

The National Agricultural
Law Center



University of Arkansas · System Division of Agriculture
NatAgLaw@uark.edu · (479) 575-7646

An Agricultural Law Research Article

**Estate Planning for Farm and Ranch Families
Facing Long-Term Health Care**

by

Roger A. McEowen

Originally published in NEBRASKA LAW REVIEW
73 NEB. L. REV. 104 (1994)

www.NationalAgLawCenter.org

Estate Planning for Farm and Ranch Families Facing Long-Term Health Care

TABLE OF CONTENTS

I. Introduction	105
II. Medicaid Eligibility	106
A. Circumstances Test	106
B. Income Test	110
1. Available Income	110
2. Deeming	110
3. The "Name-on-the-Check" Rule	111
4. Countable Income v. Actual Income	112
III. Estate Planning Techniques and Considerations	112
1. Exempt Assets	113
2. Asset Transfers Prior to August 10, 1993	115
3. Asset Transfers After August 10, 1993	116
4. Trusts Prior to August 10, 1993	118
5. Trusts After August 10, 1993	122
6. Income-Producing Property Used in Trade or Business	125
7. Retained Life Interests	126
8. Medicaid Retirement Planning	127
9. Minority Business Interests	129
10. Long-term Care Insurance	130
11. Medicaid Appeals Process	133
IV. Protecting the Medicaid Beneficiary and Beneficiary's Estate from Reimbursement Claims	138
V. Conclusion	141

Copyright held by the NEBRASKA LAW REVIEW.

* Assistant Professor of Agricultural Economics and Extension Specialist, Agricultural Law and Policy, Kansas State University, Manhattan, Kansas. Member of Kansas and Nebraska Bars.

I. INTRODUCTION

Estate and business planning for farm and ranch clients is complex due to their unique planning needs.¹ This complexity is multiplied exponentially when a member of the farm or ranch family suffers (or is likely to suffer) from an illness, disease, or injury that will require long-term health care.

The cost of long-term health care is high.² Quite often an important planning goal for farmers and ranchers is to transfer the farming or ranching operation intact to the next generation. As a result, avoidance of an unnecessary depletion of operating assets as well as sale of the land to pay for long-term health care becomes a primary objective.

The Medicaid program is the primary source of public assistance for persons living in nursing homes³ and is the primary public financier of long-term health care.⁴ While many practitioners may believe that the Medicaid qualification rules limit benefit eligibility to only the very poor, significant planning opportunities exist which can be utilized to qualify an individual for Medicaid benefits who otherwise has the financial resources to pay the cost of long-term care. Conse-

1. The unique planning needs of farmers and ranchers include the traditionally close relationship of the farm family to the farm firm and the historic dominance of the sole proprietorship organizational form. For example, in 1987, 86.7% of all farms were operated as sole proprietorships. Of those farms operated in the corporate form, 90.7% were family held. 1987 CENSUS OF AGRICULTURE, (Geographic Series, Vol. 1 1990). Other factors contributing to the unique planning needs of farmers and ranchers include the constraints placed on the use of some traditional organizational forms (i.e., state restrictions on corporate farming); the existence of land as a major portion of the farm and ranch estate leading to a low ratio of liquid to fixed assets; and the relatively modest use of life insurance.
2. In 1992, the national average annual nursing home cost was \$36,000. In addition, it is estimated that for those persons born in 1925, 43% will enter a nursing home at least once before they die. Peter Kemper and Christopher M. Murtaugh, *Lifetime Use of Nursing Home Care*, 324 NEW ENG. J. MED. 595 (1991).
3. See, e.g., 42 U.S.C. § 1396 (1988).
4. The Medicare Program, to a limited extent, covers nursing home care. Medicare will pay the nursing home bill for the first 20 days if admission to the nursing home is within 30 days of a discharge from a hospital stay of three or more days. Medicare pays a portion of the nursing bill for days 21-100 and nothing for residencies extending beyond 100 days. 42 U.S.C. § 1395d(a)(2)(A) (1992).

The Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services which directs the Medicare and Medicaid programs, estimates that the number of Americans covered by Medicaid in fiscal year 1992 was 31.6 million with outlays from the federal government totalling 67.8 billion (\$2,145.57 per person). Department of Health and Human Services, News Release Medicare and Medicaid Guide, New Developments (CCH) ¶ 41,312 (Mar. 17, 1993).

Total outlays (federal and state) are projected to be \$359 billion annually by the year 2000 (\$1,436.00 for every man, woman, and child in the United States assuming a near constant U.S. population of 250 million). *Id.* at ¶ 41,527. In addition, about 40% of persons with AIDS have their health care costs (estimated to average \$38,000 per person/per year in 1992) paid for by Medicaid. *Id.*

quently, it becomes imperative for practitioners to consider the impact of traditional planning techniques on Medicaid eligibility as well as the feasibility of incorporating Medicaid planning options into the overall estate and business plan.

This Article will focus on specific planning options that practitioners should consider when counseling clients facing long-term health care. Both recent changes in Medicaid rules as well as significant recent case law will be discussed in this Article. However, a detailed analysis of the various Medicaid rules and regulations, including a discussion of the Medicaid eligibility rules, is not within the scope of this Article.⁵

II. MEDICAID ELIGIBILITY

Recent court decisions have helped clarify some of the Medicaid statute's eligibility rules and regulations. The Medicaid eligibility rules constitute the most important part of the Medicaid program because they serve as the primary barrier to receipt of program benefits for Medicaid applicants.

A. Circumstances Test

The circumstances test entitles certain categories of persons to Medicaid benefits.⁶ States participating in the Medicaid program have the option to cover "medically needy" persons.⁷ "Medically needy" persons are those persons whose income is too high to entitle them to Medicaid benefits but who otherwise meet all categorical criteria for entitlement.⁸ "Medically needy" persons become eligible for Medicaid benefits when their combined income and asset levels are insufficient to meet the costs of their health care.⁹

A recent Connecticut federal district court case dealt with the eligibility status of individuals denied participation in Connecticut's home based health care program (HCBS) because they had too much income.¹⁰ However, had these individuals been institutionalized in a nursing home, their asset and income levels would have been insuffi-

5. For a thorough discussion of the Medicaid statute, rules and regulations, including a discussion of the Medicaid qualification rules, see Roger A. McEowen and Neil E. Harl, *Estate Planning for the Elderly and Disabled: Organizing the Estate to Qualify for Federal Medical Extended Care Assistance*, 24 *IND. L. REV.* 1379 (1991).

6. *Id.*

7. 42 C.F.R. § 435.1(b)(3)(i) (1993). See also *Correll v. Division of Social Serv.*, 418 S.E.2d 232 (N.C. 1992).

8. 42 C.F.R. § 435.1(b)(3)(i) (1993).

9. *Id.* See also *Ross v. Department of Human Serv.*, 469 N.W.2d 739 (Minn. Ct. App. 1991).

10. *Skandalis v. Rowe*, 811 F. Supp. 782 (D. Conn. 1993).

cient to meet the costs of their nursing home care. The Medicaid program permits states to operate a home care program.¹¹ The Medicaid HCBS program allows a state to provide medical services at the state's option to any group or groups of individuals who are not categorically needy but who would be eligible under the state plan if they were in a medical institution. If not for this provision of home or community based services, such individuals would require the level of care provided in a hospital, nursing facility, or intermediate care facility.¹²

In addition, the Medicaid statute conditions a state's participation in the HCBS program upon a finding by the Secretary of Health and Human Services (hereinafter Secretary) that the estimated Medicaid expenditure will not exceed "the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted."¹³ In *Skandalis v. Rowe*,¹⁴ the plaintiffs' were denied participation in the state waiver program on the ground that their income exceeded 300% of the monthly Social Services income grant. Had they been institutionalized, they would have been eligible for Medicaid benefits as medically needy. Yet they were denied participation in Connecticut's HCBS.

At issue was whether the provision for the Medicaid home and community based services program required the state of Connecticut to include those persons eligible for Medicaid benefits as "medically needy." The court found the plaintiffs' to be eligible for the HCBS program under the statute's express terms.¹⁵ The court added that the statute provided no basis for denial of participation in the HCBS program to an individual based on the manner in which such individual qualified for Medicaid. Further, the court stated that Congress intended to enable the elderly to avoid institutionalization when they could be safely cared for in the community, so long as that goal could be accomplished without increasing Medicaid expenditures.¹⁶ Consequently, Connecticut's scheme would result in an incongruity whereby the state could be required to provide Medicaid coverage for the plaintiffs' institutional care but not for the plaintiffs' home care, although experience has proven the latter alternative to be less costly, equivalently appropriate, and safe.

