from their spouses for the entire year pay tax on the lesser of (1) 85 percent of each and every Social Security benefit dollar or (2) 85 percent of provisional income.

FIRST TIER

1.	50% of Social Security benefits	_____
2.	Modified adjusted gross income (AGI) (generally AGI plus tax-exempt income)	_____
3.	Total of Lines 1 and 2—Provisional income	_____
4.	Less \$32,000 (joint filers) or \$25,000 (all others)	_____
5.	Income over base	_____
6.	50% of Line 5	_____
7.	50% of Social Security benefits	_____
8.	Enter smaller of Line 6 or 7	_____
	If Line 3 does not exceed \$44,000 (joint filers) or \$34,000 (other taxpayers), Line 8 amount = portion of Social Security benefit includible in gross income	_____
	If Line 3 exceeds \$44,000 (joint filers) or \$34,000 (other taxpayers), continue with Line 9	_____

SECOND TIER

9.	Enter smaller of Line 8 or \$6,000 (married persons filing jointly) or \$4,500 (other taxpayers)	_____
10.	85% of Line 3 less \$44,000 (joint filers) or \$34,000 (other taxpayers)	_____
11.	Line 9 plus Line 10	_____
12.	85% of Social Security benefits	_____
13.	Lesser of Line 11 or 12 = portion of Social Security benefit includible in income	_____

.08 Strategies for Dealing With Tax on Benefits

Retired people who are affected by the tax on Social Security benefits, especially those subject to the 85-percent inclusion rules, may be able to reduce their exposure by using the following techniques. However, taxes should never be the sole motivating factor behind any investment decision.

- Switching funds into investments that pay monthly checks that include a tax-free return of capital component. Annuities are prime examples of such investments. That part of each annuity payment representing the return of the purchaser’s investment is not currently taxed and is not factored into the Social Security income inclusion. By contrast, interest (tax-free or not) and dividends directly affect the amount of Social Security income that is taxed.
- For those who are not expending all their investment income for living expenses, deferral techniques might make sense. For example, Series EE and Series I bonds provide tax deferral. The interest buildup in a Series EE or Series I bond is not taxed until the bondholder redeems or elects to report it. Another alternative that may be appropriate would be a switch of some cash from income funds into growth funds.
- When retirees have a choice, they should consider withdrawing interest from their municipal bond funds before withdrawing cash from IRAs for living expenses. This strategy is helpful because municipal bond fund interest is taken into account in computing the tax on Social Security benefits, regardless of whether it is withdrawn, but interest accruing in an IRA is not. In addition, usually, withdrawing cash from non-IRA accounts before dipping into the IRAs will provide more tax benefits. Withdrawals of the principal from a money market account or mutual

fund are not taxed (only the interest or dividend earnings are included in income). By contrast, each dollar withdrawn from a traditional IRA is included in gross income (unless the taxpayer made nondeductible contributions).

- Retirees should try to avoid selling appreciated assets because a large profit could subject a full 85 percent of their Social Security benefits to tax, or time the sale of appreciated assets to take place before applying for Social Security benefits.
- Consider converting a traditional IRA to a Roth IRA before applying for Social Security benefits so that withdrawals (if any) from the Roth IRA are not included in AGI.

.09 Lump-Sum Social Security Benefits

Prior to changes made by the Bipartisan Budget Act of 2015, effective November 2, 2015, a taxpayer could have incurred a large tax liability if the taxpayer received a large lump-sum payment of Social Security benefits in a single year that the taxpayer should have received over several years. This strategy is no longer permitted. A person now receives the benefit he or she is entitled to when the claim for benefits is made. No retroactive lump sum is available. This issue is discussed further in ¶3535 that follows.

.10 Social Security Benefits in Lieu of Workers Compensation Benefits

Workers compensation benefits are generally excluded from gross income.⁷ However, to the extent that workers' compensation benefits reduce Social Security benefits, the workers' compensation benefits will be taxable as Social Security benefits.⁸

¶3510 Medicare

Medicare is a federal health insurance program primarily designed for individuals entitled to Social Security who are age 65 or older (although younger individuals can also qualify; for example, those receiving Social Security disability and those with end-stage renal disease). One may obtain more information about Medicare by calling (800) MEDICARE (633-4227) or by visiting the Medicare website at www.medicare.gov.

.01 In General

Basic Medicare consists of two parts. Part A covers inpatient hospital services and services furnished by other institutional health care providers, such as skilled nursing homes, home health agencies, and hospices. Part B is a voluntary insurance program and covers the services of doctors, suppliers of medical items and services, and various types of outpatient services.

Certain items and services are excluded from coverage under both parts. Also, services that involve custodial care (that is, the type of services normally associated with long-term care patients, such as observation and help with daily living activities) are not covered. In addition, services determined by Medicare not to be reasonable are not covered.

The patient must pay a portion of the cost of some covered services because of deductible and coinsurance requirements.

Medicare Part C (Medicare Advantage Plans), managed by private insurance companies, combines Medicare Parts A and B (and sometimes Part D) coverage.

Medicare Part D (Medicare Prescription Drug Coverage) is a voluntary program that helps cover the cost of prescription drugs.

⁷IRC Section 104(a)(1).

⁸IRC Section 86(d)(3).

Note: If a person is covered by Medicare, they are deemed to have adequate health care coverage under the Affordable Care Act. There is no requirement to purchase a health insurance policy on an exchange, and no penalty is due.

.02 Enrollment

Part A coverage is automatically provided without charge for persons entitled to Medicare because they, or a spouse, had 40 or more quarters (credits) of Medicare-covered employment. Eligibility is based on entitlement to Social Security or Railroad Retirement benefits. Part B coverage, however, must be paid for through monthly premiums. For 2016, the standard premium for Part B Medicare subscribers is \$104.90 per month. However, higher income individuals are charged higher premiums. This is referred to as an *IRMAA adjustment* (income related monthly adjustment amount). For 2016, higher Part B premiums apply to individuals with AGI above \$85,000 on a single return or \$170,000 on a joint return. For 2016, the monthly premium for a single individual with income in the \$85,001 to \$107,000 range is \$170.50; a single person with income between \$107,001 and \$160,000 pays \$243.60 per month; a single person with income between \$160,001 and \$214,000 pays \$316.70 per month; and a single person with income above \$214,000 pays \$389.80 per month. For joint filers with income in the \$170,001 to \$214,000 range, the monthly premium is \$170.50 for 2016; joint filers with income between \$214,001 and \$320,000 pay \$243.60; joint filers with income between \$320,001 and \$428,000 pay \$316.70, and joint filers with income over \$428,000 pay \$389.80.

Note that beginning in 2018, the IRMAA adjustments will be recomputed and changed (narrowed) to require more people at various levels of income to pay higher Part B premiums.

The Social Security Administration will generally use income from the second preceding year when determining the current year's premium. For example, the income reported on a 2014 tax return is used to determine the monthly Part B premium for 2016. An individual whose income has decreased since that year can request that the income from a more recent tax year be used to determine the premium, but they must meet certain criteria. Accordingly, to avoid potentially higher Medicare premiums in 2018, income planning must be addressed for 2016 income.

Persons not automatically entitled to Medicare can voluntarily enroll in the program if they pay a monthly Part A premium and also enroll in Part B. The Part A monthly premium is \$411 for 2016 but is reduced to approximately \$230 for persons with 30–39 quarters (credits) of Social Security coverage or for persons married or formerly married to such a person for certain lengths of time.

.03 Part A Coverage and Limitations

Here is a brief summary of Part A coverage and limitations.

Covered services. Part A covers most hospital services, including the following items and services furnished to an individual admitted to a hospital as an in-patient:

- Room and board
- Drugs and biologicals
- Supplies, appliances, and equipment
- Diagnostic and therapeutic items and services
- Nursing services
- The services of staff doctors not directly related to the personal treatment of individual patients
- The services of all interns, residents, and teaching physicians

Part A also covers certain home health services and hospice care.

Part A covers generally the same inpatient services provided in a participating skilled nursing facility as it covers in a hospital. However, the services must be skilled nursing services and not merely custodial care.

Limitations—Inpatient hospital stays. Part A is limited in terms of how long the program will pay for services, and it requires beneficiaries to share some of the costs. For example, in-patient hospital coverage expires after 90 days of benefits have been used per benefit period (although the beneficiary has an additional 60 "lifetime reserve days" that can be used only once.) A *benefit period* is a period of consecutive days that begins with a hospitalization and ends when the patient has not been an in-patient for 60 consecutive days. A benefit period is sometimes referred to as a *spell of illness*.

Beneficiaries must pay a separate in-patient hospital deductible for each benefit period. The deductible is \$1,288 for 2016. There are also coinsurance requirements. For example, there is a per-day coinsurance charge for in-patient hospital stays of more than 60 days in the same benefit period. The 2016 charge is \$322 per day for the 61st day through the 90th day of an in-patient hospital stay (there is no coinsurance for the first 60 days) and \$644 per day if lifetime reserve days (days 91–150) are used. There is no coinsurance beyond 150 days (that is, the patient is responsible for all the costs).

If a person is discharged from a hospital, remains out of the hospital for at least 60 days, and then is readmitted to the hospital, a new benefit period begins (that is, the first 60 days of such new period costs the patient \$1,288 in 2016, and the "lifetime reserve days" are not counted here). If the patient is discharged and then readmitted to the hospital within 60 days, a new period does not begin (that is, there is not a new spell of illness, and the number of days used continues from the number of days reached where the previous hospital stay left off).

Skilled nursing home stays. For stays in a skilled nursing home to be covered by Medicare, the patient must have spent at least three consecutive days in a hospital, be admitted to the nursing home within 30 days after having been discharged from the hospital, and require skilled nursing care, as distinguished from custodial nursing care. *Skilled nursing care* refers to the daily availability and treatment by skilled medical personnel or physical, speech, or occupational therapists. There must also be a physician certification of need.

