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Demystifying Social Security and Medicaid Benefits

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SUMMARY OF SOCIAL SECURITY PROGRAMS

There is great confusion in the public regarding Social Security programs. Eligibility for some of these programs is dependent upon the recipient's income and assets, while eligibility for others is not. The following is a brief and basic description of the most common Social Security programs and their eligibility criteria.

The Social Security Administration (SSA) provides cash payments for basic food and shelter for disabled persons of limited income and assets through the Supplemental Security Income program. SSA also provides disability payments for workers who become unable to work due to disability, retirement benefits for a retired worker, and child's benefits, spousal benefits, widow's and widower's benefits, disabled adult child's benefits, and mother's and father's benefits for the worker's dependents and survivors. The key to receipt of these latter benefits is that there is a worker on whose earnings record benefits can be paid, and closely related family members who are dependents or survivors have a relationship to the worker. The benefit amount is based entirely upon the worker's earnings on which Social Security taxes were paid. Each dependent or survivor classification will receive a percentage based on the worker's Social Security record, but benefits might be reduced due to receipt of benefits on the dependent's or survivor's own Social Security record, receipt of workers' compensation, receipt of government pensions, or due to receipt of maximum family benefits on the record of any worker.

It is not uncommon for family members, social workers, or even attorneys to confuse Social Security insurance benefits with Supplemental Security Income. The SSA commonly uses similar acronyms such as OASDI, SSDI, and SSI when describing the benefits. The most defining method to find out which type of benefit that the person is receiving, other than reviewing a Social Security or SSI entitlement letter, is to determine what day the check arrives. If on the third or some other day later in the month, it will always be a Social Security insurance benefit. If on the first of the month, it is Supplemental Security Income. Individuals may be eligible for both programs if disabled or elderly. As most checks go by direct deposit, ask to see the last bank account statement.

A. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) (42 U.S.C. § 1381 et seq., 20 C.F.R. § 416) is a federally-administered Social Security program that provides monthly payments for ***food and shelter*** needs to persons who are aged, blind or disabled and whose assets and income are low enough to meet a "means test". There are **three categories of SSI eligibility**: aged by being age 65 or older; disabled by meeting the Social Security definition of disability;

and by being blind by meeting the Social Security definition of blindness. Other general eligibility requirements are: a U.S. resident for 30 days or longer; U.S. citizenship or "lawfully present" alien status; not living in institution, including a correctional facility, for more than 30 days, except if Medicaid pays for more than 50% of the care; no current parole violations or outstanding warrants in connection with a felony.

SSI is a federally uniform program, and unlike Medicaid that has a strong state administration component, all SSI rules and interpretations generally come from one source, the SSI policy office in Baltimore. The SSI program policies are found in the Program Operations Manual System (POMS) online at https://secure.ssa.gov/poms.nsf/home!readform. SSI recipients must meet the same disability criteria as for SSDI; however, it is **not** necessary that a person have worked or paid Social Security taxes to be eligible for SSI. An SSI recipient may have only limited "countable income" (maximum **$841** for individual, **$1,261** for couple) (2022) and limited "countable assets" (maximum $2,000 countable assets for individual, $3,000 for couple). Since the SSI program is intended to provide a minimal level of support assistance and pays a maximum monthly payment of $841, any other ***countable*** income received by the SSI recipient (through alimony, gifts, earnings, trust disbursements, etc.) will reduce this payment dollar for dollar. Therefore, countable income of $841 or more per month will disqualify the recipient for SSI benefits. Not all types of income are fully counted. All *unearned* income (such as alimony, interest, dividends, Social Security payments, rent payments) is countable. Only two-thirds (2/3) of child support payments from an absent parent are countable income to the child. POMS SI 00830.420(B)(1). For *earned* income, the first $85 and one-half of the remaining earned income are not counted (as well as certain disability-related expenses necessary for employment, called "Impairment Related Work Expenses" or IRWE). Therefore, a person with only earned income of up to $1,765 may be eligible for at least one dollar of SSI payment each month, but a person with unearned income (such as a Social Security Disability or Survivor's payment, or trust or rental income) of $841 or more will not be eligible for any payment from SSI. Also, the "countable resources" (assets) limit is $2,000 for an individual and $3,000 for a couple. Certain assets are not counted (including the home, one automobile, household contents, burial spaces, life insurance up to $1,500, and assets held in certain "special needs" trusts). The general income and resources policies are set forth below.

Income: "Income" is generally defined for **SSI** purposes as anything of value received during a month which could be used to purchase food or shelter support. 20 C.F.R. § 416.1102. Income does not include: medical care and services; social services; proceeds from sale or exchange of a resource; income tax refunds; payments from credit life or credit disability insurance; loan proceeds; payments made to others for non-food/shelter items or services. 20 C.F.R. § 416.1103. "Earned income" includes gross wages and net earnings from self-employment, including in-kind payments. 42 U.S.C. § 1382a(a); 20 C.F.R. § 416.1110. "Unearned income" includes: payments from trusts or annuities, pensions, Social

Security benefits, disability benefits, veterans' benefits, railroad retirement, unemployment compensation, alimony or other support payments; dividends, interest and royalties; rents (net of lease expenses); life insurance benefits, gifts and inheritances; prizes and awards; and in-kind support and maintenance. 42 U.S.C. § 1382a(a)(2); 20 C.F.R. § 416.1121. "Countable income" for SSI purposes is calculated by subtracting from the individual's total earned and unearned income various amounts, including the first $20 of unearned income, the first $65 of earned income, earned income used to pay impairment-related work expenses of a disabled (not blind) person, and one-half of the remaining earned income. Income from non-eligible family members can be "deemed" available to the SSI applicant. Food and shelter expenses paid for by another (including by a trust) is considered "in-kind support and maintenance" (ISM) and will generally reduce the recipient's SSI payment by one-third (if the recipient resides in the household of another) or by one-third plus $20 (if the recipient lives in a household other than that of the person providing ISM).

The SSI benefit will be decreased dollar for dollar by the individual's other countable income until the SSI benefit becomes $0 at the maximum SSI payment level for the individual's category. Money or goods received in a particular month are considered income for that month. If the same money or goods are retained in the following month(s), they become a resource and cannot exceed the countable resource level. Income of an ineligible parent (for children under 18) or ineligible spouse living in the same household is "deemed" or considered as available, after certain deductions, for SSI eligibility purposes to the eligible individual.

EXAMPLE: Mary is disabled and has $40 per month in interest income and earns $1,000 at her job. Her eligibility under SSI income rules is calculated as follows:

Total **countable unearned** income: $20 ($40 interest - $20 deduction)

Total **countable earned** income: $467 ($1,000 - $65 deduction = $935; $935 ÷ 2 (one-half reduction) = $467.50 rounded down to $467)

Total countable income: $487 ($20 unearned + $467 earned)

Therefore, **Mary is eligible for an SSI payment of $354** ($841 maximum payment - $487 countable income)

EXAMPLE: Assume that an individual receives monthly Social Security benefits of $300, interest on savings of $10, work earnings of $395, a distribution from a special needs trust paid to the beneficiary of $100, and Food Stamps valued at $150. The countable income calculation is as follows:

	$300	Social Security
+	10	interest
-	(20)	unearned income disregard
+	$395	work income
-	(230)	earned income disregard ($65 + 1/2 the remainder)
+	100	trust distribution for shelter expenses
=	**$555**	**countable monthly income**.

The Food Stamp payment is not counted because it is considered excludable assistance payments. If a Shared or Living Alone federal benefit rate of $841 is applied, the monthly SSI benefit would be $286, ($841 – $555).

In another example, a supplemental needs trust trustee makes rent payments each month directly to the beneficiary's landlord in the amount of $500. The SSI program has a rule that states that any in-kind payment for food or shelter related expenses **("in-kind support and maintenance"** or **ISM**) will reduce the SSI benefit. Stated simply, ISM distributions are a dollar-for-dollar reduction of the beneficiary's SSI, but with a cap. The reduction can be either one-third (1/3) (the value of one-third reduction, or **"VTR" rule**) or one-third (1/3) + $20 (the presumed maximum value, or **"PMV" rule**), depending upon the beneficiary's living arrangement. The 1/3 reduction is one-third of the federal benefit rate (FBR), **not** 1/3 of the beneficiary's SSI payment. This means that ISM distributions **can** eliminate a beneficiary's SSI in some cases.

Under the VTR rule, the beneficiary's SSI is reduced by one-third when s/he lives throughout a month in another person's household and receives **both** food and shelter from others living in the household. This reduction in the FBR has an income value, known as the value of the one-third reduction, or VTR." POMS SI 00835.200.A.1.a.