Under the circumstances test, all recipients of categorical welfare assistance are entitled to Medicaid.¹⁷ In 1972, Congress restructured

11. 42 U.S.C.A. § 1396n(c)(1) (West Supp. 1994).

12. *Id.* § 1396n(c)(2)(C).

13. *Id.* § 1396n(c)(2)(D).

14. 811 F. Supp. 782 (D. Conn. 1993).

15. *Id.* at 785.

16. *Id.* at 787.

17. 42 U.S.C.A. § 1396a(a)(10) (West Supp. 1994); 42 C.F.R. §§ 435.120-135 (1993).

the Social Security program and replaced three of the four welfare assistance programs with Supplemental Security Income (SSI) for the aged, blind, and disabled.¹⁸ This restructuring broadened Medicaid income eligibility requirements, resulting in a significant increase in the number of individuals categorically eligible for Medicaid in many states.¹⁹ As a result, in 1974, Congress offered participating states the ability to elect to provide Medicaid only to those persons who would have been eligible under that particular state's Medicaid plan in effect on January 1, 1972.²⁰ This election is commonly known as the "section 209(b) option," and states making the election are known as "section 209(b) states."²¹

In section 209(b) states, Medicaid eligibility criteria must be at least as restrictive as the SSI criteria and may be no more restrictive than the criteria in effect under a particular state's Medicaid plan as of January 1, 1972.²² Before 1988, it was commonly thought that only those states whose plans in effect on January 1, 1972, contained eligibility criteria more restrictive than the SSI criteria could elect to become a section 209(b) state. In addition, it was believed that section 209(b) states could not provide Medicaid coverage to persons who would not qualify for Medicaid in an SSI state. In 1988, Congress enacted the Federal Methodology Statute²³ which stated that ". . . [t]he methodology to be employed in determining income and resource eligibility for individuals under . . . [section 209(b)] . . . may be less restrictive, and shall be no more restrictive than the methodology . . . [under the Supplemental Security Income program]. . . ."²⁴ The effective date of this statute was October 1, 1988.

In *Indiana Department of Public Welfare v. Payne*,²⁵ the state Medicaid agency argued that Indiana, as a section 209(b) state, was prevented from providing Medicaid coverage to persons who would not also be eligible for Medicaid in an SSI state. The court disagreed and held that the Federal Methodology Statute allowed Indiana (and other section 209(b) states) to use its state plan even if that plan employed a

18. 42 U.S.C. §§ 1381-1391. Aid to Families with Dependent Children (AFDC) was not federalized under SSI. *Id.* §§ 601-617.

19. *See, e.g.,* *Darling v. Bowen*, 878 F.2d 1069, 1071 (8th Cir. 1989). *cert. denied sub. nom.* *Stangler v. Darling*, 494 U.S. 1066 (1990).

20. 42 U.S.C. § 1396a(f) (1988).

21. Presently, 13 states are § 209(b) states. These states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.

22. 42 C.F.R. § 435.121(a) (1993).

23. 42 U.S.C. § 1396a(r)(2) (1988).

24. *Id.*

25. 598 N.E.2d 608 (Ind. 1992).

more liberal income or resource eligibility methodology than those used in SSI states.²⁶

The Indiana Medicaid program was also at issue in *Roloff v. Sullivan*.²⁷ As a qualification on the section 209(b) exception, section 209(b) states must perform an "income spend down" when calculating available income by deducting "incurred expenses for medical care."²⁸ When income spend down is used, a recipient's Medicaid payments are reduced by the applicant's excess income.²⁹ Under Indiana's Medicaid program, an applicant's income is calculated on the first day of the month in which application for benefits is made without regard to any depletions of the applicant's income occurring later in the month. Thus, an applicant who depleted excess income during the month of application must wait until the beginning of the next month to qualify for Medicaid.

The plaintiffs in *Roloff* argued that Indiana's procedures violated the Medicaid statute because they were more restrictive than the state's criteria in effect on January 1, 1972.³⁰ The court, in ruling for Indiana's procedure, found that the petitioners failed to show that they were entitled to receive SSI benefits in the month they were denied Medicaid benefits. As a result, the court ruled that section 209(b) only applied to those applicants entitled to receive SSI benefits under current federal standards who also would have been entitled to receive Medicaid benefits under Indiana's plan in effect on January 1, 1972.³¹ Moreover, the court only approved Indiana's rule to the extent that it excluded from Medicaid coverage categorically needy persons ineligible for benefits under the January 1, 1972 plan.³²

26. Hence, the resource eligibility rule authorizing resource spend-down was found not to be inconsistent with the rule requiring the applicant's resources to be evaluated as of the first day of the month but was merely an additional eligibility criterion. *Id.* at 610.

27. 975 F.2d 333 (7th Cir. 1992).

28. 42 U.S.C.A. § 1396a(f) (West Supp. 1994). Income spend down is the process whereby an applicant's income is reduced for the purposes of determining Medicaid eligibility by the amount of incurred but unpaid medical expenses not covered by third-party payers. State Medicaid agencies are not required to consider debt owed by a Medicaid applicant when determining Medicaid eligibility. If a Medicaid applicant has access to bank account funds, the applicant must apply those funds toward the outstanding debt. *Gill v. Ohio Dep't of Human Serv.*, No. 60567, 1992 WL 205070 (Ohio Ct. App. Aug. 20, 1992).

29. *See* 42 C.F.R. § 435.831 (1993).

30. Indiana adopted its "first day of the month" rule in 1984. 470 Ind. Admin. Code tit. 470, § 9.1-3-17.

31. *Roloff v. Sullivan*, 975 F.2d 333, 341 (7th Cir. 1992).

32. *Id.*

B. Income Test

1. Available Income

With respect to income, Medicaid eligibility hinges upon the amount of an applicant's available income.³³ Recent court cases demonstrate how broadly "available income" is defined.³⁴ For example, in *Peura v. Mala*,³⁵ the Ninth Circuit held that mandatory tax withholdings constitute available income.³⁶ Also, one court has recently held that cost of living adjustments (COLA's) to Social Security payments of recipients residing in section 209(b) states constitute available income³⁷ as does income paid to an ex-spouse for child support under a divorce decree.³⁸ In addition, while the cash value of an insurance policy has been held to be available for Medicaid eligibility purposes,³⁹ a recent Indiana appellate court has held that the owner of a life insurance policy with a cash value that places the owner over the Medicaid eligibility limit can still qualify for Medicaid because the policy is not considered available income until the proceeds are converted to actual use.⁴⁰ However, the owner-applicant will still be requested to convert the policy to cash.⁴¹

2. Deeming

Available income can also be "deemed" from the applicant's spouse to the applicant for Medicaid eligibility purposes.⁴² A maintenance level of income and resources for the noninstitutionalized spouse is specified, and any funds exceeding the maintenance level are deemed available for contribution toward the costs of institutionalization.⁴³ Medicaid benefits are usually terminated if the noninstitutionalized spouse fails to contribute any excess.⁴⁴

33. 42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994).

34. For a discussion of earlier case law on the "available income" issue, see McEowen and Harl, *supra* note 5, at notes 37-38.

35. 977 F.2d 484 (9th Cir. 1992).

36. *See also* Himes v. Shalala, 999 F.2d 684 (2d Cir. 1993)(stating that mandatory payroll deductions and court-ordered support payments constitute "available income"); *Ross v. Department of Human Serv.*, 469 N.W.2d 739 (Minn. Ct. App. 1991).

37. *Noland v. Sullivan*, 785 F. Supp. 179 (D.D.C. 1992).

38. *Emerson v. Steffen*, 959 F.2d 119 (8th Cir. 1992)(construing Minnesota law).

39. *See Wilczynski v. Harder*, 323 F. Supp. 509 (D. Conn. 1971).

40. *Indiana Dep't of Public Welfare v. Teckenbrock*, 620 N.E.2d 740 (Ind. Ct. App. 1993).

41. *Id.*

42. 42 U.S.C.A. § 1396r-5 (West Supp. 1994).

43. *Id.* § 1396r-5(d) (West Supp. 1994).

44. "Deeming" is subject to many technical rules, and the rules vary between § 209(b) states and non-§ 209(b) states. For an overview of the deeming rules, see McEowen and Harl, *supra* note 5, at notes 39-75.