Skilled nursing care. A patient is deemed to be receiving *skilled nursing care* if he or she requires nursing or rehabilitation services such as intravenous or intramuscular injections and intravenous feeding; insertion and sterile irrigation and replacement of catheters; therapeutic activities or maintenance therapy, when necessary, based on the needs, capability, and tolerance of the beneficiary. Whether skilled nursing care is required for the patient is often a subject of controversy and litigious appeal.

Medicare will pay in full for this care for the first 20 days of each benefit period. From days 21–100, the patient must pay coinsurance of \$161 (2016) per day. After 100 days, the patient pays the entire cost. The 100 days of skilled nursing home coverage are renewable if there is a break of at least 60 days between the patient's discharge from a skilled nursing facility and his or her readmission to such a facility.

Medicare will pay for skilled nursing care services such as the following

- A bed in a semi-private room
- All meals, including special diets
- Regular nursing services
- Drugs furnished by the skilled nursing facility
- Medical supplies
- Physical, occupational, and speech therapy

- Use of appliances
- Medical social services
- Most blood transfusions

Home health visits. Medicare Part A will cover the cost of the first 100 medically necessary home health visits for patients who are confined to the home and require intermittent skilled nursing care; physical, speech or occupational therapy; medical supplies; and medical social services under the direction of a physician. Such requirement must be prescribed by a physician and evaluated by a Medicare-certified home health agency.

Medicare will cover up to 35 hours per week of such visits. Performance of general household chores, such as shopping or meal preparation, is not covered under these rules. Neither are payments for assistance with the activities of daily living, such as bathing and dressing.

Part-time or intermittent services are defined as the combined services of less than 8 hours each day and 28 or fewer hours a week, or less than 8 hours each day and less than 35 hours a week determined on a case-by-case basis. *Intermittent* is defined as skilled nursing care on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions allowed in exceptional circumstances when the need for additional care is finite and predictable.

Hospice care. Medicare Part A will cover hospice care for the *terminally ill*, defined as persons having less than 6 months to live. Medicare covers two 90-day periods of hospice care and an unlimited number of additional periods of 60 days each, but the patient must be certified as terminally ill at the beginning of each period. The beneficiary must elect the hospice care, which limits the availability of Medicare coverage for aggressive health services for conditions related to the terminal illness. If hospice care is chosen, the beneficiary may receive both home and in-patient care.

.04 Part B Service and Limitations

Part B coverage is defined in terms of which specific services are involved. Only those services specifically listed as covered will be paid by Medicare, although some of the listed services are quite broad in scope. Not all the covered services are listed here; however, *covered services* include such items as the following:

- Physicians' services, including wellness checkups
- Drugs that cannot be self-administered, such as the flu vaccine
- Outpatient services
- Therapy services
- Diagnostic tests

Many items are specifically excluded (for example, eyeglasses and hearing aids, most dental work, and personal comfort items).

Medicare Part B also provides numerous preventive services. Medicare covers bone mass measurements once every 24 months for qualified individuals and more often if medically necessary. The individual's physician can determine if the individual is a qualified individual. Medicare also covers several different kinds of colorectal cancer screenings for covered individuals age 50 and older. (Note that most people are not eligible for Medicare coverage until attaining age 65, absent a prior disability). These screenings include a fecal occult blood test once every 12 months and a flexible sigmoidoscopy once every 48 months. Medicare covers a colonoscopy for covered individuals, regardless of age, once every 24 months for individuals at high risk for colon cancer or once every 10 years for other individuals, as long as the colonoscopy is not within 48 months of a screening flexible sigmoidoscopy. A physician may use a barium

enema instead of a flexible sigmoidoscopy or a colonoscopy. Medicare also covers glucose monitors, test strips, and lancers for covered individuals with diabetes. Certain individuals with diabetes are also eligible for diabetes self-management training. Medicare covers a glaucoma screening once every 12 months for covered individuals who are at high risk for glaucoma. Medicare covers a mammogram screening once every 12 months for women age 40 and over. In addition, Medicare allows one baseline mammogram between ages 35-39 if the woman is covered by Medicare. All women with Medicare may receive a Pap test and pelvic examination once every 24 months. These preventive exams are allowed once every 12 months for women who are at high risk for cervical or vaginal cancer or if the woman is of childbearing age and has had an abnormal Pap test in the previous 36 months. Medicare covers a prostate cancer screening, including a digital rectal examination and a prostate specific antigen (PSA) test once every 12 months for all covered men age 50 and older. Medicare covers an annual flu shot in the fall or winter for all covered individuals. In addition, Medicare covers one pneumonia shot and allows a Hepatitis B shot for certain covered individuals who are at medium to high risk for Hepatitis B.

Part B has deductible and coinsurance requirements for most covered items. For example, the deductible is \$166 per year (for 2016), and the coinsurance is generally 20 percent of the Medicare-approved charge.

.05 Medicare Part C

Medicare Part C or Medicare Advantage Plans are available to Medicare beneficiaries who are entitled to Part A and enrolled in Part B. Medicare Advantage Plans are plans run by private companies that provide all Medicare Part A and Part B benefits. These plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service plans, or Medicare medical savings account plans.

The enrollment criteria for Medicare Advantage Plans are as follows:

- The individual must be enrolled in Part B and continue to pay the Part B premium.
- The individual must live in the plan's service area.
- The individual cannot have permanent kidney failure.

An eligible individual may join a Medicare Advantage plan when he or she first becomes eligible for Medicare. An eligible individual can switch to a Medicare Advantage plan during open enrollment from October 15 through December 7 of each year. If an individual enrolls during that period, the coverage becomes effective on January 1 of the next year. An individual can also join or switch Medicare Advantage plans from January 1 to March 31 of any year (but cannot drop existing prescription drug coverage during that period).

.06 Medicare Part D Prescription Drug Coverage

All Medicare beneficiaries are eligible for Medicare Part D prescription drug coverage.

There are two ways to obtain Medicare prescription drug coverage. A beneficiary can join a Medicare prescription drug plan directly or enroll in a Medicare Advantage plan that offers prescription drug coverage. Beneficiaries must pay a monthly premium, which varies by plan, and a yearly deductible (no more than \$360 in 2016). Higher-income Part D participants pay a higher monthly premium than single persons with AGI over \$85,000 and married persons filing jointly with AGI over \$170,000. Beneficiaries must also pay a part of the cost of prescriptions, including a copayment or coinsurance. Costs will vary depending on the drug plan selected. Some plans may offer more coverage and additional drugs for a higher monthly premium. Beneficiaries with limited income and resources may qualify for extra help and may not have to pay a premium or deductible. Once a beneficiary reaches the Part D initial coverage limit of having paid 25 percent of the cost of prescription drugs up to \$3,310 for 2016, there is a coverage gap (the so-called "doughnut hole"), when the beneficiary pays a substantial percentage of the cost of prescription drugs until the beneficiary has spent \$4,850 (for 2016) on drug charges. Thereafter, the beneficiary is in

the "catastrophic coverage" area, when there are modest copayments for generic and brand name drugs. Beginning in 2011, the beneficiary in the "doughnut hole" received a discount on brand name and generic drugs. In 2016, anyone reaching the "doughnut hole" will receive a 45-percent discount on the cost of brand name drugs. In 2016, the maximum copayment on generic drugs while in the doughnut hole is 58 percent. There is also a \$250 rebate payable to persons who are affected by the "doughnut hole."

.07 Medigap Policies

Generally. Medicare beneficiaries should consider purchasing a Medicare supplement policy to fill gaps in the coverage provided by Medicare. To supplement the coverage offered by Medicare's Part A and Part B offerings, private insurance companies sell "Medigap" coverage. These are supplemental insurance plans regulated by the federal government. One must have Medicare Part A and Part B to buy a Medigap policy. Medicare does not pay for any of the costs of a Medigap policy. A Medigap policy only covers one person. Spouses must each buy separate Medigap policies. Once acquired, the insurance company may not cancel Medigap policies, except for nonpayment of premiums.

The best time to purchase a Medigap policy is during the Medicare open enrollment period. This period lasts for six months and begins on the first day of the month in which a person is both 65 or older and enrolled in Medicare Part B. During this period, an insurance company cannot use medical underwriting. It is possible that a Medigap policy may enforce a 6-month waiting period with respect to a pre-existing condition. (Original Medicare will still cover the pre-existing condition even if the Medigap policy will not cover the excess). Coverage for a pre-existing condition can only be denied in a Medigap policy if the condition was treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy. However, if a person has at least 6 months of prior creditable coverage (that is, any other health coverage the person had before applying for a Medigap policy where there was no break in coverage for more than 63 days), the Medigap insurance company cannot refuse to cover a pre-existing condition.

Standard Medigap plans. The private insurance companies authorized to sell Medigap insurance must follow federal and state laws addressing these policies. The companies may offer standard Medigap insurance plans, designated A–N. Each plan has a different set of benefits. Medigap Plans E, H, I, and J are no longer sold, but if a person already has such a plan, it may be retained. For years beginning in 2006, Medigap plans can no longer be sold with prescription drug benefits, although persons who already had those policies may retain them. All plans with the same letter cover the same benefits, regardless of which insurance company offers a particular plan. However, the premium costs among the plans may vary.

Medigap Plans A–N. All of the 14 Medigap policies cover basic benefits, but each has additional benefits that vary according to the plan. The most basic plan is Plan A. Plans B–N offer everything that Plan A offers and provide additional coverage. Plans K–N offer similar coverage as Plans A–J, but the sharing of costs between the insurance policy and the participant for basic benefits are at different levels.