Under the PMV rule (that is, when the VTR rule does not apply), the calculation is "one-third the federal benefit rate (FBR) in effect for the month in which ISM is received for an individual or an eligible couple, plus $20." POMS SI 00835.300.C.2

Resources: "Resources" for **SSI** purposes refers to any cash, liquid assets, real or personal property of the individual or spouse that can be converted to cash to pay for support. 20 C.F.R. §416.1201. All funds in jointly-owned accounts that can be withdrawn by the recipient are considered the recipient's resources, regardless of source of the funds. Assets received are considered income in the month received and resources as of the first moment of the next month. Excess resources of a non-SSI family member, like income, can be "deemed" to be resources of the individual SSI recipient. The following resources, among others, are considered "non-countable" or exempt for SSI eligibility purposes: entire value of individual's home and land adjacent to it; "current market value" (CMV) of household goods, personal effects up to $2,000, and wedding/engagement rings and disability-related equipment regardless of value; CMV of an automobile of any value; trade or business assets necessary for claimant's self-support; non-business property essential for self-support; all term life insurance; cash value of all life insurance if the total face value of cash value policies is $1,500 or less; cash or in-kind replacement to replace or repair a lost or damaged resource (such as casualty insurance proceeds) if used for that purpose within nine months; value of burial spaces for claimant or entire family; up to $1,500 for an individual ($3,000 for a couple) of burial expense fund; and federal or state disaster relief funds. 42 U.S.C. §1382b(a); 20 C.F.R. §416.1210. **Assets held by a guardian or conservator are considered countable resources of the ward**.

Mississippi has **automatic Medicaid eligibility** for those individuals that receive any amount of SSI. Other Medicaid coverage groups have separate eligibility criteria. Careful consideration of the program rules of each program must be given when drafting a "special needs trust" designed to maintain eligibility for such benefits.

One component of an individual's SSI benefit rate is the **"living arrangement"** of the individual, roughly based on the formula that those individuals living alone need a higher income level than those sharing expenses, living in a group home, or receiving Medicaid paid care in an institution. For example, in 2022, the Federal rate for individuals "Living Alone" or in a "Shared Living" arrangements is $841 per month. If Living In the Household of Another" (food and shelter provided by a third party), the Federal rate is $561.

This is particularly important when trying to decide whether or not to create a trust to obtain or protect SSI eligibility. If expected in-kind distribution amounts exceed the difference between the individual's other countable income and the individual's maximum SSI payment standard, then the individual will lose SSI anyway, and a non-special needs trust may avoid an unnecessary Medicaid payback on death. For example, if the state has a $841 SSI rate and in-kind payments will exceed $280 each month, and other countable income exceeds $561 (also factoring in the $20 unearned income disregard amount), then no SSI would be payable at all.

The income and resources of some ineligible persons living with an eligible person are "deemed" or considered as available to the eligible person in considering the eligibility and payment amount, even if the income and resources are not actually provided to the eligible person. The ineligible persons whose income and resources are deemed are allowed an allocation for a "living allowance" which is not counted. The principal categories of deeming include a spouse to spouse and a parent to a child under age 18. The same rules for calculating the effect of the resources or income on eligibility apply as if the resources and income belonged to or was received by the eligible person. For example, resources of two parents deemed to a child have the resource limit of a couple, $3,000. Income of an ineligible spouse uses the same earned and unearned income exclusions and disregards as if the income were received by one member of an eligible couple.

B. Social Security Disability Income (SSDI).

Social Security Disability Income (SSDI) (42 U.S.C. § 401, 423; 20 C.F.R. § 404.315) is designed to pay a monthly income to persons who are not yet retired and eligible for Social Security Retirement, but who have worked and paid into the system and have become "disabled" as defined in 42 U.S.C. § 1382c(a)(3). This law states that a person is disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in

death or which has lasted or can be expected to last for a continuous period of not less than twelve months. . . an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." In general, to get disability benefits, you must meet two different earnings tests: (1) A "recent work" test based on your age at the time you became disabled; and (2) a "duration of work" test to show that you worked long enough under Social Security. The claimant must have accrued a certain number of "quarters of coverage" in covered employment to become "fully insured" for SSDI, but special rules allow younger or disabled workers to accrue as few as six quarters of coverage to become "currently insured" and thereby eligible for SSDI. (Younger adults and their families may be unaware of this possible eligibility based on special rules and a short work life.)

A person must be determined by the Disability Determination Service (in Mississippi) to be disabled from performing "substantial gainful activity". After a person is determined through the federal application and hearing process to be eligible for SSDI, **earnings** from part-time or sporadic work of no more than **$1,350** per month ($2,260 if blind) will be considered "not substantial" and will usually not disqualify the person. **Unearned** income (interest, dividends, rental payments, loan payments received, trust payments, etc.) will not disqualify one for SSDI. Eligibility for SSDI is **not** dependent upon the recipient's current assets or income (except for the "earned income" issue).

C. Social Security Retirement.

Social Security Retirement (42 U.S.C. § 410(a), (j); 20 C.F.R. §§ 404.1003-1038) pays a monthly income to persons over age 65 (or age 62 who elect early participation) who have, during their work-life, paid into the Social Security retirement system for a minimum of 40 "quarters of coverage" (QOC). This is an insurance-type program in that one pays into the system and, at the prescribed age, begins to draw benefits from their "paid-up" account. The participant must have been an employee or been self-employed in "covered employment." A quarter of coverage is acquired when a worker receives wages or self-employment earnings above a certain amount ($1,510 in 2022), and a worker may not be credited with more than four QOC's in one calendar year. A worker may be "fully insured" (with at least 40 QOCs), "currently insured" (at least 6 QOCs during the 13-quarter period ending in death or entitlement to disability or retirement benefits), or "insured for disability benefits" (greater of 6 QOCs or one QOC for each year after age 21). Such insured status determines whether a benefit is payable, not how much is payable. Fully insured status is required to receive old age retirement benefits and to allow certain spousal and dependent

child's benefits based on the worker's earnings record. The monthly payment amount is determined by the amount of the recipient's "average indexed monthly earnings" during the 35 highest earning years and the amount of Social Security taxes paid in. A full benefit amount, known as the "primary insurance amount" (PIA), is payable beginning at the worker's full retirement age based on year of birth, with reduced amounts payable as early as age 62 and increased amounts payable for deferred application as late as age 70. The amount or eligibility for such payment does not depend on the recipient's assets or income (except for "early retirement" recipients over age 62 in some circumstances). See section on Timing Spousal Retirement Benefits below.

There are several Social Security benefits based on **marital or dependent relationship** to the primary worker:

D. Spouse's benefit.

Spouse's benefit. (42 U.S.C. § 402(b), (c); 20 C.F.R. § 404.304, 404.330) A spouse may be eligible for a Social Security benefit based on the worker spouse's insured status. The spouse must (1) meet the definition of "spouse" under state law and comity **and** (a) have been married to the worker at least one year, (b) be the natural parent of the worker's natural child, or (c) in the month before marriage to the worker, be eligible for benefits as a spouse, surviving spouse, parent or disabled child; (2) be at least 62 years old ***or*** have "in care" the worker's child under age 16 or disabled; (3) apply for benefits; and (4) not be entitled to a larger Social Security benefit in his/her own right. The benefit amount will be equal to fifty percent (50%) of the worker's benefit if the spouse applies at her full retirement age, or a lower amount if she applies between age 62 and her full retirement age.

E. Divorced spouse's benefit.

Divorced spouse's benefit. (42 U.S.C. § 402(b)-(c), 416(b), (f); 20 CFR § 404.331, 404.335) When a divorced spouse reaches age 62, is not remarried and has been divorced for at least two years, and was married to the ex-spouse for at least ten years immediately prior to the divorce, she may begin to receive a *divorced spouse's benefit* (if the insured ex-spouse is at least 62, even if the ex-spouse has not yet begun receiving Social Security payments). The divorced spouse's benefit amount will be equal to fifty percent (50%) of the worker's full retirement age benefit if the divorced spouse applies at her full retirement age, or a lower amount if she applies between age 62 and her full retirement age. If the ex-spouse dies before the divorced spouse reaches her "full retirement age" (66 for those born from 1943 through 1954), she can receive the ex-spouse's full retirement benefit amount, even if he had remarried and his new wife is receiving that benefit too.

F. Children's Benefits.

***Children's Benefits*.** (42 U.S.C. § 402(d)(2); 20 C.F.R. § 404.353(a)) Children of a worker entitled to old age or disability benefits, and children of a worker who died fully or currently insured, may be entitled to benefits equal to one-half (1/2) of the worker's primary insurance amount if the worker is still living, or three-fourths (3/4) of the PIA if the worker is deceased. Families with several children are subject to a family maximum limit. An eligible child is a natural or adopted child or stepchild who is dependent on the worker, unmarried, and either under age 18, full-time student under age 19 in secondary school, or over age 18 and disabled.

G. Childhood Disability Benefits.

***Childhood Disability Benefits*.** A **disabled adult child** may be entitled to Childhood Disability Benefits (CDB) (formerly Disabled Adult Child, or DAC) based on the eligibility of the parent for SS Retirement or SSDI, if the child is dependent on the worker, was disabled prior to age 22 and remains disabled after age 22. (Note: The adult child will lose the CDB benefit if s/he marries someone who does not receive a similar disability benefit.)

H. Social Security Survivor benefits.

Social Security Survivor benefits (42 U.S.C. § 402(e)(2), (f)(3); 20 C.F.R. § 404.338) entitles the surviving spouse (including divorced spouse if married over ten years) and/or child(ren) under age 18 of a deceased recipient of Social Security Retirement or SSDI to a monthly payment based on the eligibility of the deceased spouse or parent. If the surviving spouse or child is entitled to a benefit under any program of the Social Security system in his/her own right, s/he will generally be entitled to receive the higher of the two benefits only. (An exception to this rule is where a person receives a Social Security Survivor's or SSDI benefit that is less than $841 and an additional SSI payment for the difference between the maximum SSI amount and the other unearned income.) Survivor's benefits are **not** dependent on the income or assets of the recipient.