The major exception to the spousal deeming rules is for undue hardship.⁴⁵ If the Secretary determines that spousal deeming would be inequitable, deemed spousal income may be considered unavailable.⁴⁶ Absent a showing of undue hardship, however, a state may deny Medicaid benefits to an institutionalized spouse by deeming income and resources from the community spouse.⁴⁷

3. The "Name-on-the-Check" Rule

An issue closely related to the available income issue involves the "name-on-the-check" rule. This rule "requires that a Medicaid applicant's eligibility for benefits be based on the amount of money that the applicant receives each month in his or her name."⁴⁸ While the term "income" when used in a federal statute is to be defined in accordance with state law,⁴⁹ the "name-on-the-check" rule does not recognize state community property law in its application.⁵⁰ Instead, the "name-on-the-check" rule looks only at the amount of income an individual actually receives in the individual's own name. Consequently, if the spouse in whose name all (or a large portion of) income is received is institutionalized and a Medicaid application is made, all of the couple's income will be considered "available" to the institutionalized spouse for Medicaid eligibility purposes.⁵¹

The Tenth Circuit has recently dealt with the issue of the application of the "name-on-the-check" rule in a community property state. In *New Mexico Department of Human Services v. Department of Health and Human Services*,⁵² the court ruled that the Secretary may not force a community property state to calculate Medicaid eligibility

45. See 42 C.F.R. § 435.734(b)(2) (1993). See also 42 U.S.C.A. § 1396r-5 (West Supp. 1994).

46. See 42 C.F.R. § 435.734(b)(2) (1993). See also 42 U.S.C.A. § 1396r-5 (West Supp. 1994).

47. *Bowden v. Delaware Dep't of Health*, No. 92A-08-001, 1993 WL 390480 (Del. 1993)(holding no undue hardship where community spouse found to have excess assets).

48. See, e.g., *Washington Dep't of Social & Health Serv. v. Bowen*, 815 F.2d 549, 552 (9th Cir. 1987).

49. See *Poe v. Seaborn*, 282 U.S. 101, 110 (1930)(stating that the term "income of" in a federal tax statute indicates ownership as defined under state law).

50. In a community property jurisdiction, all marital property is owned in common by the spouses with each spouse owning an undivided one-half interest by reason of marital status. In community property states, one-half of the earnings of each spouse are considered owned by the other spouse. Whereas in common law states, each spouse owns whatever he or she earns. Presently, nine states are community property jurisdictions. Those states are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

51. It should be noted that the "name-on-the-check" rule could produce a favorable result in community property states in situations where a spouse earning no income is institutionalized.

52. 4 F.3d 882 (10th Cir. 1993).

in accordance with the "name-on-the-check" rule.⁵³ The court found the "name-on-the-check" rule to be contrary to state community property law and inconsistent with the Medicaid statute.⁵⁴

4. *Countable Income v. Actual Income*

In addition to income being available to a Medicaid applicant, income must also be countable.⁵⁵ Only an applicant's income that is received in cash or check *and* is available to meet the applicant's basic needs is considered income for Medicaid eligibility purposes.⁵⁶

There appears to be a split of authority concerning whether items that were not considered countable income in determining a Medicaid applicant's eligibility can be considered countable income after eligibility has been established in order to assess the amount the recipient must contribute toward the cost of the recipient's care. In *Lamore v. Ives*,⁵⁷ the court held that Veteran's benefits, while not considered as countable income in the eligibility determination, are to be considered in the post-eligibility phase in determining how much the recipient must contribute toward the cost of care.⁵⁸ However, in *Ginley v. White*,⁵⁹ the court held that the identical provision operated to bar participating states from including in income in the post-eligibility phase those items that were excluded during the eligibility phase.⁶⁰

III. ESTATE PLANNING TECHNIQUES AND CONSIDERATIONS

Estate planners with elderly clients, clients with medical conditions, or clients whose families have a history of needing long-term care should carefully consider the available options for minimizing the financial impact that long-term care can have on the family's wealth position.⁶¹ Arguably, the Model Rules of Professional Conduct require

53. *Id.* at 886.

54. *Id.*

55. See 20 C.F.R. § 416.1104 (1993).

56. 42 U.S.C.A. § 1396a(a)(17)(B) (West Supp. 1994); 20 C.F.R. § 416.1102 (1993) (stating that income includes food, clothing, shelter, or something that can be used to obtain food, clothing, or shelter).

57. 977 F.2d 713 (1st Cir. 1992).

58. *Id.* at 720, citing 42 U.S.C. § 1396a(a)(17) (1988).

59. Medicare and Medicaid Guide, New Developments (CCH) ¶ 40,003 (D. Pa. 1992).

60. *Id.*, citing 42 U.S.C. § 1396a(a)(17) (1988).

61. Some individuals claim that attorneys who advise clients on how to employ estate planning techniques to shift assets away from clients facing long-term health care are engaging in unethical conduct. For example, the Ohio Senate Ways and Means Committee in 1992 considered legislation that would disbar attorneys if they advised clients on how to transfer assets in order to qualify for Medicaid. The legislation (Substitute Senate Bill 366) never made it out of committee.

such a consideration.⁶² If, after adequate research, an attorney does not feel he can competently advise the client on such estate planning techniques, competent representation requires that the lawyer refer the client to another attorney better versed in the subject matter.⁶³

1. *Exempt Assets*

Some assets are exempt from the income and asset restrictions in the Medicaid law.⁶⁴ The beginning point in counseling clients facing potential long-term health care and an application for Medicaid is to arrive at a knowledge of what assets a client may continue to own without having those assets being counted toward the Medicaid eligibility limits.⁶⁵

Once an individual is institutionalized, that person's home is exempt from the resource calculation if the noninstitutionalized spouse ("community spouse") or a dependent relative continues to live in the

However, advising clients how to legitimately and legally transfer assets and utilize other estate planning techniques to qualify for Medicaid benefits is good lawyering, though it may be personally unpalatable to some attorneys. There is no legal obligation to deplete one's resources paying for one's medical care when other legal avenues are available. The similarity to tax planning is obvious. In *Helvering v. Gregory*, 69 F.2d 809, 810 (2nd Cir. 1934), *aff'd* 293 U.S. 465 (1935), Judge Learned Hand said: "Any one may so arrange his affairs that his taxes shall be as low as possible; he is not bound to choose that pattern which will best pay the Treasury; there is not even a patriotic duty to increase one's taxes." In addition, there may be a two-edged sword at work here—failure to advise a client on how to qualify for Medicaid might subject an attorney to a malpractice action. *See, e.g., Darke County Bar Assoc. v. Brumbaugh*, 602 N.E.2d 606 (Ohio 1992)(holding that a lengthy delay in recertifying client's Medicaid entitlement, causing client to incur \$4,000 debt was sufficient to warrant a six month suspension from law practice).

62. "A lawyer shall provide competent representation to a client." MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.1 (1981). In addition, an argument can be made that attorneys practicing in Iowa are presumed to know the Medicaid laws since, in Iowa, all *citizens* are presumed to know and understand the rule against perpetuities. *See Millwright v. Romer*, 322 N.W.2d 30 (Iowa 1982).

63. "[C]ompetent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation." MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.1 (1982). *See, e.g., Horne v. Peckham*, 158 Cal. Rptr. 714 (Cal. Ct. App. 1979)(finding an obligation to conduct research and make informed decisions as to course of conduct, and to refer to specialist if reasonably skillful practitioner would do so).

64. *See, e.g.,* 20 C.F.R. § 416.1210 (1993).

65. Even though the level of assets that may be retained without being subject to the Medicaid eligibility limits is small, for individuals with small estates and for individuals who wait until the last minute before contacting their attorney, knowledge of the exempt assets is crucial. In addition, the list of exempt assets may vary from state to state. Planners should consult their own state's list of exempt assets.

home.⁶⁶ If there is no community spouse or dependent relative, the home is exempt if the institutionalized individual intends to return to the home.⁶⁷ However, if an otherwise exempt home is sold, the proceeds of sale are not exempt unless used to purchase another home within three months of the receipt of the proceeds.⁶⁸

Household goods and personal items having an equity value of \$2,000 or less⁶⁹ as well as the total fair market value of one automobile necessary for employment, medical treatment, or to provide transportation for essential daily activities⁷⁰ are also exempt resources. If the automobile is not necessary for one of these reasons, it is excluded as a resource up to \$4,500 in value.⁷¹

Other exempt assets include the cash surrender value of life insurance policies with combined face values of \$1,500 or less per individual;⁷² up to \$6,000 of equity in trade or business property essential for self-support if such property produces a net annual income of at least six percent of excluded equity;⁷³ and up to \$6,000 of equity in nonbusiness property used to produce goods or services for daily activities.⁷⁴ Also exempt is up to \$1,500 in a designated account or fund earmarked for burial arrangements⁷⁵ and contracts for the purchase of burial space.⁷⁶ One exempt asset of particular importance to farmers is disaster relief assistance and any interest earned on such assistance for a period of nine months beginning on the date the assistance is received.⁷⁷