Newest Plans M and N. Plans M and N became available June 1, 2010. At that time, Plans E, H, I, and J were eliminated as the preventive care benefit and the at-home recovery benefits were removed, and these plans become identical to the other remaining plans. A new hospice care benefit coinsurance coverage was added to all new Medicare supplement plans. Plan M offers similar benefits to Plan D, but only covers 50 percent of the Part A deductible and none of the Part B deductible. Plan M costs 85 percent of Plan F and 92 percent of Plan D. Plan N offers similar benefits to Plan D but has a \$20 copayment for doctor visits and a \$50 copayment for emergency room visits, presumably applied after the Part B deductible is met. The cost of Plan N is about 70 percent of the cost of Plan F (Plan F is a high-deductible plan—there is a \$2,180 deductible for 2016 before the Medigap plan covers anything) and 77 percent of the cost of Plan D.

Limitations in Medigap coverage. Despite the wide varieties of additional policy options, none of the standard Medigap plans cover private-duty nursing services, hearing aids, vision or dental care, or long-term care to help with bathing, dressing, eating, or using the bathroom (toileting).

Supplementing the Part A hospitalization coverage. Recalling the earlier discussion of the benefits available under Medicare Part A ([¶3510.03](#)), once the patient has paid the hospital deductible (\$1,288 in

2016), Part A pays all hospital costs for up to 60 days in a benefit period. If the patient stays in the hospital more than 60 days, the patient pays \$322 (in 2016) per day for days 61–90. If the patient stays longer than 90 days in a benefit period, the cost for each day is \$644 (in 2016) for up to 60 days over the lifetime of the patient.

All the Medigap plans cover the patient's costs for days 61–150. In addition, once the patient has used all 150 days of Medicare hospital benefits, all Medigap plans cover the cost of 365 more hospital days in the patient's lifetime.

Plans F or J are high-deductible options, so that the patient must first pay the annual Medigap deductible before these costs will be covered. Plans K or L will require the patient to pay a portion of the hospital deductible before the patient's costs will be covered, unless the patient has already met the annual out-of-pocket maximum for the year. With Plans K and L, after a person meets the yearly Part B deductible (\$166 in 2016) and the out-of-pocket yearly limit (Plan K \$4,960; Plan L \$2,480), the Medigap plan pays 100 percent of the covered services for the rest of the calendar year.

Supplementing the Part B medical coverage. Recalling the earlier discussion of the benefits available under Medicare Part B ([¶3510.04](#)), once the patient pays the yearly Part B deductible (\$166 in 2016), Medicare will generally pay 80 percent of physician and other medical services, and 100 percent of certain other preventive services.

The Medigap plans cover all or part of the patient's share of the services mentioned earlier (that is, 20 percent of the Medicare-approved amount for physician services and 50 percent for mental health services). The *Medicare approved amount* is the amount that Medicare determines is a reasonable payment for a medical service.

Medigap Plans A–N pay for the first three pints of blood each year, which are not otherwise covered by either Medicare Part A or Part B. Medigap Plans C and F pay the annual Medicare Part B deductible (\$166 in 2016).

Starting in 2020, "first dollar" supplemental Medicare insurance premiums, or so-called "Medigap" policies, will no longer cover the Part B Medicare deductible for new Medicare beneficiaries. F or C Medigap plans that currently carry no deductibles and no co-pays will not be available for persons purchasing Medigap policies in 2020 or later. Those who already have this coverage will be permitted to keep it.

Supplementing skilled nursing home coverage. Part A of Medicare pays all of the patient's skilled nursing home costs for the first 20 days of each benefit period. If the patient remains in a nursing home for more than 20 days, the patient pays a portion of each day's bill. Medigap Plans C–N pay a portion of the difference (\$161.00 per day in 2016) for days 21–100. There is presently no Medigap plan that pays for any skilled nursing home stay longer than 100 days in a benefit period.

Supplementing physicians who do not accept assignment. In situations in which a physician does not accept assignment, but treats Medicare patients, the physician is not accepting the approved Medicare amount as payment in full. In such a situation, the physician can charge the patient up to 15 percent more than the Medicare approved amount. Medigap Plans F, I, and J pay 100 percent of these excess charges. Medigap Plan G pays 80 percent of the excess charges.

Supplementing skilled home care. Medicare covers a limited amount of skilled home care given by a nurse or a physical, occupational, or speech therapist. Medicare does not pay for home health care for the activities of daily living, such as bathing and dressing. The patient pays for this type of care. Medigap Plans D, G, M, and N cover this type of home assistance if the patient is already receiving skilled home health care that is covered by Medicare. These plans cover home assistance for up to eight weeks after the patient no longer requires skilled care. There are, however, financial limitations because these plans will not pay more than \$40 per visit, seven visits per week, or a maximum of \$1,600 each year.

Supplementing foreign travel care. Medicare does not cover any health care received by a patient outside of the United States or its territories, with the limited exception of certain hospital stays in Canada or Mexico. Medigap Plans C–G and M and N cover some emergency care outside the United States. After the patient meets the annual deductible of \$250, this benefit pays 80 percent of the cost of the patient’s emergency care during the first 60 days of the patient’s trip. There is, however, a \$50,000 lifetime maximum benefit applicable to the patient.

Medicare SELECT. Medicare SELECT is a type of Medigap policy sold in some states that requires the use of hospitals and, in some cases, doctors, within its network to be eligible for full insurance benefits, except in cases of emergency. Medicare SELECT can be any of the standardized Medigap plans. The SELECT policies generally cost less than the other Medigap policies. A person with a SELECT plan who goes out of network will pay some or all of what the standard Medicare coverage does not pay.

Differences in Medigap policy costs. Note that Medigap Plans K and L offer similar coverage as Plans A–J, but there are different cost-sharing arrangements for the benefits provided, and there are annual limits on how much the patient must pay for services. The out-of-pocket limits are different for Plans K and L and are adjusted each year for inflation. For 2016, the out-of-pocket limits are \$4,960 for Plan K and \$2,480 for Plan L.

Renewals of Medigap coverage. Once a Medigap plan has been purchased, the insurance company must offer ongoing renewals. The insurance company may not change what is covered by the policy and may not cancel the policy unless the patient does not pay the premium. However, the insurance company can increase the premium and must notify the patient in advance of any such increases.

Premium costs will vary. Premium costs of comparable Medigap programs vary widely—by company, region of the country, and age of the person insured. For persons with low incomes, there is assistance. The Qualified Medicare Beneficiary Program typically covers cost-sharing for Medicare beneficiaries with incomes of up to 100 percent of the federal poverty level and assets of \$4,000 for an individual and \$6,000 for a married couple. The federal income limits for assistance in this program for 2016 are \$1,010 a month for an individual and \$1,355 a month for a married couple. Some states provide higher limits for assistance. These numbers are subject to change each year.

Planning Pointer. Is a Nonworking Spouse Eligible for Medicare at Age 65? A nonworking spouse is eligible for Medicare based on a working spouse’s work history when the nonworking spouse turns age 65 in the following circumstances:

1. The nonworking spouse is married, and the working spouse is eligible and has applied for Social Security benefits (either retirement or disability benefits), and the spouses have been married for at least one year when the nonworking spouse applies; or
2. The nonworking spouse and the working spouse are divorced, and the working spouse is eligible for, and has applied for, Social Security benefits (either retirement or disability), and the spouses must have been married for at least 10 years, and the nonworking spouse must now be single; or
3. The nonworking spouse is a widow or a widower and was married to the working spouse (who had at least 40 work credits and therefore was eligible for benefits) for at least nine months before the working spouse died. The nonworking spouse must be single at the time of application.

Consider a situation in which the non-working spouse turns age 65 before the worker spouse. Can the non-worker get Medicare, or must the non-worker wait until the worker turns age 65?

If the worker is at least age 62 and has worked for at least 10 years in Medicare-covered employment, the non-working spouse can get Medicare Parts A and B at age 65.

If the worker has worked at least 10 years in Medicare-covered employment but is not yet age 62 when the non-working spouse turns age 65, he or she will not be eligible for premium-free Medicare Part A until

the worker's 62nd birthday. In this case, the non-working spouse should still apply for Medicare Part B at age 65 so that he or she can avoid paying a higher Part B premium, unless the worker is still working and the spouse is covered under the worker's group health plan. The non-worker could then delay enrollment in Part B without paying higher premiums.

A problem could arise when the nonworking spouse is younger than the spouse who worked. Even if the spouse who worked is 65 and enrolled in Medicare, the nonworking spouse cannot enroll in Medicare until he or she turns age 65. There is an exception here if the nonworking spouse has been collecting Social Security disability insurance for at least 24 months.

Planning suggests determining whether any employer health coverage or retiree health benefits that the worker spouse may be eligible to receive will cover the medical expenses of the nonworking spouse until he or she reaches age 65 and can qualify for Medicare. In many situations, an older working spouse postpones his or her retirement until the younger nonworking spouse turns age 65 so that there is no gap in the younger nonworking spouse's health insurance coverage.

.08 Checklist of Medicare Mistakes to Avoid

1. Assuming you don't qualify for Medicare if you haven't worked long enough.
2. Failing to enroll in Part B when you should.
3. Believing you don't need Part B if you have retiree or COBRA coverage.
4. Thinking you must reach full retirement age before enrolling.
5. Not signing up for Part D because you don't take prescription drugs.
6. Misunderstanding enrollment periods.
7. Choosing a Part D Plan based on its premium cost.
8. Waiting too long to purchase Medigap with its full protections.
9. Failing to understand the Annual Notice of Change (of premiums).
10. Not realizing help may be available to lower costs (the Qualified Medicare Beneficiary Program).