I. Widow(er)'s benefit.

***Widow(er)'s benefit*.** A married spouse is entitled to receive a *widowed spouse's benefit* if s/he is at least age 60 (or 50 if disabled) when her fully insured spouse dies. The benefit amount will be equal to the deceased worker's full benefit entitlement at death if the widowed spouse applies at his/her full retirement age, or a lower amount if she applies between age 60 and full retirement age.

Timing of Benefits for Two-Income Couples

The Senior Citizens Right to Work Act instituted changes in the way that dual income baby boomers can file and collect their Social Security retirement benefits. Currently, 75% of Social Security recipients have taken reduced benefits prior to their normal retirement age. Many financial advisors state that a significant number of early electors are making a significant financial mistake. Additionally, a recent survey found that 77 percent of their respondents expected to receive advice regarding their Social Security distributions from the Social Security Administration. None of them were aware that the SSA is prohibited from giving advice regarding collecting benefits. This presentation is designed to provide an understanding of the basic rules regarding Social Security retirement benefits, the various elections available to dual income earners, and the income tax and mortality issues that surround the decision making process.

1. Fundamental issues in retirement timing decisions
   - How long will your client work?
   - How much do they need?
   - How they will claim their benefits — can be more important than
   - How have they saved
   - How are they invested

2. The traditional approach to evaluating the timing decisions as to whether or not one takes Social Security early or late, hinge on the "break even" analysis.
   - Assumption that funds are not needed till a later date and invested, not consumed.
   - Invested amounts are compounded at a given rate of return
   - "Cross-over" point graphed as to how long a person needs to live in order to break even, and pull ahead in terms of net benefits.

3. The Dual Income retiree has more options relative to the selection of benefits.

4. Additionally, because of survivor benefits, delays in taking benefits by the higher paid worker will frequently continue (with cost of living adjustments) for the life of the survivor.

5. Changes in mortality data suggest that recipients are living longer and healthy claimants may be making a significant financial mistake by taking benefits early.

6. The Senior Citizens Right to Work act of 2000 allows recipients to work past Full Retirement Age without having to take a reduction in their Social Security Benefits.

7. The payment of Social Security Benefits represents a significant flow of inflation protected benefits for which the participant does not have to adsorb any investment costs or risks as compared to alternative sources of retirement income.

8. Although men historically were more likely than women to be insured, the gender gap is shrinking. The proportion of men who are insured declined slightly from 1970 to 2020, with 91% fully insured and 79% insured for disability in 2020. By contrast, the proportion of women who are insured increased dramatically—from 63% to 87% fully insured and from 41% to 75% insured for disability.

9. Of all adults receiving monthly Social Security benefits, 45% were men and 55% were women. Eighty-four percent of the men and 70% of the women received retired-worker benefits. Eleven percent of the women received survivor benefits.

10. In 2020, benefits were awarded to about 5.8 million persons; of those, 58% were retired workers and 11% were disabled workers. The remaining 31% were survivors or the spouses and children of retired or disabled workers. These awards represent not only new entrants to the benefit rolls but also persons already on the rolls who become entitled to a different benefit, particularly conversions of disabled-worker benefits to retired-worker benefits at FRA.

11. In 2020, more than four-fifths of all OASDI beneficiaries in current-payment status were aged 62 or older, including 24% aged 75–84 and 9% aged 85 or older. About 11% were persons aged 18–61 receiving benefits as disabled workers, survivors, or dependents. Another 4% were children under age 18.

C. Social Security Claims Basics.

Full Retirement Age (FRA).

FRA is that point in time when a person is eligible for his full retirement benefit based on his/her PIA. That age is a moving target — based on the year of birth:

1937 or Earlier — Age 65
1938-1942 Add 2 months per year
1943-1954 — Age 66
1955-1959 — Add 2 months per year to 67
1960 and later — Age 67

Early Retirement.

Persons taking their retirement benefit prior to their FRA will experience a reduction in their benefits, based on the number of months before their FRA that they begin to take their benefit.

a. During the period of early retirement, there is an earnings test that requires repayment of Social Security benefits when earnings exceed the statutory level.

b. The amount of the earnings test depends on whether you are earning money (from wages — not interest / dividends and the like) in the year you reach your Full Retirement Age, or the years prior.

- For 2022, if the year is NOT your year of FRA, then you can earn up to $19,560 before repayment of benefits begins.
- Once you reach $19,560, you must repay one dollar of benefits for every two dollars that is earned.
- In the year you reach FRA, the formula changes so that the exempt amount is increased to $51,960. For every three dollars you earn above that amount, one dollar must be repaid.

Cash flow planning issues:

Clients often do not consider how the earnings test works from a cash flow point of view, and it may create serious disruption to cash flow in future years. Assume the client fails the earnings test in 2022 and decides to retire completely in the summer of 2023. The Social Security Administration is not notified of the earnings for 2022 until February of 2023. By the time it figures out the required reductions, it may be the summer or later. The client will now have all Social Security benefit checks stopped until the required "repayment" is completed. This may create a serious disruption to cash flow.

It is important to remember that taking benefits early on your own record will also cause a reduction in spousal benefits that are available. At age 62 the reduction for the PIA is 25%, but the reduction for a spousal benefit is 30%.

Delayed Retirement Credits (DRC).

- The opposite effect of taking benefits early is an increase in the monthly benefit for those who take benefits after FRA.
- The benefit increase is computed monthly and amounts to 8% per year for the group in the 1943-1954 age group. Therefore for that group, benefits increase by 32% for the four years between 66 and 70.

Important rule: The spousal benefit is only calculated on the worker's PIA or primary insurance amount. Increases in the worker's benefit due to DRCs do not increase the spousal benefit at all.

Starting to put it together — understanding some of the issues for dual income claiming.

- In a dual income family where both participants are the same age, there are 91 possible whole year age combinations for claiming benefits.

- Social Security calculations however, are modified by the month in which they are claimed. There are 108 months in 9 years, so there are 11,664 possible monthly age combinations for a same-age couple.

The Deeming Provision

For persons born after January 1, 1954, when a person applies for benefits, he or she is ***deemed*** to have applied for all the benefits (spousal or based on own record) he or she may be eligible for. In other words, you go to the window and turn in both hats (worker and spouse) at the time of filing.

Claiming Strategies

a. Do Over

- A claimant is entitled to rescind his/her claiming decision within 12 months of beginning to receive benefits, claim later.
- All benefits must be repaid
- Any taxes paid on the benefits may be reclaimed.

Note: If you suspend your retirement benefits and if you are enrolled in Medicare Part B (Supplementary Medical Insurance), you will be billed by the Centers for Medicare & Medicaid Services (CMS) for future Part B premiums. These premiums cannot be deducted from your suspended retirement benefits. If you do not pay the premiums timely, you may lose your Part B Medicare coverage. You will have the option of automatically paying the bill from an account at your bank or financial institution.
Exception: If you also receive benefits as a spouse or ex-spouse, we can deduct your Part B premium from that benefit payment.
If you also receive Supplemental Security Income (SSI) benefits, suspending your retirement benefits will make you ineligible for SSI.

b. Stop-N-Go

- An Individual takes early retirement benefits, but suspends benefits after reaching FRA.
- This would enable DRCs to accumulate, but on a reduced base amount (because the claimant was taking early retirement benefits). If that person does so, he or she will earn delayed retirement credits at the rate of 2/3 of a percent for each month that the benefit payment is suspended. However, if an application for a benefit suspension is submitted and granted, dependents will no longer be able to receive a benefit on the account of the suspended benefit.

The core issue when considering the combination of strategies is to look to the present value of all the family benefits, rather than the break-even point for one or both people as individuals.

Decision Tree Summary:

- Do you need the supplemental income?
- Are you actually retiring?
- What's the expectation of working even part-time before full retirement age?
- How is your health?
- Do you have a history/expectation of longevity?
- Status — Married / Widowed / Divorced
- Is there a big age difference between you and your spouse?
- Does your spouse have a history/expectation of longevity?
- Whose benefits will your spouse collect?
- What other sources of income do you have?

Mortality Issues

The Social Security web site includes a mortality calculator that will estimate a claimant's life expectancy.

- Life Expectancy is the point at which 50% of the members of a given age group will have died.
- Whether one takes Social Security benefits early or late, they are supposed to be actuarially equivalent.
- "Age-related adjustments to Social Security benefits are intended to be actuarially equivalent, on average, rendering lifetime benefits invariant to the timing of first receipt."
- If however, a group of individuals will generally live longer than the general mortality tables indicate, then it could be in their best interests to delay retirement to enable DRCs to increase COLA adjusted benefits across possibly two lifetimes.
- The current trend as illustrated by the Social Security Administration's statistical survey shows that longevity is increasing.

TIAA-CREF has their own mortality tables based on their experience with a pool of annuitants that exceeds 300,000.

- In a study published in 2003, they reported the following relative to their cohort of highly educated individuals who had good access to health care:
- Age 65 life expectancy is increasing 1 - 2% every 5 years
- Mortality rates and life expectancies differ significantly between their annuitant population and the general population mortality tables.

- Their population is not the "general population" which includes the disabled and all socio-economic groups.
- Data for couples shows that TIAA-CREF experience is that there is a 72% chance that one person will survive to age 90 while the general population table 2000 numbers show a 50% chance of survival to age 92.
- It is possible however, to obtain at a reasonable cost, a somewhat custom Life Expectancy analysis from various vendors

Analysis from various vendors.