-
66. 20 C.F.R. §§ 416.1210(a), 416.1212(c) (1993). The home is an exempt resource regardless of value unless there is income producing property on the home-site that does not qualify under the home exclusion. See 20 C.F.R. §§ 416.1220-416.1224.
67. *Id.* § 416.1212(c). Medicaid applicants need not actually own their homes to be able to exclude the value of a contiguous parcel of real estate that they do own from the resource calculation. *Correll v. Division of Social Serv.*, 418 S.E.2d 232 (N.C. 1992) (construing North Carolina law).
68. 20 C.F.R. § 416.1212(d) (1993). In addition, proceeds received from state condemnation of a Medicaid recipient's home while the recipient is institutionalized are exempt. *Zeringue v. LaFourche Parish Office*, 597 So. 2d 1142 (La. 1992) (determining that condemnation is an involuntary conversion of house to cash).
69. 20 C.F.R. §§ 416.1210(b), 416.1216(b) (1993).
70. *Id.* § 416.1218(b)(1)(i-iv) (1993).
71. *Id.* § 416.1218(b)(2) (1993). If the market value exceeds \$4,500, the excess is counted against the resource limit. *Id.*
72. *Id.* § 1230(a) (1993).
73. *Id.* § 416.1222(a) (1993).
74. *Id.* § 416.1224 (1993). This type of property includes real estate used to produce vegetables and livestock for personal consumption in the applicant's household. *Id.*
75. *Id.* § 416.1210(l) (1993).
76. *Id.* § 416.1231(a)(3) (1993).
77. *Id.* § 416.1237(a-b) (1993). The assistance must be the result of a catastrophe in a presidentially declared disaster area. In addition, the initial nine month exemption period can be extended for up to an additional nine months if the recipi-

2. Asset Transfers Prior to August 10, 1993

The rules concerning asset transfers have changed significantly with the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).⁷⁸ OBRA '93 became effective on August 10, 1993, and the new asset transfer rules apply as of October 1, 1993 to all transfers made after August 10, 1993.⁷⁹ Thus, it is important to determine when a particular transfer was made in order to know which rules apply.

For transfers occurring on or before August 10, 1993, Medicaid benefits are denied to individuals if a Medicaid application is made within thirty months of the transfer, and the transfer was made with the intent to qualify for Medicaid.⁸⁰ The time period for benefit denial is set at the number of months (up to thirty) that would be needed to spend the uncompensated value of the transferred asset(s) on nursing home care in the applicant's state or (at state option) in the applicant's community.⁸¹

Transfers made within thirty months of a Medicaid application raise a presumption that the transfer was made with the intent to qualify for Medicaid.⁸² The presumption is rebuttable with a showing of intent to dispose of the assets either at fair market value or that the transfer was for a purpose other than to qualify for Medicaid.⁸³

There have been some recent developments concerning the ability to overcome the presumption that a particular transfer was made with the intent to qualify for Medicaid.⁸⁴ The major development concerns a split of authority on the issue of whether a surviving spouse's waiver of marital rights to take an elective share of the deceased spouse's estate constitutes a disqualifying asset transfer.

Until 1993, the prevailing view was that a surviving spouse's waiver to take an elective share did not constitute a disqualifying asset transfer.⁸⁵ Courts reasoned that a disqualifying transfer had not

ent is prevented from making necessary repairs or replacing damaged property by circumstances beyond the recipient's control. *Id.* § 416.1237(c) (1993).

78. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13611, 107 Stat. 312, 622 (1993) (codified as amended at 42 U.S.C.A. § 1396p(c)(1) (West Supp. 1994)).

79. *Id.*

80. 42 U.S.C.A. § 1396p(c)(1)(A) (West Supp. 1994).

81. *Id.* § 1396p(c)(1)(B). For example, if a Medicaid applicant transfers an asset worth \$50,000 and receives nothing in return, the uncompensated value of the transfer is \$50,000. If the cost of nursing home care in the transferor's state or community is \$2,000 per month, the Medicaid ineligibility period will be 25 months ($\$50,000 \div 2,000$) beginning from the date of application.

82. 42 U.S.C.A. § 1396p(c)(2)(C) (West Supp. 1994).

83. *Id.*

84. For a review of prior cases on this issue, see McEowen and Harl, *supra* note 5 at notes 191-218.

85. *See, e.g.,* Bradley v. Hill, 457 S.W.2d 212 (Mo. Ct. App. 1970).

occurred because the surviving spouse's rights to a statutory share did not automatically vest upon the decedent's death absent an order from the probate court.⁸⁶ However in *Hinschberger v. Griggs County Social Services*,⁸⁷ the North Dakota Supreme Court held that a surviving spouse's release of his interest in his wife's estate constituted a disqualifying transfer for less than fair market value to the extent the release was less than the surviving spouse's interest in the estate.⁸⁸ Under North Dakota law, the surviving spouse was entitled to an elective share of \$12,855 plus an additional \$5,000 allowance for exempt property, for a total elective share of \$17,855. The surviving spouse, however, only took \$14,000. Consequently, the court found a disqualifying transfer of \$3,855.

3. Asset Transfers After August 10, 1993

As previously mentioned, OBRA '93 significantly changed the rules regarding asset transfers.⁸⁹ While the new asset transfer rules apply as of October 1, 1993 to all transfers made after August 10, 1993, some states may need to draft legislation to come into compliance with the requirements of the new federal law. Depending on a particular state's legislative sessions, the new rules may not apply in some states until some time after October 1, 1993.⁹⁰

Under OBRA '93, the look-back period for asset transfers has been extended to thirty-six months.⁹¹ The ineligibility period remains set at the number of months that otherwise would be required to spend the uncompensated value of the transferred assets on nursing home care in the applicant's state (or the community at the state's option). However, the ineligibility period is no longer capped at any particular number of months.⁹² Transfers occurring outside of the thirty-six month look-back period need not be reported to the state Medicaid agency. Also, Medicaid eligibility can be immediate if all other requirements are met. But, all transfers made during the look-back pe-

86. See, e.g., *Stamer v. Estate of Wright*, 701 S.W.2d 789 (Mo. Ct. App. 1985); *Estate of Savage v. Pogue*, 650 S.W.2d 346 (Mo. Ct. App. 1983).

87. 499 N.W.2d 876 (N.D. 1993).

88. *Id.* at 882.

89. See *supra* note 78 and accompanying text.

90. This creates a quandary for practitioners attempting to counsel clients with long-term care needs. Since it is impossible to know beforehand whether particular state legislation will be retroactive, the prudent path to take would be to assume the new law became effective October 1, 1993 and applies to transfers made after August 10, 1993.

91. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13,611(a)(1), 107 Stat. 312, 622 (1993)(codified as amended at 42 U.S.C.A. § 1396p(c)(1)(A) (West Supp. 1994)).

92. *Id.* § 13611(a)(1), 107 Stat. 312, 622 (codified as amended at 42 U.S.C.A. § 1396p(c)(1)(B)(i) (West Supp. 1994)).

riod must be added together to calculate the number of months of ineligibility.⁹³

The previous Medicaid law contained a waiver provision that could operate to set aside an otherwise prohibited transfer if application of the transfer rule would cause "undue hardship."⁹⁴ Yet the waiver was seldom used. Under the new law, the Secretary is required to establish criteria for states to follow in establishing procedures for permitting waiver of transfer penalties where undue hardship would result.⁹⁵ It appears that Congress intends for states to use their discretion to protect individuals where application of the penalty would cause undue hardship and run counter to the purpose of the Medicaid programs. Further, it appears that by mandating state procedures and requiring the Secretary to set criteria, Congress wants more waivers to be granted.⁹⁶

The new law also contains several exceptions to the transfer rules. The new law maintains the prior law's exception for transfers between spouses or to minor or disabled children of the transferor⁹⁷ as well as the exception for transferring the home to caretaker children and certain siblings of the Medicaid applicant.⁹⁸ Moreover, transfers to trusts created solely for the benefit of disabled children of the Medicaid applicant or to certain trusts created for a disabled child or grandchild under age sixty-five are exempt from the transfer rules.⁹⁹

Another significant change in the new law concerns the treatment of jointly held property.¹⁰⁰ Under the new law, any action of a co-owner of jointly held property that reduces an applicant's ownership interest in or control of an asset will be considered a disqualifying transfer.¹⁰¹ This new provision also covers property owned jointly as

93. *Id.* § 13611(a)(1), 107 Stat. 312, 622 (codified as amended at 42 U.S.C.A. § 1396p(c)(1) (West Supp. 1994)).