¶3515 Medicaid

Medicaid is a program of government-financed medical care for specified groups of low-income people. It is a partnership program between the federal and state governments. A detailed discussion of it is beyond the scope of this chapter. Additional information about Medicaid is available online at <http://cms.hhs.gov>, which is the website for the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) administered by the U.S. Department of Health and Human Services. However, because many middle class individuals give their assets away in an attempt to qualify for Medicaid so that the costs of medical care will not wipe out their assets, this chapter provides some details on allowable income and resources. The treatment is brief and is not intended to be exhaustive.

The financial eligibility standards that govern Medicaid eligibility allow an individual, a couple, or a family to keep a small amount of income plus the following assets: a home, a car, personal and household items, (within limits) property essential for self-support, \$1,500 of cash value life insurance, burial spaces, very limited amounts of cash or cashable assets, and a few other resources. The government counts all additional income and resources when determining eligibility for Medicaid.

Most of the income that a single Medicaid recipient can keep while living at home becomes available to pay for nursing facility care if the individual enters a nursing facility. Medicaid covers long-term nursing facility care that Medicare rejects as custodial.

The Medicaid system has been significantly affected by the Affordable Care Act. The Affordable Care Act gave states the option to cover persons with income at 133 percent of the federal poverty level in their Medicaid programs in exchange for the federal government accepting all of the extra costs of benefits for several years. Many states accepted this program; many others did not. As a result, Medicaid availability varies widely from one state to another, and several million people have been added to the Medicaid rolls. The Affordable Care Act has generously accepted persons into the Medicaid health care coverage program based solely on their income and without regard to their level of wealth. In the short term, this will lead to higher costs of coverage for the increased number of eligible Medicaid recipients. Perhaps states will attempt to recover their costs from the assets of the estates of these persons when they die. Only time (and further political and court developments) will tell.

.01 Spousal Impoverishment

A primary concern of a married couple with one spouse in a nursing facility is that they will use a substantial portion of their income and resources to pay the facility. Thus, very little will be left for the spouse who is not in the nursing facility, referred to as the *community spouse*.

Income. The law addresses this issue by allowing the community spouse (the spouse who does not live in the nursing facility) to keep enough of the couple's income to raise his or her income to at least 150 percent of the federal poverty line for a couple. The community spouse can keep even more income if the income is in his or her separate name. Community spouses with costly shelter and utility needs within specific limits can keep some additional monthly income. The total monthly income that a community spouse can keep ranges from a minimum of \$1,939 (for 2016) to a maximum of \$2,980.50 (for 2016) unless a higher limit is established by a fair hearing or a court order.

Community spouses can keep a monthly income of \$69 or more (as determined by the state) as a personal allowance. They can also use some of their income to pay for non-covered or noninsured medical expenses that they incur and to maintain dependents.

Resources. The community spouse can keep a share of the couple's "countable resources" that is the greatest of (1) in 2016, a level between \$23,844 and \$119,220 established by the state, (2) one-half of the couple's countable resources if that half does not exceed \$119,220 in 2016, or (3) a higher limit established by a fair hearing or a court order. This amount is called the protected resource amount. The institutionalized spouse may transfer assets to the community spouse so he or she may obtain the greatest permissible share.

.02 Trusts

Individuals may think that they can use trusts to shelter assets that would otherwise render them ineligible for Medicaid. However, the law deems all of a trust's funds or payments that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to be available to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Any of the trust's funds or payments that are not available to pay for such care are deemed to have been transferred with a delay in Medicaid coverage as a result, and a 60-month delay in Medicaid coverage (the "look back period") applies. Exceptions apply for trusts that contain assets of disabled individuals under age 65, specific retirement income trusts in certain states, and "pooled" trusts managed by non-profit organizations for disabled individuals.

.03 Transfer of Assets

Portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁹ cast a shadow over asset transfers made to qualify for Medicaid. Effective January 1, 1997, it was a criminal misdemeanor or felony to knowingly and willfully dispose of assets in order for an individual to qualify for Medicaid or to assist in such transfers, within (1) 36 months of applying for Medicaid, in the case of an outright transfer, or (2) within 60 months of applying for Medicaid, in the case of a trust. Penalties included up to \$25,000

⁹P.L. 104 191.

in fines, up to 5 years in prison, and revocation of Medicaid eligibility for up to 1 year. These sanctions were to apply in addition to the delay of eligibility and recovery provisions discussed in the following text. This provision was amended on August 5, 1997. The amended rule applied only to those who, for a fee, advised an individual to make such a transfer. The penalty was to be a maximum of 1 year in prison and a fine of up to \$10,000. However, this provision was ruled as an unconstitutional infringement on the right of free speech under the First Amendment and never enforced.¹⁰

Medicaid eligibility for nursing facility or home and community-based long-term care is delayed for an individual who disposes of assets for less than fair market value on or after a look back date that is 60 months before the date on which the individual is both (1) a Medicaid applicant and (2) in an institution.

.04 Strategies to Gain Medicaid Eligibility

One of the most effective ways to gain Medicaid eligibility is to make gift transfers well in advance of applying for Medicaid and wait out the look back periods, now 60 months under the Deficit Reduction Act of 2005 (DRA). Transfers of assets between spouses, when one spouse is institutionalized, are exempt from the transfer penalties. (Refer to 42 U.S.C. 1396p(c)(2)(B).) However, the community spouse support requirements and the required pooling of resources make this strategy less attractive than it first appears. There are a number of other effective techniques for transferring family assets to achieve faster Medicaid eligibility. These strategies include the following:

- a. **Pay bills.** The payment of living expenses and the repayment of legitimate debt is not a gift or otherwise ineligible transfer that requires look back. Accordingly, if an individual has more cash than he or she would be allowed to retain, use some of the excess cash to pay off a mortgage on the person's residence. Since asset testing is measured from the time of institutionalization, such a debt should be repaid before the person has been institutionalized. If other debts are outstanding, such as car loans, credit card debt, or bills for professional services, these should be paid as well.
- b. **Exempt assets.** Planning suggests moving family assets into exempt asset categories noted in [¶3515](#) to the greatest extent possible.
- c. **Fix up the home.** The expenditure of funds for home improvements has the effect of moving assets from countable assets (bank balances, securities) to exempt assets (the home). All of those long-ignored projects can now be addressed appropriately.
- d. **Purchase a new home.** Sell the old home, and purchase a new, more expensive home. The transactions will move assets from countable to exempt. This may finally be the time for the client who has been a renter to become a homeowner.
 - i. **Caution regarding homes.** The previous suggestions regarding home improvement and purchase must be conditioned on another provision introduced into the law by the DRA. This law makes a person ineligible for Medicaid if he or she has equity in his or her home in excess of \$552,000, or at the state's option, \$828,000 (2016 numbers). This provision is indexed annually for inflation. The home with equity above these levels is a countable resource (to the extent of the excess equity) for Medicaid eligibility purposes unless the home is occupied by the applicant's spouse, a child under the age of 21, or a blind or disabled child.
 - ii. **Planning regarding homes.** If the community spouse is alive and healthy, consider purchasing an expensive home as a way to shelter family assets. The DRA does not affect a home occupied by the community spouse. If this is not desired or possible, consider using a reverse mortgage or home equity loan to reduce the value of the property owner's equity. However, be careful here. If the healthy spouse needs to apply for Medicaid, loan repayments cannot be made from his or her funds without denying Medicaid eligibility, so the home may be subjected to a forced sale to repay the home equity loan. Similarly, if the homeowner is absent from the home for

¹⁰*New York Bar Association v. Janet Reno et al.*, 999 F. Supp. 710 (N.D. N.Y. 1997).

a prolonged period of time, the terms of a reverse mortgage may require its repayment, and the necessary sale of the home.

- iii. **Transfer the home.** An effective strategy may be for the institutionalized spouse to transfer title to the home to his or her spouse, to a child who is under age 21 or who is blind or permanently and totally disabled, to a sibling who was living in the home for at least one year before the individual became institutionalized and who had an equity interest in the home, or to a child who resided in the home for at least two years immediately before the date the individual was institutionalized and who provided care that allowed the individual to reside at home rather than in an institution. If the home must be sold, nursing home residents enjoy a special tax benefit. All other persons must have lived in the residence for two of the preceding five years as a precondition to excluding the first \$250,000 of capital gain from income tax liability (\$500,000 for a married couple filing a joint return), but a nursing home resident needs to have lived in the residence for only one of the past five years. IRC Section 121(d)(7).
- iv. **Transfer the home to a defective grantor trust.** In this plan, the elderly person transfers (as a gift) a principal residence to a trust for the benefit of children. The grantor retains a power over the trust, such as the power of substitution, which makes the grantor taxable on the trust income, but keeps the trust property out of the grantor's estate. Children are named trustees of the trust. Next, the children, as trustees, sell the residential property. Because the parent is the trust grantor, the trust income is taxable to the parent. Assuming the parent met the two of five year use and ownership tests of IRC Section 121, the \$250,000 or \$500,000 exclusion may limit all of the taxable gain. Now, the children are holding the proceeds of sale of the home as the trust beneficiaries. They now use these funds to create a special needs trust for the benefit of the parent(s). Arguably, the children are the grantors and owners of that trust. As such, it will not be considered the property of the parents for Medicaid purposes, and any remaining unused balance will not have to be repaid to Medicaid upon the death(s) of the parent(s).
- e. **Purchase household or personal goods.** Although the Medicaid allowance for such items is only \$2,000, it is often not enforced, particularly against property such as furniture, clothing, and other personal items the value of which depreciates quickly after they are purchased.
- f. **Purchase a car.** If the community spouse purchases a new car when the other spouse is institutionalized, the purchase will constitute a permissible use of funds as part of a Medicaid "spend down." Nothing in the federal regulations mandates how expensive a car may be owned, though some states do impose limits that must be addressed. Therefore, this can be a good opportunity to spend down funds while continuing to enjoy what they are able to purchase.
- g. **Prepay funeral expenses.** Prepayment may be done either through the use of an irrevocable trust created for the purpose of paying funeral expenses, or by the irrevocable assignment of a life insurance policy for funeral services. There are no limits on the amount that can be prepaid, so items such as the gravesite, burial, perpetual care, or monument can be addressed.
- h. **Purchase an annuity.** Any immediate annuity purchased in which the annuitant's reasonable life expectancy is commensurate with the annuity's duration is deemed actuarially sound and does not constitute a transfer of assets subject to a penalty period. If an annuity is not actuarially sound, the transferor will be treated as having transferred assets without adequate consideration equal to the annuity's payout. (Refer to 42 U.S.C. 1396p(c)(1)(G)(ii)(II).) The purchase of an "actuarially sound" immediate annuity for the benefit of a community spouse not to be paid out longer than the actuarial life of the annuitant will not be considered a countable asset where it is irrevocable and non-assignable, and there is no way for such spouse to convert the annuity to cash to be used for his or her support and maintenance. Such annuities must provide for installment payments in equal amounts during their terms, with no deferral and no balloon payments. However, under the DRA, all annuities must be disclosed, and the state must be named to receive the remainder interest on a term-certain annuity up to the amount of Medicaid benefits paid on behalf of the institutionalized