- Using an analysis from 21st Services, a custom analysis for a couple showed the following disparity in data:
- Couple was both age 62, with the woman being 9 months older than the man.

Client	SS Life Expectancy	TIAA CREF Table	Custom Analysis
Male	83 — 21.1 years	60% to age 80 41% to age 90	70% to Age 85 50% to Age 90 30% to Age 94.4
Female	84 — 22.8 years	53% to age 90+ at Age 65	70% to Age 85 50% to Age 90 30% to Age 94.4

Income Taxation

Social Security Income is tax preferred

- It can be tax free, and it can be included in taxable income either at the 50% level, or at the 85% level, depending on other income.
- For single taxpayer, SS benefits will not be taxable unless the total Adjusted Gross Income plus one half of Social Security benefits exceeds $25,000.
- For a married taxpayer, then the first threshold is $32,000.

The following table shows the relationship between the income level at which Social Security benefits are 50% taxable and 85% taxable:

Taxpayer who is:	50% Taxable	85% Taxable
Single – Head of Household	Over $25,000	Over $34,000
Married filing jointly	Over $32,000	Over $44,000

When you examine the effect of delaying Social Security to increase its benefit and then reducing other income, you will find that there is leverage in the tax code that will benefit your clients.

Take the following scenario:

Couple #1 with $72,000 of Gross Income consisting of:

- $42,000 of Ordinary Income, IRA, 401k, tax free, or other income
- $30,000 of Social Security Benefits

Couple #2 with $72,000 of Gross Income consisting of:

- $20,000 of Ordinary Income
- $52,000 of Social Security Income

Tax Result: Couple #2 would pay substantially less income tax because the income on which taxable SS computed is lower (lower ordinary income ***and*** only one-half of SS benefits included).

SUMMARY OF MEDICAID PROGRAMS

A. OVERVIEW OF THE NEED

According to the *Analysis of Recent National Trends in Medicaid and CHIP Enrollment* published by Kaiser Family Foundation, data for February 2022 show that total Medicaid/CHIP enrollment grew to 87.4 million, an increase of 16.1 million from enrollment in February 2020 (22.7%).[1] The growth was predominately in the adult population (10.7 million). The Mississippi Medicaid population increased by 18.4% during that period to 728,359 recipients in February 2022. Advances in medical treatment and technology have led to increased survival rates and longer life expectancies for children and adults with disabilities. A great number of these individuals have no medical insurance coverage and no real hope of obtaining it. Many disabled adults who are unable to work rely on the Medicaid program to meet their basic medical expense needs and on the Supplemental Security Income (SSI) program of the Social Security Administration to assist with the costs of food and shelter. Children under 18 who meet the Social Security definition of disability are eligible for Medicaid, and those whose parents' household income is very low are also eligible for SSI assistance. Many seniors who enter nursing

[1] https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/:~:text=After%20declines%20in%20enrollment%20from%202017%20through%202019,,by%20the%20Families%20First%20Coronavirus%20Response%20Act%20(FFCRA).

home care have insufficient income and assets with which to pay for such care and, therefore, rely on Medicaid to pay some or all of their nursing home costs.

Every lawyer has clients, friends or family members who have a disability or who provide care-giving assistance to someone with a disability. Persons with disabilities and their care-givers are often overwhelmed by the daily stresses of coping with the problems associated with disability. The pain and physical difficulties of a disability can become the focus of all energy for the affected person. The spouse, child or other family care-giver can have his or her hope drained away by the daily demands and drudgery of care-giving duties. And the negative financial impact on the family often comes from a "double whammy" – the **increased costs** of medical, therapeutic and care-giving expenses and the **lost income** of the disabled person and/or the care-giving family member. It is, therefore, essential to maximize the economic resources available to meet the needs of the person with a disability.

Persons with disabilities and their families struggle not only with the pain and physical limitations, the daily care-giving demands, and the financial hardships. An additional demoralizing force is the perceived, if not real, limitation on their freedom and actions not imposed on those without disabilities. They may now be unable to have accessible public transportation or access to public facilities. They, like the general population, often believe that many common myths and misconceptions are true. "If I have to go into the nursing home, Medicaid will take my house." "I have to wait three years after giving anything away to be eligible for Medicaid." "If my nursing home care costs more than my income and my spouse's income combined, my spouse won't have anything to live on." Many such despair-fostering beliefs are either totally false or are true only under limited sets of circumstances. The legal or health-care professional who understands the truths and facts about such matters such as basic eligibility rules for public benefit programs can be a source of education, assurance, help and empowerment to the disabled client and his or her family.

B. OVERVIEW OF THE MEDICAID PROGRAM

Medicaid (Title XIX of Social Security Act; 42 U.S.C. § 1398 *et seq.*; 42 C.F.R. Parts 430 - 456) provides payment of medical expenses for persons age 65 or over or disabled (in accordance with Social Security disability definitions), who also qualify in

terms of limited assets and income. Medicaid is administered by state agencies under a federally approved medical assistance plan. For many disabled individuals who cannot obtain other medical insurance, Medicaid provides the only safety net for health care. Medicaid pays for more services than Medicare, including prescription drugs and nursing home care. In Mississippi, any SSI recipient is automatically entitled to receive Medicaid benefits as "categorically needy". If the beneficiary receives income or has assets that are in excess of the SSI limits, s/he is likely to lose his or her SSI eligibility -- and the automatic Medicaid coverage along with it. The loss of Medicaid coverage can be a more serious problem than the loss of SSI benefits, especially if alternative medical insurance is not readily available. Medicaid coverage is often dependent upon income and assets.

C. ELIGIBILITY FOR MEDICAID

1. Basic Eligibility Requirements

(a) Aged (over 65) or blind or disabled

(b) U. S. Citizen or alien lawfully admitted for permanent residence or alien lawfully residing in U.S.

(c) Mississippi resident (where living with intent to remain permanently or indefinitely)

(d) Income and resources within specified limits

(e) File an application

2. Eligibility Exceptions

An individual is not eligible if:

(a) Fails to apply for any and all other benefits for which he/she may be eligible (such as retirement pensions or annuities, Social Security RSDI benefits including early retirement at age 62, retirement or disability benefits including veteran's pension and compensation, worker's compensation, and unemployment insurance)

(b) Resident of a public institution

(c) Refuses to accept vocational rehabilitation services

(d) Fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments

(i) MCA §43-13-305 gives Medicaid a lien on any third-party recovery

3. Coverage Groups and Financial Need

Categorically Needy. Section 1902(a)(10) of the Social Security Act describes persons to whom medical assistance may be provided as "categorically needy" or "medically needy." Mississippi does not cover the latter group. The "categorically needy" group consists of "mandatory" groups (those receiving cash assistance program payments under TANF, SSI, title IV-E, etc.) and "optional" groups (needy persons who share financial and categorical requirements such as age or disability). MCA §43-13-115 establishes the following eligibility groups (subsection number of statute in parentheses):

(a) **Mandatory categorically needy groups**:

(i) TANF recipients or pre-1996 eligibles *(1)*

(ii) Pregnant women and children under age 8 who would be eligible for TANF except for Social Security increases *(1)*

(iii) Children under 1 year of age if mother eligible *(5)*

(iv) Eligible mother for 60 days after birth *(1)*

(v) Children under 18 subject to title IV-E foster care or adoption *(23)*

(vi) Pregnant women and children under 6 with incomes less than 133% of federal poverty level (FPL) *(9)*

(vii) Pregnant women and children under 19 with family incomes less than or equal to FPL *(9)*

(viii) SSI recipients *(2)*

(ix) Persons eligible for SSI except for Social Security increases *(17)*

(x) Qualified Medicare Beneficiaries (QMBs) with Medicare Part A, income under FPL and resources less than twice the SSI resource limit ($4,000). Pays Medicare cost-sharing expenses only. *(12) [Note: Mississippi has removed the resource test for this group.]*

(xi) Qualified Working Disabled Individuals (QWDIs) with no Social Security Disability Insurance, income less than 200% FPL and resources less than twice the SSI resource limit. Pays Medicare Part A premiums

only. *(15) [Note: Mississippi has removed the resource test for this group.]*

(xii) Specified Low-Income Medicare Beneficiaries (SLMBs) with Medicare Part A, income less than 120% FPL and resources less than twice the SSI resource limit. Pays Medicare part B premiums only. *(13) [Note: Mississippi has removed the resource test for this group.]*

(xiii) Qualified individuals (QI-1 and QI-2) with income 120% - 135% FPL [QI-1 – pays full Medicare Part B premium] *(13) [Note: Mississippi has removed the resource test for this group.]*

(b) **Optional categorically needy groups**:

(i) Foster children under 21 in custody of DHS *(6)*

(ii) Pregnant women and children under age 1 with income less than or equal to 185% FPL *(9)*

(iii) Children under 19 on CHIP Program (family income less than or equal to 200% FPL)

(iv) SSI–eligible individuals in long-term care *(7)*

(v) Persons in long-term care facility with income under 300% maximum SSI benefit *(7)*

(vi) Severely disabled children under age 18 living at home *(10)*

(vii) Hospice care eligibles using institutional income limit

(viii) Eligibles for "Physically Handicapped" HCBS waiver program, using institutional criteria *(16)*