94. 42 U.S.C. § 1396p(c)(2)(D) (1988).

95. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13611(a)(1) 107 Stat. 312, 622 (1993) (codified as amended at 42 U.S.C.A. § 1396p(c)(2)(D) (West Supp. 1994)).

96. Planners may want to test the availability of an undue hardship waiver in situations where it seems applicable.

97. 42 U.S.C.A. § 1396p(c)(2)(B) (West Supp. 1994).

98. *Id.* § 1396p(c)(2)(A)(iii-iv) (West Supp. 1994).

99. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13611(a)(1), 107 Stat. 312, 622 (1993) (codified as amended at 42 U.S.C.A. § 1396p(c)(2) (West Supp. 1994)). However, the "under age 65" language raises an important question. Must the trust be funded while the beneficiary is under age 65, or must the trust be terminated before the beneficiary reaches age 65? If the trust must terminate before the beneficiary reaches age 65, the exception may effectively be gutted since all trusts must have remaindermen. Perhaps directing payment of all trust assets to the disabled beneficiary's estate will solve the problem.

100. *Id.*

101. *Id.*

tenants-in-common and as tenants-by-the-entirety as well as property titled in the survivorship form.¹⁰²

4. *Trusts Prior to August 10, 1993*

Before OBRA '93, most trust Medicaid planning involved creating a discretionary trust as opposed to a support trust.¹⁰³ Planners would carefully draft language into the trust document explicitly evidencing the settlor's intent to give the trustee complete discretion to distribute trust income and principal. Similar language was employed to assure that the settlor's intent was to supplement rather than supplant public benefits otherwise available.¹⁰⁴

102. *Id.* It is uncertain whether a Medicaid applicant will be permitted to prove lack of contribution to the jointly held asset in order to establish lack of an ownership interest. An example would be the following. For federal estate tax purposes, I.R.C. § 2040 (West 1993) includes in a decedent's gross estate property that the decedent owned in joint tenancy except to the extent it can be proved that consideration was provided by the surviving joint tenant(s). This is commonly referred to as the "consideration furnished" rule.

103. A support trust directs the trustee to distribute trust income or principal as necessary for the support and maintenance of the beneficiary. RESTATEMENT (SECOND) OF TRUSTS § 154 (1959). A discretionary trust gives the trustee complete discretion to distribute all, some, or none of the trust income or principal to the beneficiary as the trustee deems necessary. *Id.* § 155.

104. For example, *Trust Co. of Oklahoma v. State ex rel. Dep't of Human Serv.*, 825 P.2d 1295 (Okla. 1991), involved a trust created for the primary purpose of providing nonmedical support which contained a provision giving the trustee discretion to provide medical care if the beneficiary ceased to qualify for medical assistance programs. Since the trust instrument clearly directed the trustee to use the trust income for the support of the beneficiary and gave the trustee no discretion to distribute or accumulate income not necessary for the beneficiary's care, the trust was not deemed an available resource for Medicaid eligibility purposes.

Similarly, a trust giving the trustee complete discretion to distribute trust assets and explicitly evidencing the settlor's intent to supplement rather than supplant government financial assistance was held not to be an available asset in *In re Leona Carlisle Trust*, 498 N.W.2d 260 (Minn. Ct. App. 1993). See also *Alabama Medicaid Agency v. Primo*, 579 So. 2d 1355 (Ala. Civ. App. 1991)(finding trust funds not an available resource where access to principal was restricted and distributions made at sole discretion of trustees).

However, the settlor's intent may not be followed with respect to a "trigger trust" whereby trust income and corpus is to be paid to the beneficiary while the beneficiary is not institutionalized, but such payments are to be suspended upon the beneficiary's placement in a nursing home. In *Arkansas Dep't of Human Serv. v. Walters*, 866 S.W.2d 823 (Ark. 1993), the court applied a state statute retroactively to render a "trigger trust" void as a matter of public policy to preserve the fiscal integrity of the Medicaid program. *Id.* at 826.

The settlor's intent to create a discretionary trust rather than a support trust was at issue in the recent Kansas Supreme Court case of *Meyers v. Kansas Dep't of Social and Rehabilitation Serv.*, 866 P.2d 1052 (1994). In *Meyers*, the decedent executed a will which provided for a trust for the care, support, and maintenance of her son. The decedent's son had been receiving public medical assistance from

Obviously, great care had to be exercised so as to not create a "Medicaid Qualifying Trust" (MQT).¹⁰⁵ Amounts included in a MQT were considered to be available to a Medicaid applicant to the maximum extent possible.¹⁰⁶

As for discretionary trusts, the MQT provisions provided that if a trustee had discretion to make payments, then the sum payable by the

the state of Kansas before the decedent's death and before the funding of the trust. After the decedent's death, the beneficiary applied for Medicaid assistance but was denied benefits because the state Medicaid agency claimed that the beneficiary had resources in excess of the applicable benefit eligibility level. In other words, the state Medicaid agency held that the trust assets were considered to be available to the beneficiary to meet his medical needs. *Id.* at 1053. The pertinent language of the decedent's testamentary trust at issue in the case was as follows: "B) During my son's lifetime, my trustee shall hold, manage, invest and reinvest, collect the income there from [sic] any [sic] pay over so much or all the net income and principal to my son as my trustee deems advisable for his care, support, maintenance, emergencies and welfare." *Id.* at 1054.

The state Medicaid agency maintained that the decedent's trust was a support trust containing mandatory language requiring the trustee to inquire into the basic support needs of the beneficiary and provide for those needs. The court disagreed with the state Medicaid agency's position and held the trust to be a discretionary trust with language giving the trustee full discretion to decide whether payments from the trust income or principal were advisable. The court held that the trust language tied payment of both income and principal to a determination of need and to the discretionary language "as my trustee deems advisable." *Id.* at 1055, 1059.

Conversely, the court held that the nondiscretionary language of "shall" pertained primarily to the management functions of the trust and did not control or override the discretionary language of "as my trustee deems advisable," which pertains to whether payment of net income or principal would be made at all and, if so, the amount and purpose of any such payment. In addition, the court stated that its holding would appear to be consistent with the intent of the decedent since provisions in the trust directed the trustee at the death of the decedent's son to distribute the principal and any undistributed net income to the remainderman. The court felt that this language indicated the testator's intention not to necessarily exhaust trust principal. *Id.* at 1058-59.

105. A "Medicaid Qualifying Trust" is:

a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payment, from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

42 U.S.C. § 1396a(k)(2) (1988).

106. *Id.* § 1396a(k)(1). In addition, the MQT provisions could not be avoided by terminating the trust beneficiary's rights in the trust assets upon the beneficiary's institutionalization. *See, e.g.,* Gulick v. Department of Health and Rehab. Serv., 615 So. 2d 192 (Fla. Dist. Ct. App. 1993). Similarly, a trust directing that the trustee "shall" make income and principal payments to a Medicaid applicant/beneficiary constituted an MQT. *See, e.g.,* Zimmerman v. Department of Health and Social Serv., 485 N.W.2d 290 (Wis. Ct. App. 1992).

trustee is available even if it was not actually distributed.¹⁰⁷ However, if trust principal could not be paid out within the trustee's discretion, then it was not available under the MQT rules.¹⁰⁸ Therefore, to avoid the application of the MQT rules, it was important to avoid drafting a trust which tied the payment of income to a determination of the beneficiary's need or which evidenced the grantor's intent to use trust income to prevent the beneficiary from becoming destitute. A trust drafted in this manner was considered available for Medicaid eligibility purposes.¹⁰⁹

While the MQT rules were clearly aimed at discouraging the use of discretionary trusts, there did exist several possibilities for avoiding the restrictions on sheltering assets through the use of discretionary trusts.¹¹⁰ Several of these methods have been the subject of recent cases.¹¹¹ One exception to the MQT rules exists for trusts in which the settlor and the beneficiary are not spouses. However, some states have attempted to limit the usefulness of these types of trusts by declaring them to be in violation of state fraudulent conveyance statutes or in violation of public policy.¹¹² One such recent case occurred in New York in *In re Cangelosi*.¹¹³ There, the court refused to permit the transfer of proceeds remaining from the compromise of a medical malpractice action into a trust for the benefit of a mentally retarded beneficiary. The court opined that since the purpose of the trust would be to permit the beneficiary to achieve Medicaid eligibility by diverting ownership from the beneficiary, the policy of the New York Estates, Powers and Trusts Law would be violated.¹¹⁴

107. 42 U.S.C. § 1396a(k)(3)(B) (1988). See also *Viera v. Connecticut Dep't of Income Maintenance*, No. CV. 90-04381515 1991 WL 273329 (Conn. Super. Ct. Dec. 11, 1991) (holding that funds in an irrevocable spendthrift trust were to be considered as an asset even though the trustees had complete discretion in disbursing the funds).