spouse. (In the case of a person with a minor or disabled child, such child may be named the first contingent beneficiary of the annuity, with the state in second position). An annuity is not subject to the transfer of assets provisions if it is owned by an IRA or purchased with the proceeds of an IRA, a SEP or a Roth IRA. (Refer to 42 USC 1396p(e); 42 USC 1396p(c)(1)(F).)

- i.* **Cash in or assign life insurance policies.** Since only \$1,500 of cash value in a life insurance policy is an excluded resource, consider cashing in a more valuable policy and using the cash received to pay for an asset in one of the other excluded categories discussed earlier. Alternatively, consider transferring the policy to a younger generation family member. Such a transfer will be subject to the 60-month look-back rule, but will be measured only by the cash value of the policy, not the death benefit which will remain available to the family if the policy is transferred rather than cashed in.
- j.* **Purchase a life estate in a child's home.** The DRA provides a "safe harbor" for a parent's purchase of a life estate in another person's home (the child's home) so long as the parent paid full consideration for the life estate (based on the fair market value of the child's home and the parent's actuarial life expectancy) and the parent resides in the home for at least one year after the date of the purchase. If these criteria are satisfied, the payment by the parent will not be treated as a transfer for testing Medicaid eligibility purposes. (Refer to 42 USC 1396p(c)(1)(J).) The advantages of this technique to the parent include allowing the parent to remain in the community and allowing this transfer to avoid the five year look back rule. For the child, there will be a capital gain on the sale of the life estate, but at least a portion of the gain should be offset by a proportionate allocation of the child's cost basis in the home, as well as the use of a proportionate part of the available IRC Section 121 capital gain exclusion (\$250,000 for a single filer, \$500,000 for a joint filer).

Caution: If the child's home is subject to a mortgage, be careful of triggering the mortgage's "due on sale" clause. Permission of the lender may have to be obtained, as the law protects transfers to spouses and children from invoking the due on sale clause, but not transfers to parents. (See 12 USC 1701j-3.)

- k.* **Enter into a care agreement.** A parent may enter into a formal care agreement with a child whereby the child provides care to the parent for compensation, which will be income to the child. Such payments by the parent pursuant to a written agreement, prospective in nature, and providing for reasonable compensation, will not be subjected to Medicaid look back rules. Consider transferring the parent's residence to a child in exchange for personal care services. (Refer to *Reed v. Missouri Dept. of Social Services*, 193 S.W. 3d 839 (Mo. Ct. App. 2006).)
- l.* **Create a trust for a disabled person.** Transfers of otherwise countable assets into a trust for any disabled individual under the age of 65 are protected from the penalty provisions. A disabled person (via a parent, guardian, or court order) may transfer his or her own assets into a special needs trust to pay for things that Medicaid does not provide, and be granted Medicaid eligibility. Such a trust is subject to the obligation to reimburse the state for funds expended when the trust beneficiary dies. (See 42 USC 1396p(d)(4)(A).) This is *not* the same as a special needs trust created by a third party for the benefit of a disabled person. Such a trust, properly drafted, is not counted as a resource of the disabled person, and there is no obligation to use the assets of such a trust to reimburse Medicaid when the beneficiary dies.
- m.* **Consider notes and loan transactions.** For transfer of assets purposes, promissory notes, loans, and mortgages are considered transfers unless they include an actuarially sound repayment term as calculated by the Office of the Chief Actuary of the Social Security Administration; payments are made in equal amounts during the term of the loan with no deferral or balloon payments; and the document prohibits the cancellation of the balance upon the death of the lender. The note should contain a provision that it is non-assignable, that the lender cannot demand prepayment, and that the borrower cannot prepay the note. In *Sable v. Velez*,¹¹ the court found that an intra-family note designed to create Medicaid eligibility was a disqualifying resource and a "trust like device."

¹¹437 Fed. Appx. 73 (3rd Cir. 2011).

- n. Create a self-settled trust.** An individual is considered to have established a trust if the individual's assets were used to fund all or part of a trust and the trust was established by the individual, or the individual's spouse, or a person, court or administrative body acting on behalf or at the direction of the individual or the individual's spouse. (Refer to 42 USC 1396p(d)(2).)
- i. **Revocable trusts.** The principal of a revocable trust is considered a resource available to the individual, and any payments from the trust to or for the benefit of the individual are considered resources of the individual. Payments from the trust to third parties are considered assets disposed of or transferred by the individual. (See 42 USC 1396p(d)(3)(A).)
- ii. **Irrevocable trusts.** If an irrevocable trust is created, and there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the trust (principal or income, or both) from which payment to the individual could be made is considered a resource available to the individual. Actual payments made to or for the benefit of the individual are considered income to the individual. Payments made for any other purpose are considered a transfer of assets subject to the transfer penalty rules. (Refer to 42 USC 1396p(d)(3)(B).) Consider the creation of an income-only trust for the grantor with a duration limited to five years.
- iii. **Trusts with no retained interest.** If the trust income and principal cannot be distributed to the trust grantor, the trust will not be counted as a resource in determining eligibility for Medicaid. However, the creation of the trust and its funding will be considered a transfer of assets for less than fair market value and the 60-month look back period and possible transfer penalty rules will be applicable.
- iv. **Disability trusts.** Several specific types of disability trusts will be included in the determination of a person's eligibility for Medicaid.
- o. Use the half-a-loaf strategy.** Transfer half of a person's non-exempt assets and pay for the person's care with the remaining assets during the five-year penalty period.
- p. Use the reverse half-a-loaf strategy.** Transfer all of the assets, apply for Medicaid, incur the penalty for transferring assets within the look back period, and have the recipient return half the assets, thereby reducing the ineligibility penalty.
- q. Divorce the institutionalized spouse.**
- i. A far more drastic way to achieve a greater asset balance for the community spouse is to have him or her divorce the institutionalized spouse. This may be an appealing financial option when a family has assets far in excess of the community spouse resource allowance (such as substantial qualified retirement plan assets that could be transferred in divorce by means of a qualified domestic relations order), which would require substantial private pay support of the institutionalized spouse before Medicaid eligibility would be achieved.
- ii. Obviously, there are moral and emotional issues to address here beyond the financial issues, but this planning technique should not be ignored, particularly in the cases of families with more substantial wealth. A state could certainly attempt to challenge a divorce as being obtained for improper means, (that is, solely for Medicaid purposes) and refuse to recognize it, but even if such a challenge arises, there may be other factors (such as the prolonged incapacity of one of the spouses) that could be raised in justification.
- iii. A community spouse may receive an equitable distribution settlement in a divorce that may exceed the community spouse resource allowance. The community spouse may obtain an alimony award that may exceed the minimum monthly needs allowance. When a divorce is being considered, it must be viewed as an arms'-length transaction, each party must be represented by separate counsel, there must be full disclosure of the assets of all parties, and

the settlement agreement must be approved by a court after testimony and entered into the court record.

¶3520 Types of Social Security Benefits

The benefits that most persons think of when they say "Social Security" are of four basic types: old age or disability benefits for the worker; benefits for the dependents of retired or disabled workers; benefits for the survivors of a worker who has died; and the lump-sum death benefit. The following table describes these benefits in more detail and indicates the insured status that the worker must have before he or she may receive the benefits.

.01 Insured Status and Benefit Table

OLD-AGE OR DISABILITY BENEFITS	
<i>Monthly benefits can be paid to</i>	<i>If the worker</i>
a retired worker age 62 or over.	is fully insured.
a disabled worker under age 66.	would have been fully insured had he or she attained age 62 in the month the disability began (except in the case of a person disabled because of blindness) and has 20 quarters of coverage out of the 40 calendar quarters ending with the quarter in which the disability began.
a worker disabled before age 31 who does not have sufficient quarters of coverage to meet requirement.	has quarters of coverage in one-half of the quarters elapsing in the period after attaining age 21 and up to and including the quarter of becoming disabled, but no fewer than 6, or, if disabled in a quarter before attaining age 24, he or she has 6 quarters of coverage in the 12 calendar-quarter period immediately before he or she became disabled.
(A worker may be disabled after age 31 if he or she had a period of disability prior to age 31.)	
DEPENDENTS OF RETIRED OR DISABLED WORKERS	
<i>Monthly benefits can be paid to</i>	<i>If the worker</i>
the spouse of a person entitled to disability or retirement insurance benefits, if he or she is	is fully insured or insured for disability benefits, whichever is applicable, as shown previously.
<ul style="list-style-type: none"> age 62 or over (may be divorced spouse in certain circumstances) or 	
<ul style="list-style-type: none"> caring for a child who is under age 16 or disabled and entitled to benefits. 	
An unmarried child or grandchild (if parents are deceased) of a person entitled to disability or retirement insurance benefits if the child or grandchild is	is insured for retirement or disability benefits, whichever is applicable, as shown previously.
<ul style="list-style-type: none"> under age 18, 	
<ul style="list-style-type: none"> under age 19 if a full-time elementary or secondary school student, or 	
<ul style="list-style-type: none"> age 18 or over and under a disability that began before the child or grandchild reached age 22. 	