(ix) Working Disabled – if SSI-eligible except for earned income up to 250% FPL (subject to premium if between 150% - 250% FPL) *(19)*

(x) Women under 65 with breast cancer, no other health insurance, and income under 250% FPL *(24)*

(xi) Elderly and Disabled Waiver participants under institutional income limit (300% SSI benefit rate) and with deficits in 3 or more ADLs. Provides case management, adult day care, home delivered meals, institutional respite, in-home respite care, homemaker services, escorted transportation and extended home health visits. *(16)*

(xii) Independent Living Waiver participants – communicative persons with orthopedic or neurological impairments, under SSI or institutional income limits. Provides personal care attendant and case management services. *(16)*

(xiii) Intellectually Disabled/Developmentally Disabled (ID/DD; formerly Mentally Retarded/Developmentally Disabled or MR/DD) Waiver for ICF-MR eligibles, under SSI, TANF, DCAH or institutional income limit. Provides, in addition to regular Medicaid services, in-home and community respite care, residential habilitation, attendant care aide, day habilitation, pre-vocational and supported employment services, PT, OT, Speech/language/hearing services, behavioral support and intervention, and specialized medical supplies. *(16)*

(xiv) Assisted Living Waiver for persons in licensed personal care homes, community residential care facilities or Medicaid-approved congregate housing programs, who have deficits in 3 or more ADLs (or dementia and 2 ADLs), and under the institutional income limit. In addition to regular Medicaid services, participants receive care management, personal care, homemaker services, chore services, attendant care, medication oversight and administration, therapeutic social and recreational programming, intermittent skilled nursing services, and transportation. *(16)*

(xv) Traumatic Brain Injury/Spinal Cord Injury Waiver for those with income eligibility under any other group and who are medically stable. Provides case management, in-home nursing respite, in-home companion respite, institutional respite, attendant care services, accessibility adaptations. *(16)*

(xvi) Healthier Mississippi Waiver for those with end-stage renal disease on dialysis, cancer on chemotherapy, or organ transplant on anti-rejection drugs, with income no higher than 135% FPL *(26)*

(xvii) Persons entitled to Medicare Part D, with income no higher than 150% FPL *(27)*

4. Low Income Coverage Groups.

Mississippi Health Benefits includes four Medicaid programs and the Children's Health Insurance Program (CHIP). Individuals who may qualify are:

- Children up to age 19
- Low-income adults with children under age 18
- Pregnant women

Eligibility for many of the following Medicaid programs is based on family incomes within certain multiples of the **Federal Poverty Level (FPL)**. The Federal Poverty Levels for 2022 are:

2022 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline	Monthly
1	$13,590	$1,132
2	18,310	1,525
3	23,030	1,919
4	27,750	2,312
5	32,470	2,705
6	37,190	3,099
7	41,910	3,492
8	46,630	3,885

For families/households with more than 8 persons, add $4,720 for each additional person.

> **SOURCE:** *Federal Register*. The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

a. Infant Survival Program (IS-88)

Pregnant women whose income does not exceed 185% of FPL may qualify in this program. Pregnant women are eligible if family income does not exceed the appropriate family size which includes the pregnant woman, her spouse and children, if applicable, and unborn(s). The expected due date must be verified by a healthcare professional. Eyeglass

and dental services are not available to pregnant women in this program. There is no resource limit for this group.

b. Expanded Medicaid Program (EM-71)

Medicaid coverage is provided in this program for **children up to age 1** whose family income does not exceed 185% of Federal Poverty Level (FPL). There is no resource limit for this group.

c. Expanded Medicaid Program (EM-72)

Medicaid coverage is provided in this program for **children age 1 to 5** whose family income does not exceed 133% of Federal Poverty Level (FPL). There is no resource limit for this group.

d. Expanded Medicaid Program (EM-73)

Medicaid coverage is provided in this program for **children age 6 to 19** whose family income does not exceed 100% of Federal Poverty Level (FPL). There is no resource limit for this group.

e. Children's Health Insurance Program (CHIP-99)

CHIP provides insurance coverage for **uninsured children up to age 19** whose family income does not exceed 200% of FPL. A child must be determined ineligible for Medicaid before eligibility for CHIP can be considered. Children with current health insurance coverage at the time of application are not eligible for CHIP. There is no resource limit for this group.

5. Income and Resources

Recipients of SSI and Medicaid benefits must comply with the SSI or Medicaid income and resource rules. These rules address what resources and income will be "counted" in determining the recipient's income and resources for eligibility purposes. [NOTE: A few Mississippi Medicaid programs, such as the Children's Health Insurance

Program (CHIP) and certain programs for pregnant women, welfare-eligible families and children under age 19 mentioned above, do not have a resources limit for eligibility.]

a. Income: "Income" is generally defined for **SSI** purposes as anything of value received during a month which could be used to purchase food or shelter support. 20 C.F.R. § 416.1102. Income does not include: medical care and services; social services; proceeds from sale or exchange of a resource; income tax refunds; payments from credit life or credit disability insurance; loan proceeds; payments made to others for non-food/clothing/shelter items or services. 20 C.F.R. § 416.1103. "Earned income" includes gross wages and net earnings from self-employment, including in-kind payments. 42 U.S.C. § 1382a(a); 20 C.F.R. § 416.1110. "Unearned income" includes: payments from annuities, pensions, Social Security benefits, disability, benefits, veterans' benefits, railroad retirement, unemployment compensation; alimony or other support payments; dividends, interest and royalties; rents (net of lease expenses); life insurance benefits, gifts and inheritances; prizes and awards; and in-kind support and maintenance. 42 U.S.C. § 1382a(a)(2); 20 C.F.R. § 416.1121. "Countable income" for SSI purposes is calculated by subtracting from the individual's total earned and unearned income: (1) up to $10/month of infrequent or irregular income (i.e., received no more often than once per calendar quarter from non-regular sources); (2) up to $2,040/month of earned income, with a maximum $8,230/calendar year, for a blind or disabled child attending school; (3) up to $20/month, used first against unearned income then earned income; (4) $65 of earned income; (5) earned income used to pay impairment-related work expenses of a disabled (not blind) person; (6) one-half of the remaining earned income; (7) earned income used to pay work-related expenses of a blind person; and (8) any income used to fulfill an approved plan to achieve self-support for a blind or disabled person. Income from non-eligible family members can be "deemed" available to the SSI applicant. Food and shelter expenses paid for by another is considered "in-kind support and maintenance" (ISM) and will generally reduce the recipient's SSI payment by **one-third** if the recipient resides in the household of another (the "**VTR**" or value of one-third reduction) or by **one-third plus $20** if the recipient lives in a household other than that of the person providing ISM (the "**PMV**" or presumed maximum value).

Mississippi's Medicaid Eligibility Policy and Procedures Manual ("EPPM"), Chapter 200, Page 2002 defines "income" as "anything an individual receives in cash (and in some cases in-kind) that can be used to meet his/her needs for food or shelter." Medicaid is required, in accordance with 42 C.F.R. 435.721, to use SSI financial eligibility requirements. SSI income policy applies unless a subsequently issued Medicaid statute or regulation supersedes the SSI policy. The state policy pertaining to in-kind support and maintenance is found at page 2118 of the EPPM. "In-kind Support and Maintenance (ISM) is income in the form of food and/or shelter paid for by a third party. According to Medicaid policy, the source of such payments determines whether such a payment will be countable unearned income.

b. Resources: "Resources" for **SSI** purposes refers to any cash, liquid resources, real or personal property of the individual or spouse that can be converted to cash to pay for support. 20 C.F.R. §416.1201. "Liquid" resources are those that can be liquidated for cash within 20 days. Non-saleable real property is not counted as a resource. All funds in jointly-owned accounts that can be withdrawn by the recipient are considered the recipient's resources, regardless of source of the funds. Assets received are considered income in the month received and resources as of the first moment of the next month. Excess resources of a non-SSI family member, like income, can be "deemed" to be resources of the individual SSI recipient. The following resources, among others, are considered "non-countable" or exempt for eligibility purposes: entire value of individual's home and land adjacent to it; total value of "household goods" (items found in or near home, used on regular basis, or needed for maintenance/use/occupancy of premises), "personal effects" (ordinarily worn or carried by, or intimate relationship to, the individual), and wedding/engagement rings and disability-related equipment regardless of value; one automobile regardless of value (if used for individual or member of individual's household) and a second car if needed for employment or medical treatment or if modified for a disabled person; trade or business assets necessary for claimant's self-support; non-business property essential for self-support; resources essential to fulfill a plan to achieve self-support; cash value of all life insurance if the total face value is $1,500 or less; cash or in-kind replacement to replace or repair a lost or damaged resource (such as casualty insurance proceeds) if used for that purpose within nine months; value of burial spaces for claimant or

entire family; up to $1,500 for an individual ($3,000 for a couple) of burial expense fund (reduced by face value of any excluded life insurance); and federal or state disaster relief funds. 42 U.S.C. §1382b(a); 20 C.F.R. §416.1210. Assets held by a guardian or conservator are generally considered countable resources of the ward.