108. 42 U.S.C. § 1396a(k)(2) (1988).

109. See, e.g., *State ex rel. Sec. of Social & Rehab. Serv. v. Jackson*, 822 P.2d 1033 (Kan. 1991). There were, however, several methods available for granting a trustee discretion without rendering principal available for Medicaid eligibility purposes. For example, distributions could be made subject to third-party consent. See *Miller v. Ibarra*, 746 F. Supp. 19 (D. Colo. 1990). Also, distributions could hinge upon the occurrence of certain conditions on the theory that the beneficiary had only an expectancy interest. See *Siegel v. Kizer*, 15 Cal. Rptr. 2d 607 (Cal. Ct. App. 1993).

110. For a more complete discussion of the situations in which the MQT rules do not apply, see McEowen and Harl, *supra* note 5 at notes 266-91 and accompanying text.

111. One such method was permitting distribution in the event of extraordinary circumstances with the written consent of all remaindermen. *Pollak v. Department of Health & Rehab. Serv.*, 579 So. 2d 786 (Fla. Dist. Ct. App. 1991).

112. See, e.g., N.J. Stat. Ann. § 30(4)(D) (West 1992).

113. 589 N.Y.S.2d 275 (N.Y. Sup. Ct. 1992).

114. *Id.* at 279.

Another exception to the MQT rules has been the ability of a guardian to petition the probate court for protective orders transferring all of the incapacitated ward's income to a trust. Courts have viewed these trusts as not created by the beneficiary, and thus not subject to the MQT rules.¹¹⁵

Recent developments demonstrate a growing unwillingness of courts to permit the creation of these type of trusts to avoid the Medicaid transfer rules. In *Pollak v. Department of Health & Rehabilitative Services*,¹¹⁶ the court held that a court-created trust will be considered an MQT in states with a medically needy program when both the trust provisions place no limitation on the trustee's discretion to disburse trust assets, and the trust assets remaining after the beneficiary's death will not go to reimburse the state Medicaid agency.¹¹⁷ An Ohio court has ruled that settlement proceeds received by a guardian and held in bank deposits subject to withdrawal only on the order of the probate court were available to the Medicaid applicant for eligibility purposes.¹¹⁸

Another method of avoiding the MQT restrictions is through use of a testamentary trust.¹¹⁹ Two recent Pennsylvania cases point out that careful drafting is still necessary to avoid having the trust treated as an available asset. For instance, in *Commonwealth Bank and Trust Co. v. Pennsylvania Department of Public Welfare*,¹²⁰ funds contained in a testamentary trust for the decedent mother were held to be available to the mother for Medicaid eligibility purposes because the trust made no specific reference to supplement public benefits, and the remaindermen were only to benefit if funds remained available. Conversely, trust funds contained in a trust created for two equal beneficiaries, where one beneficiary received public benefits before the testator's death but after the will was executed, were held

115. See, e.g., *Miller v. Ibarra*, 746 F. Supp. 19 (D. Colo. 1990); *Kegal v. State*, 830 P.2d 563 (N.M. Ct. App. 1992). See also *Forsyth v. Rowe*, 629 A.2d 379 (Conn. 1993)(stating that act of conservator in creating trust is not legally attributable to the ward).

116. 579 So. 2d 786 (Fla. Dist. Ct. App. 1991).

117. *Id.* at 788.

118. *Gorenflo v. Ohio Dep't of Human Serv.*, 611 N.E.2d 425 (Ohio Ct. App. 1992). In *Gorenflo*, the court determined that jurisdiction over the ward's funds is imposed by statute and is not evidence that the court was acting as trustee. In addition, the court had previously released funds on the guardian's petition. However, in *Young v. Department of Public Welfare*, M-6355, Mass. Sup. Jud. Ct., (Dec. 17, 1993), the court upheld a probate court determination that the trustee of a supplemental needs trust did not have discretion to distribute trust corpus or income to the primary beneficiary where such distributions would make the beneficiary ineligible for Medicaid.

119. Under the MQT definition, a "Medicaid Qualifying Trust" is defined in part as "a trust, or similar legal device, established (*other than by will*) . . ." 42 U.S.C. § 1396a(k)(2) (1988) (emphasis added).

120. 598 A.2d 1279 (Pa. 1991).

to indicate that the testator did not intend that these trust assets interfere with the beneficiary's eligibility for public benefits.¹²¹

5. *Trusts After August 10, 1993*

Medicaid trust planning has been severely restricted with the passage of OBRA '93.¹²² Notwithstanding, as with the asset transfer rules, the new rules applying to trusts may not take effect in some states until some time in 1995.¹²³

Under the new law, the MQT concept is eliminated.¹²⁴ In its place, a trust is defined as "any legal instrument or device that is similar to a trust."¹²⁵ While annuities are not included in the definition of a trust, the new law gives the Secretary the authority to establish regulations that would include annuities under the trust provisions.¹²⁶

The major change with respect to trusts concerns the assets of non-testamentary trusts created or funded by a Medicaid applicant or such person's spouse. These assets will be considered available to the applicant and/or the applicant's spouse to the extent the applicant derives *any* benefit from them.¹²⁷ In addition, court-created trusts or trusts created by anyone acting on behalf of the applicant or the applicant's spouse will be considered to have been created by the applicant or the applicant's spouse for eligibility purposes.¹²⁸ These new trust rules apply regardless of both the trust's purpose and any restrictions placed upon the distribution of trust assets.¹²⁹ No longer will practitioners be able to draft language into trust instruments evidencing the settlor's intent to supplement rather than supplant public benefits. Consequently, the major effect (and purpose) of the new trust rules will be to foreclose the use of income-only discretionary trusts, a major tool in Medicaid planning.

The new rules are not nearly as clear in their application to irrevocable trusts. The corpus of an irrevocable trust that benefits the grantor (grantor retained interest trusts, or GRITs) may be considered available to the grantor for Medicaid eligibility purposes if the grantor

121. *Snyder v. Pennsylvania Dep't of Public Welfare*, 598 A.2d 1283 (Pa. 1991).

122. *Transfer of Assets; Treatment of Certain Trusts*, Pub. L. No. 103-66, § 13611, 107 Stat. 312, 622-27 (1993)(codified as amended at 42 U.S.C.A. § 1396p(c)(1) (West Supp. 1994)).

123. *See supra* note 90 and accompanying text.

124. *Omnibus Budget Reconciliation Act of 1993*, Pub. L. No. 103-66, § 13611(b), 107 Stat. 312, 622-27 (1993)(to be codified as amended at 42 U.S.C.A. § 1396a(k)). However, the MQT rules apply to trusts created and funded on or before August 10, 1993.

125. *Id.* § 13611(b)(6), 107 Stat. 312, 626.

126. *Id.*

127. *Id.* § 13611(b), 107 Stat. 312, 624-26.

128. *Id.*

129. *Id.*

subsequently applies for benefits. The new law treats any income that is paid to the grantor-applicant as causing the underlying corpus generating that income to be available.¹³⁰ The final language as passed by the Senate states as follows:

- (i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual. . . .¹³¹

The language which causes confusion over how income will be counted concerns the phrase, "or the income on the corpus from which." A review of the legislative history behind this language reveals that the Congressional intent was to bar income-only trusts.¹³²

Arguably, trust income will be counted as an asset. This interpretation would effectively cause principal of an income-only trust to be counted as an available asset. However, if trust income is counted as an asset for eligibility purposes, the possibility exists that an income stream from an income-only trust should be capitalized to place a value on it for either eligibility or transfer disqualification purposes. If this is the case, income-only irrevocable trusts are essentially worthless as a Medicaid planning tool.

An argument can also be made that the final language will treat the trust corpus as an available asset only to the extent payment may be made from the trust corpus, and the trust income as available only to the extent payment is made from the income. If this proves to be an acceptable interpretation, GRITs retain some usefulness.

A third approach would be to count income as income and resources as resources. This approach seems to fit with the statutory language, and seems to indicate that to the extent payments are made to the individual, they will be treated as income. Alternatively, to the extent payments are made to a third party, they will be treated as an asset. Arguably, under this approach, the establishment of an irrevocable trust with the grantor reserving an income interest for life but with no corpus being distributed to the grantor will not cause the corpus to be an available resource for Medicaid eligibility purposes once the applicable asset transfer period has passed. If this approach is accepted, income-only irrevocable trusts cause no problems unless payments are made to third parties, regardless of whether such payment comes from income or principal. Given the uncertainty surrounding income-only trusts, the best approach may be to avoid drafting income-only trusts altogether.