SURVIVOR'S BENEFITS	
<i>Monthly benefits can be paid to</i>	<i>If the worker</i>
a widow or widower (may be a surviving divorced spouse in certain circumstances) age 60 or over.	is fully insured.
a widow or widower and, under certain conditions, a surviving divorced spouse, if the widow or widower or divorced spouse is caring for a child entitled to benefits if the child is under age 16 or disabled.	is either fully or currently insured.
a disabled widow or widower (may be a surviving divorced spouse in certain circumstances), age 50 or over but under age 60, whose disability began within a certain period.	is fully insured.
An unmarried child or grandchild (if parents are deceased) of a deceased worker if the child or grandchild is	is either fully or currently insured.
<ul style="list-style-type: none"> • under age 18, 	
<ul style="list-style-type: none"> • under age 19 if a full-time elementary or secondary school student, or 	
<ul style="list-style-type: none"> • age 18 or over and under a disability which began before the child or grandchild reached age 22. 	
a dependent parent, age 62 or over, of the deceased worker.	is fully insured.
LUMP-SUM DEATH PAYMENT	
<i>The lump-sum death payment (\$255) will be paid in the following order of priority:</i>	<i>If the worker</i>
<ul style="list-style-type: none"> • The widow(er) of the deceased wage earner who was living in the same household as the deceased wage earner at the time of death 	is either fully or currently insured.
<ul style="list-style-type: none"> • The widow(er) (excluding a divorced spouse) who is eligible for, or entitled to, benefits based on the deceased wage earner's record for the month of death 	
<ul style="list-style-type: none"> • Children who are eligible for, or entitled to, benefits based on the deceased wage earner's record for the month of death 	
If no surviving widow(er) or child, as defined previously, survives, no lump sum is payable.	

.02 "Fully Insured" and "Currently Insured" Status

Forty quarters (credits) of coverage assure "fully insured" status for life. If a person reached age 62 in 1984, 33 quarters of coverage will suffice, with 34 required if he or she reached age 62 in 1985; 35 if he or she reached age 62 in 1986; 36 if he or she reached age 62 in 1987; 37 if he or she reached age 62 in 1988; 38 if he or she reached age 62 in 1989; 39 if he or she reached age 62 in 1990; and 40 if he or she reached age 62 in 1991 or later. In 2016, a worker receives one credit for each \$1,260 of earnings up to a maximum of 4 credits per year. Therefore, earnings of \$5,040 in 2016 will constitute qualifying for a full year of coverage. This earnings threshold will continue to increase with inflation.

Fully insured status means that an individual is entitled to full benefits, including retirement benefits.

¶3525 Computation of Social Security Benefits

The computation of benefits is quite complicated. The following steps are required:

- 1. Elapsed years.** Count the calendar years after 1950 (or after attaining 21, if later) and before the year in which the worker will attain age 62. In figuring disability benefits, the count ends the year before disability.
- 2. Computation years.** From the "elapsed years," deduct five years to get the "computation years." There are special rules for computing disability benefits.
- 3. Base years.** List the worker's earnings for each year beginning with 1951 and ending with the year before the year in which the benefits will begin. The following table lists the maximum creditable amounts for each year.

1951-1954	\$3,600	1989	48,000
1955-1958	4,200	1990	51,300
1959-1965	4,800	1991	53,400
1966-1967	6,600	1992	55,500
1968-1971	7,800	1993	57,600
1972	9,000	1994	60,600
1973	10,800	1995	61,200
1974	13,200	1996	62,700
1975	14,100	1997	65,400
1976	15,300	1998	68,400
1977	16,500	1999	72,600
1978	17,700	2000	76,200
1979	22,900	2001	80,400
1980	25,900	2002	84,900
1981	29,700	2003	87,000
1982	32,400	2004	87,900
1983	35,700	2005	90,000
1984	37,800	2006	94,200
1985	39,600	2007	97,500
1986	42,000	2008	102,000
1987	43,800	2009	106,800
1988	45,000	2010	106,800
		2011	106,800
		2012	110,100
		2013	113,700
		2014	117,000
		2015	118,500
		2016	118,500

4. Indexing. The earnings in step 3 must be indexed to national average earnings over the same period in accordance with the following listing of average earnings, **which are always two years “behind” in their calculation:**

1951	\$2,799.16	1980	12,513.46
1952	2,973.32	1981	13,733.10
1953	3,139.44	1982	14,531.34
1954	3,155.64	1983	15,239.24
1955	3,301.44	1984	16,135.07
1956	3,532.36	1985	16,822.51
1957	3,641.72	1986	17,321.82
1958	3,673.80	1987	18,426.51
1959	3,855.80	1988	19,334.04
1960	4,007.12	1989	20,099.55
1961	4,086.76	1990	21,027.98
1962	4,291.40	1991	21,811.60
1963	4,396.64	1992	22,935.42
1964	4,576.32	1993	23,132.67
1965	4,658.72	1994	23,753.53
1966	4,938.36	1995	24,705.66
1967	5,213.44	1996	25,913.90
1968	5,571.76	1997	27,426.00
1969	5,893.76	1998	28,861.44
1970	6,186.24	1999	30,469.84
1971	6,497.08	2000	32,154.82
1972	7,133.80	2001	32,921.92
1973	7,580.16	2002	33,252.09
1974	8,030.76	2003	34,064.95
1975	8,630.92	2004	35,648.55
1976	9,226.48	2005	37,197.43
1977	9,779.44	2006	38,695.99
1978	10,556.03	2007	40,375.23
1979	11,479.46	2008	41,334.97
		2009	40,711.61
		2010	41,673.83
		2011	42,979.61
		2012	44,321.67
		2013	44,888.16
		2014	46,481.52

The formula for indexing uses the worker’s actual earnings for a given year, national average earnings in the indexing year (which is the second year before the eligibility year), and national average earnings in the year being indexed, as follows:

$$\text{Worker's Actual Earnings} \times \frac{\text{Average Earnings in Indexing Year}}{\text{Average Earnings in Year Being Indexed}}$$

5. Primary insurance amount. The next step involves the use of another formula to find the worker's primary insurance amount (PIA). For the worker whose eligibility year is 2016, convert the average indexed monthly earnings (AIME) to a PIA by adding 90 percent of the first \$856 or less of AIME, 32 percent of any AIME above \$856 to \$5,157, and 15 percent of any AIME above \$5,157. The result rounded down to the next-lower multiple of 10¢ (if it is not already a multiple of 10¢) is the PIA.

The PIA is the amount payable to a retiree applying at normal retirement age (age 65-67 depending on the year of birth) and is the basis for computing almost all benefits. For example, retirement benefits at age 62 are a percentage of the PIA.

The PIA is increased by cost-of-living adjustments for the 3 preceding years in the case of a worker whose benefits commence at normal retirement age (age 65-67 depending on year of birth). On the other hand, the PIA amount of a worker whose benefits begin at age 62 would not be increased to reflect past cost-of-living adjustments.

Social Security benefit calculators can be found on the Social Security Administration website at www.ssa.gov.

.01 Increases in Benefits—Cost of Living Adjustment

Social Security benefits are subject to change to reflect increases of three percent or more in the Consumer Price Index (CPI).

If reserves in the old age and disability trust funds fall below 20 percent, the cost-of-living adjustment will be based on the lower of the increase in the CPI or the average increase in wages. There was no cost-of-living adjustment (COLA) for 2016.

.02 Delayed Retirement Credit

For each month a worker delays retirement past normal retirement age, the benefit he or she will get is increased based on a credit that varies depending on age. Workers born in the period 1917–1924 get one quarter of one percent per month (three percent per year). Persons born after 1924 get larger increases with a worker born after 1943 receiving a delayed retirement credit of eight percent per year. A surviving spouse's benefits are also increased under this rule, but other dependents' benefits are not affected.

When deciding whether to delay retirement and receive a larger benefit, the individual would have to consider the present state of his or her health and life expectancy to determine if more benefits will actually be received than at full retirement age. Other considerations would include availability of other funds for living purposes and spouse desires. Full retirement age is from age 65–67, depending on the year of birth.

<i>Year of Birth</i>	<i>Full Retirement Age</i>
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

.03 Checking the Status of an Individual's Account

The Social Security Administration has a toll-free telephone number (1.800.772.1213) that can be used to obtain Form SSA-7004, "Request for Social Security Statement." One may also access and print a request form at the Social Security Administration's website at www.ssa.gov. Alternatively, a request can be submitted online at www.ssa.gov/myaccount/.

Within a few weeks of submitting a request, an individual will receive a detailed packet of information called a "Social Security statement." The Social Security Administration mails a copy of an individual's Social Security statement annually within three months of an individual's birthday once the person turns age 60. Checking the status of an individual's account each year is important to ensure that the Social Security Administration has credited the correct amount of earnings to the account.