Mississippi's **Medicaid** program generally follows the resource criteria used by the SSI program. However, effective October 1, 1989 Mississippi Division of Medicaid received approval from the federal Health Care Financing Administration (HCFA) (now the Center for Medicare and Medicaid Services) to apply more liberal resource policies than those of SSI to various coverage groups. These "liberalized resource policies" allow the spend-down of resources within a month to become eligible for that month and treat the following resources as non-countable: excess resources ear-marked for private pay nursing home costs for prior months; life estate and remainder interests; 16th Section leasehold interests, mineral rights and timber rights not under production; income-producing property if it produces net annual return of at least 6% of the equity value of the property; promissory notes and loan agreements that produce net annual return of at least 6% of the principal balance; equity value in a residence up to $500,000 (indexed for inflation - $636,000 in 2022); up to two automobiles regardless of use; all household goods and up to $5,000 equity value of personal property; cash value of all life insurance if the total face value is $10,000 or less; burial spaces for family members; and burial funds up to $6,000 for the individual and $6,000 for the spouse. EPPM, Chapter 300, page 3015.

c. Annuities. Previous law provided annuities that were "Medicaid-qualified" (that is, irrevocable, non-assignable, non-transferable, immediate, and "actuarially sound") would not be considered a "resource" in determining eligibility for Medicaid benefits. To be actuarially sound, an annuity must scheduled to pay out in full over the actuarial life expectancy of the annuitant. ("Balloon" annuities, which pay interest and a nominal amount of principal each month over the life expectancy of the annuitant with a large payment in the final month of the annuitant's original life expectancy, are no longer allowed under the new law.) Also, the purchase of such an annuity payable to either the Medicaid applicant or his/her community spouse has not been considered a "transfer" that would result in a period of ineligibility.

The Act now treats the purchase of an annuity as the "disposal of an asset for less than fair market value" ***unless*** the State is named as (i) the primary death beneficiary or (ii) the secondary beneficiary after a community spouse or minor or disabled child who is listed in first position. 42 USC §1396p(c)(1)(F) However, the following section (42 USC §1396p(c)(1)(G)) states that the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance for nursing services ***unless*** (i) the annuity is purchased within, or using assets from, an IRA account, or (ii) the annuity is a "Medicaid-qualified" type as described above. Thus, subsection (G) seems to eliminate the requirement of naming the State as beneficiary for two types of annuities – retirement plan annuities and actuarially sound non-balloon "Medicaid-qualified" annuities. It appears to do so with the wording indicating that such annuities are not included in the definition of the term "assets" when speaking of a transfer of assets and the resulting period of ineligibility. However, on July 27, 2006 the Center for Medicare and Medicaid Services (or "CMS") issued a guidance letter to state Medicaid directors in which CMS interpreted these as additional requirements. In other words, in order for the purchase by a Medicaid applicant of an immediate annuity not to be considered a transfer of assets, ***in addition*** to naming the state as a remainder beneficiary as required in the annuity subsection (c)(1)(F), the annuity must ***also*** be purchased with qualified retirement funds or be a "Medicaid-qualified" annuity (that is, irrevocable, non-assignable, actuarially sound, and provide for equal payments during its term). This guidance from CMS notes that the optional requirements of subsection (G) applies only to purchase of annuities "by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services." Therefore, as noted in the CMS guidance letter, "[T]his requirement does not apply to annuities for which the community spouse is the annuitant." Because the requirements of subsection (G) do not apply to community spouses, it appears that no annuities purchased by community spouses need be irrevocable or actuarially sound or provide for regular, equal payments so long as they name the State as primary beneficiary up to the amount of Medicaid assistance that may be paid for the community spouse. [see EPPM, Chapter 305.03.09, Page 3381.] Likewise, an annuity purchased by a nursing home resident with qualified retirement plan funds under subsection (G) need not be irrevocable or actuarially sound or provide for regular, equal payments, and may name the community spouse or a disabled child as

primary beneficiary and the State as secondary beneficiary. The July 27, 2006 CMS guidance directs the states to determine actuarial soundness using the more up-to-date life expectancy tables published by the Office of the Chief Actuary of the Social Security Administration. These tables may be found online at EPPM, Appendix A-7 and at: http://www.ssa.gov/OACT/STATS/table4c6.html.

6. <u>Medicaid Non-FPL Coverage Groups</u>.

The Medicaid program is a broad scope of services provided to many different "coverage groups". The groups of persons served by Medicaid in Mississippi are codified at Mississippi Code Annotated §43-13-115 (1972, as amended). A summary of these groups follows, along with statements for each group regarding: (1) the "income limit" for that group (i.e., the maximum countable income a person can have to be eligible); (2) the "resources limit" (i.e., the maximum cumulative value of countable resources a person can own to be eligible); and (3) whether there is a "transfer penalty" for eligibility (i.e., whether transfer of assets by the applicant will result in any period of ineligibility).

a. SSI-Eligible. Any Mississippi resident who receives any payment of SSI benefits is automatically eligible for Medicaid services. The income limits of the SSI program apply: $841/month individual, $1,261/month couple (2022). The SSI resource limits of $2,000 individual/$3,000 couple apply to countable resources. The SSI transfer rules under FCIA '99 apply. "Blind" means people with vision less than 20/200, or people who have a limited visual field of 20 degrees or less while wearing eyeglasses.

b. Disabled Child Living at Home (DCAH). Severely disabled children under age 18. "Institutional" (nursing home) income limit of 300% of SSI FBR (3 x $841) or $2,523 per month (2022), with no deeming of family income or assets to disabled child. SSI resource limit of $2,000 applies, and there is no transfer penalty. Child must require regular assistance with at least two (2) activities of daily living (ADLs) – eating, bathing, dressing, toileting or walking. Children who are not eligible for other Medicaid programs because the income or assets of their parents are too high may be eligible for Medicaid through the Disabled Children Living at Home category of eligibility. A child must meet all the following eligibility criteria:

(i) The child is under 18 years of age and determined to be disabled using Social Security disability rules.

(ii) Requires a level of care at home that is typically provided in a hospital or nursing facility or intermediate care facility (including an intermediate care facility for the mentally retarded);

(iii) Can be provided safe and appropriate care in the family home;

(iv) As an individual, does not have income or assets in his or her name in excess of the current standards for a child living in an institution; and

(v) Does not incur a cost at home to the Medicaid Program that exceeds the cost Medicaid would pay if the child were in an institution.

Qualification is not based on a diagnosis or disability alone, but the child's medically documented institutional level of care needs from the preceding 12-months. A child who is medically stable, even though disabled, is not considered in need of this level of care. This program is in compliance with federal regulations: 42 CFR §§435.225, 409.31-409.34, 440.10, 440.150, and 483.440.

c. Qualified Medicare Beneficiaries (QMB). In the Qualified Medicare Beneficiaries (QMB) Program, Medicaid will pay your Medicare premiums, deductibles, and coinsurance. To be eligible for the QMB Program you must

- Be eligible for Medicare, Part A (Hospital Insurance)
- Have a total monthly income less than **$1,183** ***for an individual or*** **$1,576** ***for a couple***. It does not matter what your resources are in this group. There is no resource test. Eligibility begins one (1) month after the date you are approved.

d. SLMB. If you are determined eligible in the Specified Low Income Beneficiaries (SLMB) Program, Medicaid will pay your Medicare, Part B premium of $170.10 per month. To be eligible for the SLMB Program you must

- Have Medicare, Part A (Hospital Insurance)
- Have a total monthly income less than: **$1,409** ***for an individual (*****$1,881** ***for a couple)***

It does not matter what your resources are in these groups. There is no resource test. Eligibility begins with the month a person is qualified, which may be up to three (3) months before the month of application.

e. Qualifying Individual (QI). You must have Medicare, Part A (Hospital Insurance) and your total monthly income must be less than **$1,579** for an individual or **$2,110** for a couple. There is no resource test in this group.

- In the QI Program, Medicaid will pay only your Medicare Part B premium.
- A QI does not qualify for any additional Medicaid benefits.
- You will not receive a Medicaid card. This group is funded by a limited federal allotment. If at any time these funds run out, this group could be affected.

f. The Healthier MS Waiver. To get Medicaid under this waiver, a person must:

- Not be entitled to Medicare
- Be determined disabled or be age 65 or over
- Have gross monthly income less than: **$1,579** ***for an individual (*****$2,110** ***for a couple)***
- Have total countable resources less than: **$4,000.00** ***for an individual (*****$6,000.00** ***for a couple)***
- This waiver has a 5,500 beneficiary enrollment cap at all times.

g. Home and Community-Based Services (HCBS) Waiver Programs. Mississippi has obtained federal waivers to use Medicaid funds to offer services in "home and community-based" programs designed to help recipients avoid institutionalization. These include: (1) ***Elderly and Disabled Waiver***, which provides respite, adult day care, meals, homemaker and other services for older persons with deficits in at least 3 of the activities of daily living; (2) ***Physically Handicapped (Independent Living) Waiver***, which provides personal care attendant services to physically disabled persons; (3) ***Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver***, which provides day-habilitation, respite care, attendant care, and speech/physical/occupational therapies to persons who would, without such services, require the level of care in an Intermediate Care Facility for the Mentally Retarded; (4) ***Assisted Living Waiver***, which provides homemaker, attendant care, medication supervision, social and recreational therapies, transportation and other services to residents of personal care homes and other congregate living facilities who would otherwise require placement in a nursing facility; and (5) ***Traumatic Brain Injury/Spinal Cord Injury Waiver***, which provides services to persons with traumatic brain injuries or spinal cord injuries necessary to help them avoid institutionalization. There are

other eligibility criteria, services and population limitations on these groups. The income limit for these groups is the institutional limit of **$2,523** (2022) per month for an individual. [**NOTE**: The "income cap" of $2,523 is **NOT** a disqualifying limit for eligibility, and someone with higher income than that can be eligible for Medicaid benefits by using an "income trust" document as part of the application.] The "countable" resource limit is **$4,000** and liberalized resource and "spousal impoverishment" rules apply (see Long Term Care Section below). There is a Medicaid transfer penalty for these groups. NOTE: There is greater demand for these programs than there is money to fund such services, resulting in "waiting lists" for many of these programs in areas of the state.

h. Long Term Care (or Nursing Home) Group. This coverage pays nursing home costs in excess of the Medicaid recipient's monthly share of cost. The Medicaid applicant may have monthly countable income of up to **$2,523** (2022) and countable assets of up to **$4,000** to qualify for Medicaid for LTC. [**NOTE**: The "income cap" of **$2,523** is **NOT** a disqualifying limit for eligibility, and someone with higher income than that can be eligible for Medicaid benefits by using an "income trust" document as part of the application.] Under "**spousal impoverishment" rules** for married applicants, the "community spouse" (CS) may keep additional income and resources as described in the following section.