130. *Id.* § 13611(b)(B)(i), 107 Stat. 312, 625.

131. *Id.*

132. For instance, the House Budget Committee report stated that irrevocable trusts which benefited the grantor may be considered available to the individual. Additionally, the corpus of the trust shall be considered available to the individual. H.R. Rep. No. 103-11, 103d Cong. 1st Sess. 207 (1993).

The new law also contains a provision construing any payment from an irrevocable trust that benefits the grantor to anyone other than the grantor-applicant as a disqualifying transfer.¹³³ The applicable look-back period for such transfers is thirty-six months.¹³⁴ Yet, a sixty month look-back period applies to revocable trusts as well as irrevocable trusts that do not benefit the grantor (an irrevocable non-retained interest trust).¹³⁵ Thus, for trusts subject to the sixty month ineligibility period, there will be a requirement to report trust transactions even though the applicant did not retain any interest in the trust.¹³⁶

The new trust rules apply regardless of both the trust's purpose¹³⁷ and whether the trustee has or exercises any discretion over the trust assets.¹³⁸ They also operate irrespective of any restrictions on making distributions or the use of trust distributions.¹³⁹ However, states are required to establish procedures for waiving application of the trust rules where undue hardship would occur.¹⁴⁰

OBRA '93 also contains several exceptions to the new trust rules.¹⁴¹ Trusts established by a parent, grandparent, legal guardian, or court for the benefit of a disabled person under age sixty-five are exempt from application of the new rules if all remaining amounts in the trust upon the beneficiary's death will be distributed to the state Medicaid agency in reimbursement for any payment made on the beneficiary's behalf during life.¹⁴² In addition, trusts established in states that limit Medicaid eligibility to persons with income less than 300% of the poverty level and whose income consists solely of pension, social security, other income, and accumulated trust income, as long as the state receives all trust funds remaining upon the grantor's death, are exempt.¹⁴³ Similarly, the trust rules do not apply to trusts established and managed by a non-profit association for disabled beneficiaries as long as separate accounts are maintained for each benefi-

133. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, §§ 13611(b)(3)(A)(iii), (b)(3)(B)(ii), 107 Stat. 312, 625 (1993)(to be codified as amended at 42 U.S.C. § 1396a(k)).

134. *Id.* § 13611(a)(B)(i), 107 Stat. 312, 622.

135. *Id.*

136. Thus, the prudent approach may be to give away assets outright to desired individuals (which would be subject to a 36 month ineligibility period) rather than create an irrevocable trust for the benefit of such persons.

137. Transfer of Assets; Treatment of Certain Trusts, Pub. L. No. 103-66, § 13611(b)(2)(c)(i), 107 Stat. 312, 624 (1993)(to be codified at 42 U.S.C. § 1396a(k)).

138. *Id.* § 13611(b)(2)(C)(ii).

139. *Id.* § 13611(b)(2)(C)(iii-iv).

140. *Id.* § 13611(b)(5), 107 Stat. 312, 626.

141. *Id.* § 13611(b)(4), 107 Stat. 312, 625-26.

142. *Id.* § 13611(b)(4)(A), 107 Stat. 312, 625.

143. *Id.* § 13611(b)(4)(B), 107 Stat. 312, 625.

ciary.¹⁴⁴ Likewise, any amounts remaining in a beneficiary's trust account upon death must be distributed to the state Medicaid agency in full reimbursement for all benefits paid to the beneficiary during life.¹⁴⁵

6. *Income-Producing Property Used in Trade or Business*

A specific estate planning technique different from the traditional asset and trust planning concepts involves income-producing property used in a trade or business.¹⁴⁶ Under a 1990 amendment to the Medicaid law, all income-producing property used in a trade or business can be excluded from countable resources for Medicaid eligibility purposes.¹⁴⁷ This is a very important planning tool for farm and ranch clients because the amendment applies to all property used in a trade or business that is essential to a person's self-support regardless of the value or rate of return.¹⁴⁸ Thus, since trade or business property *in current use* is exempt, such property can theoretically be transferred without penalty.

In order to exempt income-producing trade or business property, it is imperative that an actual trade or business be established.¹⁴⁹ At a minimum, this requires the production of tax returns, a description of the trade or business including a description of the business assets, the number of years the business has been operating, the identity of the co-owners, if any, and the estimated gross and net earnings.¹⁵⁰ Caution should be exercised if the business has been in operation for less than one year.¹⁵¹

The trade or business exception has favorable implications for farmers and ranchers. Under the amendment, the entire farm and ranch real estate, livestock, buildings, and equipment can potentially be excluded from the Medicaid applicant's available resources.¹⁵² Ad-

144. *Id.* § 13611(b)(4)(C)(i-ii).

145. *Id.* § 13611(b)(4)(C)(iv), 107 Stat. 312, 626.

146. 42 U.S.C. § 1382b(a)(3) (Supp. IV 1992).

147. *Id.* (effective May 1, 1990). The amendment specifically mentions machinery and livestock of a farmer that is used in a trade or business by such person. *Id.*

148. *Id.* However, § 209(b) states are not required to adopt the amendment. Several significant farm states are § 209(b) states. These are: Illinois, Indiana, Minnesota, Nebraska, North Carolina, North Dakota, Ohio, and Oklahoma.

149. The term trade or business, for income tax purposes, is generally defined as an activity undertaken with the expectation of making a profit. *See, e.g., Commissioner v. Groetzinger*, 480 U.S. 23, 34 (1987).

150. Since there is no finite definition for what constitutes a trade or business, the more information that an individual can produce evidencing indicia of a business and a profit motive, the better.

151. Short-term operation makes it difficult to establish the factors necessary to show the existence of a trade or business.

152. The Secretary is directed to not establish a limitation on essential trade or business property. 42 U.S.C. § 1382b(a)(3) (1988).

ditionally, liquid resources used in the trade or business may be excluded from countable resources without limit.¹⁵³

While the trade or business exception does not apply to rental property, leased land, or other non-business income-producing property,¹⁵⁴ up to \$6,000 of equity value of such property can be excluded from countable resources if the property produces a net annual return equal to at least six percent of the excluded equity.¹⁵⁵ If the property produces less than a six percent return, the exclusion can apply only if the lower return is for reasons beyond the individual's control (such as crop failure or illness), and there is a reasonable expectation that the property will again produce a six percent return.¹⁵⁶

7. Retained Life Interests

Another Medicaid planning technique involves the use of retained life interests. A retained life interest is a limited interest in property lasting only for the lifetime of the life tenant.¹⁵⁷ Under the Internal Revenue Code, a transfer of property with the retention of the use, possession, right of the income, or other enjoyment of the property will result in inclusion of the property in the transferor's gross estate.¹⁵⁸ The benefit of having the property included in the transferor's gross estate is that, upon death, the heirs will receive an income tax basis equivalent to the fair market value of the property at the date of the decedent's death.¹⁵⁹ This is likely to be significantly higher than the

153. 20 C.F.R. § 416.1220 (1993). *See also* Miller v. Ives, 780 F. Supp. 49 (D. Me. 1991)(noting that without excluding liquid resources the trade or business exclusion would be illusory). The ability to exclude liquid resources is critical to farm and ranch operations due to the seasonal nature of the business and the need to keep large amounts of cash on hand to pay operating expenses.

154. 20 C.F.R. § 416.1222 (1993).

155. *Id.* Any portion of the equity value exceeding \$6,000 is not excluded. For example, assume Steve is a lawyer who enjoys cattle ranching on the weekends. Steve owns a small ranch, three acres of which is his homesite, and an additional 40 acres not connected to the home. There are two corrals and two animal shelters located on the 40 acres. Steve also owns various pieces of ranch equipment and horses that are necessary for his ranching activities.

The value of Steve's home and the three acres on which it sits will be excluded under the home exclusion for Medicaid eligibility purposes. *See* 20 C.F.R. § 416.1212 (1993). All of the other ranch assets, including the land, will be lumped together to determine if Steve's total equity in these items is less than \$6,000 and if the annual rate of return is at least six percent of Steve's equity. The land and buildings are valued at \$4,000, and the other ranching items are valued at \$1,500. Steve sells cattle which nets him more than six percent for the year. Since the ranch assets have a total value of less than \$6,000, and Steve's net return exceeded six percent for the year in question, all of the ranching items will be exempt.

156. 20 C.F.R. § 416.1222 (1993); I.R.C. § 2036 (West Supp. 1993).