.04 Deciding When to Begin Receiving Social Security Benefits

An individual needs 40 credits of coverage to begin receiving Social Security benefits at age 62. If an individual begins receiving Social Security benefits at age 62, the amount is decreased by 5/9 of 1 percent for each month before full retirement age. Thus, if an individual's full retirement age is 65, the monthly benefits are 20 percent less than if the individual waited until age 65. If an individual's full retirement age is 67, the monthly benefits for starting benefits at 62 is about 30 percent less than they would be at age 67. To decide when to begin receiving Social Security benefits, one must consider the increase in benefits from waiting, possible taxation of benefits, loss of benefits because of earnings before full retirement age, life expectancy, and the rate of return that the recipient could earn on investments. In many cases, if the recipient is not earning over the amount at which he or she would lose benefits, the recipient will be better to begin receiving benefits at age 62. However, the financial planner should evaluate each case on its own and consider all relevant facts to advise a client properly. Statistics indicate that most persons eligible for Social Security benefits begin receiving such benefits at age 62.

¶3530 Avoiding Loss of Social Security Benefits

.01 Working While Receiving Benefits

In 2016, a person under full retirement age can earn up to \$15,720 (\$1,310 per month) without loss of Social Security benefits. If the individual has reached full retirement age, the individual will not lose any Social Security benefits because of earnings. The loss of benefits for earnings in excess of the threshold amounts is \$1 for every \$2 in excess monthly earnings for retirees under full retirement age. Once the

individual reaches full retirement age (age 65–67), he or she can earn an unlimited amount without loss of Social Security benefits.

In the first year of eligibility, a monthly test also applies to the months in the year before the individual attains full retirement age. A worker who is under full retirement age for any month in 2016 and retires in 2016 after attaining full retirement age is entitled to a full benefit for any month in which he or she neither earns more than \$3,490 nor is substantially self-employed, regardless of his or her total earnings for the year. On the other hand, if the worker earns more than \$3,490 in any month before reaching full retirement age (annualized at \$41,880), he or she will lose one \$1 of benefits for every \$3 of excess earnings.

The earnings limitation for a Social Security recipient under full retirement age may create a substantial disincentive for work that provides significant earnings. The results will vary depending on several factors:

- The amount of benefits the individual would be entitled to if he or she did not continue to work.
- In the case of a married participant, the amount of benefits, if any, that the individual's spouse would be entitled to.
- The extent to which benefits would be taxed if they were not lost because of earnings.
- The amount of earnings and Social Security taxes thereon.
- The individual's income tax bracket.
- The value of any delayed retirement credit.

.02 Escape Hatch

Income from self-employment is counted in the year in which it is received, except if it is paid in a year after one becomes entitled to Social Security and was earned before the recipient became entitled to Social Security.

On the other hand, the earnings of an employee are counted in the year in which they are earned, regardless of when they are received.

If an individual eligible for Social Security benefits is legitimately self-employed and is able to work out a deferred compensation arrangement with the person for whom he or she performs services, the individual apparently will be able to have earnings in excess of the Social Security earnings limitations without losing benefits. If the deferred income is not actually or constructively paid until he or she attains full retirement age (65–67), no loss of benefits will result. Even a deferral for a year could prove helpful as enabling the individual to retain benefits for the year of deferral.

¶3535 Social Security Planning Issues—Questions, Answers, and Case Studies

1. *The worker retired at full retirement age several months ago and began receiving the full Social Security retirement benefit. The worker is now working part-time, and his employer is deducting FICA and Medicare taxes from his paycheck. Will these additional earnings affect future Social Security payments?*

Future benefits may increase depending upon how the current paycheck compares to earnings received prior to retirement. Social Security retirement benefits are based upon the 35 highest-earning years of work, with reported earnings for past years indexed to reflect inflation. Each year, the Social Security Administration reviews the records for all recipients who work and automatically increases benefits as appropriate. By the fall of the year following the year in which the work occurs, the Social Security Administration should have determined whether the earnings were sufficient to increase the benefit, and any increase would be retroactive to that January. If the worker is receiving larger paychecks than were received during some of the 35 highest-earning years, his or her larger

paychecks would replace the lower ones in the government's calculation, and the monthly benefit would increase accordingly.

2. *The worker was forced to retire at age 60 and does not expect to be employed going forward and will not contribute to the Social Security fund. The projections the worker has seen for his benefit are based on working until age 66. Will his benefit be reduced if he does not work for the next 6 years?*

The amount estimated on the annual statement will be high for this worker. Social Security assumes that a person will work until normal retirement age when it calculates the estimated benefit. The government indexes actual earnings to account for changes in average wages since the year the earnings were paid until the worker turns age 60. There is no indexing for the wages earned in the years the worker turns age 61 or later. It then calculates average monthly indexed earnings during the 35 years the worker was paid the most. Cost-of-living adjustments are added to the worker's benefit beginning with the year the worker turns age 62, even if the worker does not start collecting benefits until full retirement age or later. Finally, a formula is applied to those earnings to calculate the basic benefit, called the primary insurance amount (PIA), or the amount the worker would receive at full retirement age. There is an online tool to help the worker pinpoint a more precise estimate. Go to www.socialsecurity.gov/estimator and input the exact information, including earnings on record and the anticipated retirement age.

3. *The worker is planning to travel or live outside the United States. Can the worker continue to collect Social Security retirement benefits?*

Yes. Although living or traveling outside the United States will make Medicare benefits unavailable, Social Security retirement benefits will continue no matter where the person lives.

4. *The worker retired at age 62 and applied for Social Security benefits. The worker then received a severance payment from his former employer. Will this severance payment count as wages that will result in the reduction of the Social Security benefit?*

If the payment to the worker is, in fact, considered wages, it will count against the worker and reduce Social Security benefits. If, however, the payment can be characterized as a pension payment, it will not be treated as wages and will not reduce Social Security benefits. As a general rule, the receipt of severance payments or a buyout from the employer are reflected on Form W-2, which would suggest they are considered part of earnings that could reduce Social Security benefits. If the payments are reported on Form 1099-R, they would then appear to be retirement-related and arguably not wages or compensation. Timing is important here because if full retirement age has been reached, there is no benefit reduction even if the payments are considered wages or compensation. There is some good news here, even if the payment is found to be compensation. If a worker has Social Security retirement benefits withheld because the worker earns too much money, the benefits for that worker are increased, starting at full retirement age, to take into account the months in which benefits were withheld. There may not be a full restoration of the lost benefits, but there is an adjustment calculated by the SSA in the worker's favor.

5. *Is there an annual minimum cost-of-living adjustment for Social Security benefits, regardless of whether there has been an increase in the cost of living?*

No. If there is no annual increase in the cost of living, there will be no increase in Social Security benefits. If there is deflation, Social Security benefits will not be reduced.

6. *The worker began receiving Social Security payments at age 62 and has now reached age 70. Can the worker return all the money collected from age 62 until the present and restart collecting Social Security benefits?*

No. The Social Security Administration had previously allowed the worker to pay back Social Security retirement benefits and file a new application allowing the worker to receive larger monthly

checks based on the older age. To do this, the worker would have filed Social Security Form 521, "Request for Withdrawal of Application." When the worker returned the past benefits, he or she did not owe any interest, and there was no adjustment for inflation. However, rules issued effective December 8, 2010 eliminated this repayment opportunity. Workers are now allowed one repayment decision to return the benefits received in a single lump sum with no interest due. However, if the worker changes his or her mind 12 months or more after becoming entitled to benefits, the application for benefits may not be withdrawn. The worker is limited to one withdrawal per lifetime, within 1 year of beginning benefits.

Another similar strategy, referred to as the *hedge your bet* strategy, had allowed a person to suspend benefits after reaching normal retirement age and then elect to claim a reinstatement of the suspended benefit and receive a lump sum in exchange for relinquishing the delayed retirement credits beyond normal retirement age. This strategy has been completely eliminated by the Bipartisan Budget Act of 2015, effective November 2, 2015 (BBA 2015). Now, when a claim for benefits is made, the benefit to which the person is entitled at the time of the claim will be paid, with no retroactive lump sum available.

7. *If both husband and wife receive separate Social Security benefits on their own earnings and one dies, does the survivor receive half of the benefit of the deceased partner? Would the survivor get both benefits or one or the other?*

The key factor to answer this question is the age of the survivor when the spouse dies. If the survivor has already reached full retirement age when the spouse dies, the survivor will generally be eligible to receive the deceased spouse's full benefit, assuming that the deceased spouse's benefit is larger than the survivor's benefit, based on earnings history. If the survivor has not reached full retirement age when the spouse dies and claims a survivor's benefit, the survivor will be eligible for a lesser amount than 100 percent of the deceased spouse's benefit. If a spouse dies and the survivor receives or is eligible for a Social Security retirement benefit based on the survivor's own earnings record, the survivor can either collect his or her own benefit or the survivor benefit, but not both at the same time. A surviving spouse can begin collecting survivor benefits as early as age 60, but at a reduced rate. There are a number of possible options to consider here. If advantageous, a surviving spouse can choose to take a survivor benefit at age 60, (age 50 if disabled) or his or her own reduced retirement benefit at age 62, and then switch to the larger full retirement or survivor payment, whichever he or she had not opted for earlier, upon reaching full retirement age.

8. *For a married couple, does it make sense for one spouse to take Social Security at normal retirement age, and the other to delay until age 70?*

If one spouse waits until age 70, that would increase that spouse's Social Security benefit. It does make a difference which spouse takes the benefit at full retirement and which one postpones until age 70, but the difference is not realized until one spouse dies. At that time, the survivor is better off if the higher earning spouse waited until age 70 because the surviving spouse is entitled to the larger of the two spouses' benefits.