7. Spousal Obligation.

Medicaid law provides some financial protection for spouses of institutionalized Medicaid recipients. These are called **"spousal impoverishment" (SI) rules**, since they are intended to prevent the impoverishment of these at-home spouses. Under SI rules for married applicants, the "community spouse" (CS) may keep his/her own separate income, plus enough of the applicant's income to get the CS's income up to **$3,435** (2022) per month (the "monthly maintenance needs allowance") if the CS's separate income is less than this amount. The CS may own separate countable resources of up to **$137,400** (the "community spouse resource allowance"). Assets may be assigned from the nursing home spouse to the community spouse to achieve these levels. In addition, the applicant (nursing home spouse) may have separate income of up to **$3,435** and separate countable assets of up to **$4,000**. The separate income (Social Security, etc.) of the applicant spouse that is not

assigned to the CS as part of the monthly maintenance needs allowance must be applied to pay nursing home cost as the applicant's "share of cost", but the community spouse's income and assets need not be spent for this care. Medicaid transfer penalties are imposed for uncompensated transfers of resources by the applicant or the applicant's spouse. [Note: In a case involving both spouses residing in a nursing home and one of them applying for Medicaid while all resources were transferred to the other spouse who would private pay, the Division of Medicaid finds that, since he resides in a nursing facility and not in the community, the private pay spouse is not a "community spouse" and there is no resource limit for the private pay spouse.]

8. "Spend-down"

Exempt resources are listed in section 5.b "Resources" above. Transfers of countable resources in exchange for, or purchases of, non-countable resources of equivalent or greater value will not give rise to a transfer penalty ineligibility period. The result of such a transaction will be a reduction of countable resources for eligibility purposes. However, the mere acquisition of non-countable resources, without consideration of the individual's family dynamics and estate planning goals, may be a bad strategy. In most cases where there are excess countable resources for eligibility, consideration should be given to using countable resources (money, etc.) to obtain non-countable resources of the following types:

a. Residence and residence improvements.

Under liberalized resource policy, the home and adjacent land is exempt for an institutionalized person regardless of whether his/her dependent spouse or child resides there and whether he/she expresses an intent to return there. However, the Deficit Reduction Act of 2005 (DRA) limits the exempt equity in a residence to **$636,000** (the DRA permits the state to raise such limit, but Mississippi uses the lowest limit). Countable resources can be spent to acquire a single residence or interest in one, or to make repairs (roof, plumbing, etc.), maintenance (painting, carpet, etc.) or renovations (addition of bathroom, etc.) to the residence. Remember, however, that if the residence is owned such that it will be in the individual's estate at death, it will be subject at that time to Medicaid's "estate recovery" claim.

b. Tangible personal property.

Funds may be used to purchase household furnishings, furniture, appliances, personal electronics, clothing, hobby items and other items without transfer penalty.

c. Other purchases.

The individual may purchase without penalty: term life insurance of any amount; income-producing property (producing net annual return of at least 6% of equity value); and personal services under a written personal services contract. The following is the Medicaid policy pertaining to "personal services contracts":

"A personal service contract should be a written contract between the recipient/applicant and the personal services provider. The contract should be executed prior to the date any payments have been made to the provider. If payments have been made prior to the date of the contract these payments should be considered as transfers.

Once an individual begins receipt of Medicaid Long Term Care (LTC) services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

The contract should be very specific as to the services to be provided and the payment to be paid for the services. Each service/duty should be listed with the number of hours for each service with the amount charged for each service. If the contract calls for a payment of a specific amount per hour, this amount should be reasonable. For example, nursing charges will not be allowed for non-nurses and CPA charges will not be allowed for persons who are not CPA's. Documentation of the services performed and the number of hours for each service should be submitted. All charges will be evaluated based on usual and customary charges for services in the community.

The contract must not provide for payment of compensation for future services. All payments should be made only as the services are actually rendered. Any payments made for future services should be considered as transfers. Contracts indicating a prior date but no payments have ever been made should be questioned as to why the payments for services were not made when the services were performed. This type of arrangement indicates services were provided for free. Services provided for free are not under obligation to be paid at a future unknown date."

See EPPM, Chapter 300, Section 306.06.08, page 3410.

d. Burial Funds.

An individual may purchase burial contracts, burial trusts or other revocable burial arrangements, or may segregate and clearly designate cash, financial account(s) or other financial assets for the individual's burial-related expenses.

e. Burial Plots.

Under liberalized policy, the individual may purchase burial spaces (gravesites, crypts, urns, etc.) and reasonable and necessary improvements (vaults, headstones, markers, containers) for the individual, his/her spouse, parent(s) child(ren) and siblings.

f. Automobile.

An individual may exclude up to 2 cars based on use, or 2 cars up to $4,500 current market value (CMV), or 1 car for use and 1 car for up to $4,500 CMV. Funds may be spent without penalty to repair or purchase an excluded automobile.

g. Prior Month Medical Expenses.

Countable resources may be excluded from counting if they are earmarked for the payment of prior months of medical expenses. The following policy is found at EPPM, Chapter 300, Section 300.03, Page 3015:

"Under liberalized resource policy, if excess liquid resources are earmarked for payment of private pay expenses for month(s) prior to a month of Medicaid eligibility, these excess resources can be excluded as a resource for any potential Medicaid months since the funds are obligated.

If Medicaid will cover any months that have been paid as private pay by the client, the amount subject to reimbursement **is** a resource in the month paid."

h. "Self-settled" Special Needs Trust.

Federal law (42 USC §1396p(d)(4)(A)) states that the assets of a disabled person placed in an irrevocable trust for that person's benefit are exempt from the application of these trust rules if the trust is:

> (A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3)) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a state plan under this title.

Thus, the essential elements of such a trust are: **age** of the beneficiary; **disability**; a **single beneficiary**; a **qualified creator** of the trust; and **repayment to Medicaid** upon the

beneficiary's death. The beneficiary whose money or assets are being used to fund the trust must be under age 65 when the trust is established. Under current Medicaid policy, the trust assets retain their exempt status after the beneficiary reaches age 65, but the person's right to contribute additional assets to the trust terminates at that time. Such a self-settled trust must be created by the beneficiary's parent, grandparent, legal guardian or a court. The individual cannot establish his/her own trust. If there is no parent or grandparent available to set up the trust, the individual may seek access to a court for appointment of a legal guardian or for establishment of the trust by the court as settlor. At the beneficiary's death, Medicaid must be first in line to recover from the trust assets the amount Medicaid has paid for the beneficiary's medical care. Any remaining balance in the SNT can be paid to those persons designated by the creator of the trust (the "remainder beneficiaries").

Establishment of such a trust does not constitute a penalized transfer of assets, and the trust assets are not countable resources of the disabled beneficiary. Such trusts may be established for a person under age 65 with a disability, with the assets of that person, thereby qualifying the person for SSI and/or Medicaid. The trust will also permit proper handling and management of the trust assets by a capable trustee.

9. Estate Recovery

Federal law requires that each state Medicaid agency seek to recover reimbursement from the estate of each deceased Medicaid recipient for nursing home or home and community based waiver services paid by Medicaid after the recipient was 55 years of age. This recovery right is codified at Mississippi Code Annotated § 43-13-317 (1972 as amended), which states as follows:

> (1) In accordance with applicable federal law and rules and regulations, including those under Title XIX of the Social Security Act, the division may seek recovery of payments for nursing facility services, home- and community-based services, and related hospital and prescription drug services from the estate of a deceased Medicaid recipient who was fifty-five (55) years or older when he received the assistance. The division shall be noticed as an identified creditor against the estate of the deceased Medicaid recipient pursuant to Section 91-7-145, Mississippi Code of 1972.

> (2) The claim shall be waived by the division (a) if there is a surviving spouse; or (b) if there is a surviving dependent who is under the age of twenty-one (21) years or who is blind or disabled; or (c) as provided by federal law and regulation, if it is determined by the division or by court order that there is undue hardship.

As codified, Medicaid's right of estate recovery does not extend to estates of deceased Medicaid recipients in coverage groups other than those expressly listed in the statute. Further, Medicaid will have no estate recovery claim if the nursing home resident has left the nursing home and no longer resides in the nursing home and is no longer receiving Medicaid assistance at the time of his death. Mississippi additionally will grant waivers of estate recovery where (1) the estate consists of only liquid assets totaling less than $5,000, (2) a relative lived in the home for at least one (1) year immediately prior to the individual's admission to a nursing facility and provided care to the individual which permitted the individual to remain at home, and has continuously resided in the home with no other residence, or (3) the property was a source of income for the family (such as a family farm).

A 2011 state court case held that Medicaid has no claim against the Medicaid recipient's ***homestead property*** at death IF the residence value is less than $75,000 equity AND s/he is survived by a spouse, child or grandchild who would take the residence as an inheritance. *Estate of Darby v. Stinson*, 68 So.3d 702 (Miss. App. 2011), cert. den. September 1, 2011. The basis of this holding is a probate statute that provides that property that is exempt from creditors under an exemption statute remains exempt from those creditors in the estate of the deceased owner/exemptioner, and will descend to that person's surviving spouse, children or grandchildren free of such claims. The court held that the statements in the decedent's Medicaid application acknowledging the existence of the estate recovery claims did not constitute a knowing and voluntary "waiver" by the applicant. However, based on suggestions in the opinion that other states have made their application forms more explicit so as to support a knowing, voluntary waiver of the protection of the statute in the execution of the application, the Division of Medicaid has revised the language pertaining to the estate recovery in its application. A 2015 Attorney General's Opinion affirmed that Medicaid will not have a recovery claim against homestead property owned by

the Medicaid recipient at his/her death, and such property will descend to that person's surviving spouse, child(ren) or grandchild(ren). Mississippi AGO No. 2015-304 (Dec. 23, 2015).

C. Medicaid and the Affordable Care Act

> *"Everybody wants to laugh, but nobody wants to cry; Everybody wants to go to heaven, but nobody wants to die."* Thomas H. "Tom" Delaney (1889-1963, jazz & blues composer)

1. Overview

July 2011 was the 45th anniversary of the enactment of Medicare and Medicaid, signed into law by President Lyndon B. Johnson on July 30, 1965. Those programs went into effect July 1, 1966, and have provided the health care safety net for millions of Americans. Prior to Medicare, one-half of America's older adults were uninsured. In 1963, when President Kennedy declared May as "Senior Citizens Month" (later changed to "Older Americans Month" by President Jimmy Carter), there were approximately 17.5 million Americans over age 65. Thirty-three percent of these seniors lived under the poverty level income. In 2013, there were approximately 40.3 million Americans over age 65, but only 9% of them live under the poverty level. A major reason for the improvement in living standard has been that Medicare's health coverage helps older Americans live healthier lives with less financial strain. Today, over one-third (34%) of the elderly have household incomes below 200 percent of the poverty threshold ($20,916 for individuals and $26,388 for couples age 65 and older), and three out of every four older adult households have an annual income of less than $40,000. Medicare covers 74 percent of the cost of their medical care.

According to the Congressional Budget Office, in 1975, a decade after the enactment of legislation creating the Medicare and Medicaid programs, federal spending on those programs, net of offsetting receipts, accounted for 1.2 percent of gross domestic product (GDP). That share rose to 2.0 percent of GDP by 1985 and has more than doubled since then, as net federal spending for the two programs grew to 4.6 percent of GDP in 2013, by CBO's estimates. Between 1985 and 2013, the share of the population enrolled in Medicare rose from 13 percent to 16 percent, and average annual enrollment in Medicaid rose from 8

percent to 18 percent of the population. Including the smaller CHIP (which was established in 1997), 20 percent of the population was enrolled in either Medicaid or CHIP, on average, in 2013, according to CBO's estimates. [http://www.cbo.gov/publication/44906, December 5, 2013]

Medicaid is the largest payer of long-term services and supports for older adults and people with disabilities. Over three million individuals receive long-term services paid for by Medicaid. The Medicaid program has evolved to become the "primary source of health and long-term care assistance" for nearly 60 million people and the "cornerstone of the nation's health care safety net." Landers, Renee M., J.D. and Leeman, Patrick A., J.D., *Medicaid Expansion Under the 2010 Health Care Reform Legislation: The Continuing Evolution of Medicaid's Central Role in American Health Care*, NAELA Journal, vol. VII, Number 1 (June 2011), p. 143-144. For every 1 percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million, and between June 2008 and June 2009 enrollment increased by approximately 3.3 million persons. Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer*, 1 (2010) [hereinafter *Medicaid: A Primer*].

According to Kaiser Family Foundation, the sum of $342 billion was spent in 2010 on long-term care services for all individuals. Of that sum, 41% was paid by Medicaid, 20% by Medicare post-acute care, 15% private pay, 7% private insurance, and 17% by other sources. Total long-term care spending on the more than 6 million elderly Medicaid beneficiaries totaled $81 billion, or almost a quarter of all long-term care spending.

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act of 2010 (PPACA) (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA) (Pub. L. 111-152) (hereinafter referred to as the Affordable Care Act, the Act, or ACA). The major goal of this legislation is to reach near universal health insurance coverage in the United States by improving access to affordable insurance coverage and requiring individuals to obtain coverage. Half the expected gains in insurance coverage were expected to result from the expansions of the Medicaid program. However, serious political and financial challenges have arisen to full implementation of the Act across all states.

2. Medicaid Eligibility Under the ACA.

The health reform law established a **new definition of income** — called Modified Adjusted Gross Income, or MAGI —that will be used in determining eligibility for premium credits. MAGI is Adjusted Gross Income as determined under the federal income tax, plus any foreign income or tax-exempt interest that a taxpayer receives. Starting in 2014, eligibility for most Medicaid and CHIP beneficiaries under age 65 will also be determined using MAGI, and family size will also be based on the tax filing unit. The family's assets will not be considered in determining eligibility. These new income eligibility rules generally will apply to all children except foster children, who automatically qualify for Medicaid, and to all adults under 65 except those who qualify for Medicaid as a disabled individual. The health reform law does *not* change Medicaid eligibility rules for beneficiaries who are 65 or older or those in eligibility categories based on disability. Starting in 2014, with the switch to MAGI, states will no longer be able to maintain their current disregards and deductions in determining whether someone qualifies for benefits. Instead, there will be a single methodology that will determine how income is counted. The use of MAGI will standardize and simplify income eligibility across states and between Medicaid, CHIP and the exchange premium subsidies, and help lower state administrative costs related to eligibility determinations, by adopting what is essentially a gross income test.

According to The Fiscal and Economic Impacts of Medicaid Expansion in Mississippi, 2014-2025 by Bob Neal, Ph.D., Senior Economist, University Research Center, Mississippi Institutions of Higher Learning (October 2012):

> "Expanding Medicaid to all non-elderly adults in Mississippi will increase the demand for healthcare. In the first three years of expansion (2014-2016) an estimated 313,000 new adults may be added to Mississippi's Medicaid rolls. The Federal government will cover 100 percent of these costs; $1.2 billion to $1.3 billion. Not every newly eligible Medicaid enrollee will be seeking healthcare for the first time. Some were already receiving healthcare services and paying for it out-of-pocket, while some were receiving uncompensated care. Newly eligible Medicaid enrollees who were deferring healthcare because they could not afford it will create additional demand for

healthcare services. Even those individuals who were paying for healthcare out-of-pocket will likely increase their demand now that the State and Federal government are paying for it.

In 2011, more than half of the counties in Mississippi had a shortage of healthcare professionals (doctors, dentists, nurses, etc.). Currently, there are 49 counties in Mississippi, containing 1.6 million residents, that are designated Healthcare Professional Shortage Areas (HPSA) by the U.S. Department of Health and Human Services. These counties are mostly rural and have high rates of poverty, unemployment and chronic illnesses. It is from these counties that many newly eligible Medicaid enrollees will come. In 2012, HPSA counties in Mississippi needed 430 additional primary care physicians to meet The Council on Graduate Medical Education (COGME) utilization requirements for primary care physicians; 55 counties needed an additional 300 dentists.

Over half of the physicians in Mississippi are located in four urban areas; 36% are located in the Jackson metro area alone. Nationally, an estimated 26 percent of physicians do not accept Medicaid patients; furthermore, 36 percent are not accepting new Medicaid patients. There is little excess capacity in the Mississippi healthcare sector, certainly none in the HPSA counties. Any increase in demand for healthcare will require additional healthcare providers.

It will be difficult to recruit healthcare professionals from other states since most other states are expected to adopt Medicaid expansion. Mississippi may be unable to train or recruit enough doctors, dentists, nurses, and other healthcare professionals to meet the new demand for healthcare. If Mississippi adopts Medicaid expansion, some of the increased demand for healthcare may go unmet because of a shortage of healthcare professionals."

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Rick and his wife, Ruthie, have adult twin daughters, one of whom has a disability. Rick has been active in community involvement as a Director of Mustard Seed, Inc., President and Director of the Cerebral Palsy Foundation of Mississippi, Inc., President of the Advisory Board of Hospice Ministries Inc., a director of the Heritage School for children with learning disabilities, member of the Occupational Therapy Council of Advisors for the Mississippi State Department of Health, and a member of the Alzheimer's Association-Middle Mississippi Chapter. He has written articles and has delivered many presentations for lawyers, health-care professionals, churches and community groups on elder law and estate planning subjects and topics of interest to senior adults, caregiver children and spouses, and families with special needs.