One of the best ways to maximize income at later ages is for the high earner to delay retirement benefits until age 70. Assume, for example, the husband was the higher earner and delayed benefits until age 70, and the wife took her own retirement benefit at age 62 at a reduced level. After the husband dies, the wife may switch to the larger survivor benefit. Whether she had taken an early retirement benefit based on her own earnings record or her husband's record would not affect her survivor benefit. What does affect the survivor benefit is the widow's age when she starts taking that benefit. Depending upon the year of birth, the full retirement age may or may not be the same for Social Security retirement benefits and survivor benefits. If the wife was born in 1956, her full retirement age for taking retirement benefits is 66 and 4 months, but her age for survivor benefits is 66. One's full retirement age and percentage reductions for workers and spouses who start collecting at age 62 for each type of benefit is found online at www.ssa.gov/retire2/agereduction.htm.

If the widow has already reached her full survivor age when she files for a survivor benefit, she generally is eligible for her deceased husband's full benefit. She could start collecting a survivor benefit as early as age 60, but that would be at a reduced rate. If the husband dies before his full retirement age of 66, having never taken Social Security retirement benefits, the widow's survivor benefit would be based on his full retirement benefit at age 66. If he dies after age 66, the survivor benefit includes any delay credits the husband may have accrued.

Another strategy that spouses may employ would be to have one spouse, upon reaching full retirement age, file for only that spouse's spousal benefit and not that spouse's earned benefit. Assume that the applying spouse will receive one-half of the benefit of an older spouse. The younger spouse may then wait until age 70 to collect on his or her own work record, thereby receiving delayed retirement credits, which will increase that spouse's benefit compared to what could have been collected at full retirement age. Presumably, with the delayed credits, the earned benefit at age 70 will exceed the otherwise available spousal benefit.

Note: Under the BBA of 2015, restricted applications for benefits are limited to people who were age 62 and older in 2015; that is, born on or before January 1, 1954. The opportunity remains available even if it means waiting as long as four years to actually implement this technique.

If the client is younger than age 62 before January 1, 2015, this strategy is no longer available. For those persons for whom this strategy is not available, the new rules provide that filing for spousal benefits will be deemed by Social Security to also trigger the applicant's own retirement benefit, and the person will receive the greater of the two benefits.

When considering these spousal strategies, note that individuals who are younger than full retirement age do not have the option of filing for a spousal benefit without also being deemed to have filed for an earned benefit. One cannot start collecting a reduced spousal benefit before full retirement age and then later switch to an unreduced benefit based on one's own earnings. Accordingly, waiting until full retirement age is central to many of the spousal strategies.

9. How exactly does the spousal benefit for Social Security work?

A married person collects Social Security based on the other spouse's earnings record when the first spouse's own Social Security benefit would not equal or exceed 50 percent of the other spouse's benefit. If one spouse has reached full retirement age and the other reaches age 62 and decides to start receiving benefits, the spouse age 62 would receive 35 percent of the other spouse's benefit amount. If, instead of taking benefits at age 62, the spouse waited until full retirement age, such spouse would be entitled to 50 percent of the other spouse's benefit amount. One spouse cannot collect Social Security based on the other spouse's record until the other spouse files for benefits. To determine one's individual benefit calculation, go to www.ssa.gov/OACT/quickcalc.

There is no marriage penalty under Social Security. That is, two single persons are not better off remaining single and collecting their own benefits as opposed to marrying. Marrying will not reduce a person's Social Security retirement benefit, but might increase it, because married individuals receive the higher of two benefits (that is, the one they are entitled to based on their own work record or the one based upon the spouse's work record). Also, upon the death of one of the spouses, the survivor may be entitled to a survivor benefit that is larger than his or her own earned retirement benefit.

10. What are the rules regarding Social Security benefits for divorced couples?

A divorced spouse can collect a Social Security retirement benefit based on the work record of an ex-spouse, and it will not affect the latter's retirement benefit or the benefit of that person's current spouse, if he or she has remarried. The Social Security Administration will not notify a person if an ex-spouse collects a retirement benefit based on that person's earnings record. As a general rule, a

divorced spouse who has never worked is allowed to claim Social Security based on the record of a working ex-spouse. For the divorced spouse to collect on that record, the worker must be at least age 62 and collecting or eligible for Social Security retirement benefits. The divorced spouse also must be at least age 62 and unmarried.

The benefit available to the divorced spouse of a worker is generally equal to half the worker's retirement benefit at his or her full retirement age. That amount is available only if the divorced spouse waits until his or her own full retirement age to start collecting benefits. If benefits are taken earlier, such as at age 62, the monthly benefit is permanently reduced to 35 percent of the worker's benefit.

An important requirement in the divorce context is that the couple must have been married for at least 10 years before the divorce became final for the divorced spouse to collect Social Security based on the other spouse's work record. If the divorced spouse remarries prior to age 60, he or she generally no longer qualifies for a retirement benefit based on a former spouse's work record. However, if a divorced spouse waits to remarry until after age 60, he or she can still qualify for a widow or widower's benefit when the former spouse dies, assuming the divorced spouse is not married at the time. To receive the largest monthly check possible, the divorced spouse should wait until his or her own full retirement age to start collecting benefits.

11. How is Social Security calculated for disabled children?

From birth to age 18, children may receive monthly payments under the Supplemental Security Income program (SSI) if they have impairments that meet the Social Security definition of *disability* for children, and the family income falls below certain limitations. If the children are not eligible for SSI because the family has too much income, they may become eligible for SSI at age 18. At that point, the income of the parents will no longer be counted in the financial limits for the children. In order to qualify, the children must be unable to do "substantial" work, meaning they are unable to earn more than \$1,130 (in 2016) per month. The substantial gainful activity threshold for blind persons is earnings of more than \$1,820 (in 2016) per month. There is also a "trial work period" threshold of \$810 per month in 2016.

Once children turn age 18, they may also qualify for a benefit based upon the work record of their parent. However, they will have to wait until the parent begins to collect Social Security retirement benefits to qualify for those payments. Under the Social Security Disability Insurance program (SSDI), adult children age 18 or older may receive monthly payments if they meet three conditions, namely

- the impairment or combination of impairments meets the Social Security definition of disability;
- the disability began before age 22; and
- one of the parents worked long enough to be insured under Social Security and is either receiving retirement or disability benefits or has died.

Even though the general rule of thumb is that dependents receive one half of the worker's retirement or disability benefit amount, the actual amount depends on three factors: the worker's earnings record, the timing of the worker's retirement benefit claim, and the number of dependents. If the family includes more than one dependent, the benefit paid to such dependents is combined into a family benefit amount. That amount could be less than the payments the worker and separate dependents would receive if the benefits were paid separately. The family could receive as much as 180 percent of the retired worker's benefits, but the exact amount will depend on a complex Social Security formula. The worker's benefit would not be reduced, but the dependents' benefits could be reduced proportionately if the family's total benefit exceeds the family benefit amount limit.

The maximum family benefit does not apply to spouses when each spouse is collecting retirement benefits based on his or her own work record.

12. *What is the planning technique called "file and suspend"?*

Note: The file and suspend strategy has been eliminated by the BBA of 2015 for persons other than those who are age 66 or older and who filed to suspend their benefits by April 29, 2016. Persons who elected to file and suspend before the April 29, 2016 deadline and submitted their application before such date are not affected by this change in the law. People may still suspend their receipt of benefits beyond normal retirement age and receive the enhanced benefit until age 70.

The rules after April 29, 2016 provide that a new filer will no longer have the option to receive benefits on anyone else's work record while their benefits are suspended, and no one else (including dependent children) will be able to receive benefits on a person's work record while that person's benefits are suspended.

An exception to the preceding rule applies to divorced spouses who may collect on their ex-spouse's benefits, even if the ex-spouse has suspended his or her benefits.

Note also that the rules enacted in BBA 2015 do NOT apply to Social Security survivor benefits. Widows and widowers will still be able to optimize the timing of when to start both Social Security survivor benefits and Social Security retirement benefits. They may still claim survivor benefits and still defer their own retirement benefits, if that will result in the optimal benefit amount.

Guidance on these points is available at www.socialsecurity.gov/planners/retire/suspend.html.

When it is, or has been, available, the file and suspend planning technique involves the higher earning spouse filing for his or her benefit at full retirement age (assume age 66) and then immediately suspending his or her claim. This allows the lower earning spouse to begin collecting spousal benefits upon attaining age 66, which may be higher than the lower earning spouse's own attained benefit at that age. When the higher earning spouse attains age 70, that spouse can qualify for the enhanced benefit available for persons who waited until age 70 to claim their benefit. The amount paid to the lower earning spouse at that time is not increased, unless the higher earning spouse dies, in which case the lower earning spouse then receives the enhanced survivor benefit.

The lower earning spouse can collect on his or her own benefit at age 62 but may not collect the spousal benefit until the spouse actually files for his or her own benefit, hence, the file and suspend technique.

Another variation of this technique was to have the lower earning spouse collect his or her full benefit and not suspend that benefit, have the higher earning spouse collect only his or her spousal benefit from age 66–70, and then apply for his or her own enhanced benefit, which will be 32 percent greater at age 70 than it would have been at age 66 with no penalty. This "restricted benefit" by one spouse may now only be done if the spouse seeking the restricted benefit was born on or before January 1, 1954.

Planning Pointer. Additional Resources from the AICPA PFP Division.

For more information on planning for Social Security and retirement health care financing, access *The CPA's Guide to Social Security Planning* (available [free to PFP/PFS members](#) and for [sale to nonmembers](#)) and *The CPA's Guide to Financing Retirement Healthcare* (available [free to PFP/PFS members](#) and for [sale to nonmembers](#)) at aicpa.org/pfp/retirement.