157. I.R.C. § 2036 (West Supp. 1994).

158. I.R.C. § 2036(a) (West Supp. 1994).

159. I.R.C. § 1015 (West 1993).

decendent's basis in the property. Even though the property is included in the transferor's gross estate, most state Medicaid eligibility rules treat a lifetime right to use and occupy as exempt.¹⁶⁰

For farm and ranch families, the Medicaid planning strategy may consist of transferring the farm to the children in full with the children then renting the farm back to the parents. The parents would then act as tenants under a lease with the children. For example, in *Estate of Nicol v. Commissioner*,¹⁶¹ a mother rented her farm to her daughter under a crop-share lease and then later conveyed the farm to the daughter while continuing to receive rental payments. The court ruled that this type of arrangement constituted a retained life estate.¹⁶² In order to insure inclusion in the decedent's gross estate and receive a stepped-up basis, the lease must not end at any time before death, and the lease consideration must be below fair market value. Similarly, in *Estate of Maxwell v. Commissioner*,¹⁶³ the court found an implied agreement of retained enjoyment sufficient to require inclusion of the residence in the parent's estate where the parent made a lifetime transfer to a child but continued to reside in the residence.

There are several issues that must be considered when using retained life interests. The possibility of death or disability of the life tenant should be considered.¹⁶⁴ Also, the possibility of waste by a life tenant may create divisive family disputes or even litigation. Finally, bankruptcy of the remaindermen may make the property subject to creditor claims.

8. Medicaid Retirement Planning

Quite often, clients presenting questions about Medicaid are at or near retirement age. As a result, practitioners need a working knowledge of how typical retirement plans fit into the Medicaid planning picture. The common scenario for non-farm clients consists of an individual who is retiring and must select whether to withdraw from a qualified pension plan or choose an annuity option.¹⁶⁵

Funds rolled over from a qualified plan to an Individual Retirement Account (IRA) are available for Medicaid eligibility purposes.¹⁶⁶ In addition, most states require liquidation of Keogh Plans and the

160. See, e.g., NEB. ADMIN. R. & REGS. § 2-009.0788 (1992).

161. 56 T.C. 179 (1971).

162. *Id.* at 181.

163. 98 T.C. 594 (1992).

164. This problem can probably be overcome, however, with the use of a properly drafted financial durable power of attorney.

165. For farm clients, the typical scenario is for the parents to be approaching retirement and desiring to sell the operation and use the proceeds for retirement.

166. Once the funds are rolled over into an IRA, the individual has the ability to liquidate the account, thereby making the funds available for Medicaid eligibility purposes. See, e.g., 42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994).

proceeds to be "spent-down" to achieve Medicaid eligibility.¹⁶⁷ Therefore, the general rule concerning availability requires that if the Medicaid applicant or the applicant's spouse can withdraw or liquidate a fund, the fund is available to the applicant for Medicaid eligibility purposes.¹⁶⁸ Neither federal nor state Medicaid regulations define "qualified pension plans." Arguably, these plans constitute an unavailable resource for Medicaid eligibility purposes because the applicant is not able to liquidate them.

Before OBRA '93, there existed the possibility that pension plans could be construed as MQT's.¹⁶⁹ Under the old law, an MQT was defined as a "trust or similar legal device . . . and . . . distribution . . . is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual."¹⁷⁰ The language "similar legal device" and "trustees who are permitted to exercise any discretion" raises a question as to whether funds handled by a fiduciary would become available for Medicaid eligibility purposes. For instance, a pension plan trustee with authority to invest funds allowing the beneficiary to benefit in any way would seemingly cause the funds to be treated as an available asset. With the elimination of the MQT concept under OBRA '93, it remains unsettled as to how pension plans will be treated for Medicaid eligibility purposes.

Practitioners have several planning options with respect to pension plans. One method might be to have the client purchase an annuity.¹⁷¹ The purchase of an annuity is not an asset transfer but rather a purchase for value. Thus, an annuity purchase should only be a prohibited asset transfer to the extent it is for less than fair market value.¹⁷²

When dealing with qualified pension plans, planners may want to consider rolling funds in those plans over into an annuity or an "in-pay status." If the funds have already been distributed and rolled over

167. Since liquidation will make the funds available for Medicaid eligibility purposes, the excess funds will need to be spent down to the applicable level. *See* 42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994).

168. 42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994). However, there are exceptions in some states. In Massachusetts, IRA's are fully available, and Keogh plans are available only if the applicant is self-employed and is the plan's sole participant. MASS. REGS. CODE tit. 106, § 505.160(c) (1992).

169. OBRA '93 eliminated the concept of the MQT. *See supra* note 124 and accompanying text.

170. 42 U.S.C. § 1396a(k)(2) (1988).

171. An annuity is a series of payments of a fixed amount for a specified number of years.

172. Another planning method might be to purchase a guaranteed term irrevocable annuity. If this is done, planners should ensure that the issuing company has the highest possible rating and that the client obtains written disclosures as to the inability to guarantee the issuing company's performance.

into an IRA, planners may want to consider rolling over into an IRA irrevocable term annuity.

9. *Minority Business Interests*

Practitioners have another available weapon in the Medicaid planning arsenal for those clients owning stock in a closely held family corporation. Once a Medicaid application is made, the applicant is required to liquidate all non-exempt available resources and then use the funds received upon liquidation to pay for the applicant's medical care (down to a specified limit) before Medicaid benefits will be received.¹⁷³ However, most state Medicaid laws will exempt otherwise non-exempt property if the applicant can show an inability to liquidate after a good faith attempt to do so.¹⁷⁴

The appropriate Medicaid planning strategy for a client who is the holder of closely held stock in a family owned corporation may be to work the potential Medicaid applicant into a minority position by making a series of gifts during life outside of the applicable look-back period until the applicant is in a minority position. Then, the strategist should argue that the applicant is no longer able to sell the stock and therefore should be immediately eligible for Medicaid benefits.¹⁷⁵ This strategy allows the practitioner to preserve the asset in question for the applicant and the applicant's family.

Another benefit of having a potential Medicaid applicant hold a minority interest in otherwise available assets is that such property can be valued at a discount in the person's estate upon death.¹⁷⁶ Property is generally included in a decedent's gross estate at its fair market value.¹⁷⁷ Typically, fair market value is determined as the price at which a willing buyer and a willing seller would arrive, neither being under any compulsion to buy or sell.¹⁷⁸ For closely held stock, however, there are no available selling prices or bid or ask prices in an established public market. Consequently, such factors as the percent of the stock in proportion to the entire outstanding stock of the corporation and the degree of the control represented by such stock become important.¹⁷⁹

173. See *infra* notes 219-24 and accompanying text for a discussion of this procedure.

174. Such property is considered to be unavailable to the applicant for Medicaid eligibility purposes. See 42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994).

175. The author has proposed this strategy to the legal counsel for the Nebraska state Medicaid agency. The Agency's counsel responded that if there was an inability to sell the property or force a liquidation due to a minority position, the state agency would not be able to count those assets as available to the applicant for Medicaid eligibility purposes.

176. See, e.g., *Estate of Campbell v. Commissioner*, 62 T.C.M. 1514 (CCH) (1991).

177. I.R.C. § 2031 (West 1993).

178. 26 C.F.R. § 20.2031-1(b) (1993).

179. Treas. Reg. § 20.2031-2(c)(as amended in 1976).

Minority discounts play an important role in the valuation of a closely held business. A minority discount is routinely available for interests not actively traded once it is shown that the owner of the interest could not control the business.¹⁸⁰ This Medicaid planning approach not only preserves the asset for the Medicaid applicant and the applicant's heirs, but once the applicant dies, a substantial valuation discount is received in the applicant's estate.¹⁸¹

10. Long-term Care Insurance

In general, long-term care insurance may be a viable option for financing long-term home care and nursing home costs.¹⁸² Before recommending the purchase of long-term care insurance, practitioners must gather several important items of information from the client. Most importantly, the determination must be made that the client is underwritable.¹⁸³ If the client can obtain long-term care insurance, the next question is whether such insurance can be obtained economically.¹⁸⁴ Practitioners must also assess an individual client's personal

180. The discount is applied through a three step process. First, the value of the entire enterprise is determined. Second, the proportionate share of enterprise value attributable to the interest in question is determined. Third, the proportionate value is then reduced by the minority discount.

181. Presently, closely held stock is discounted approximately 25% based upon the minority position. Until recently, the IRS vigorously opposed minority discounts. However, the Commissioner essentially surrendered in January of 1993. Rev. Rul. 93-12, 1993-7 I.R.B. 13. In Rev. Rul. 93-12, the Commissioner stated that the Service will ignore the aggregation of the interests in the hands of the donor before the transfer and the sibling relationship of the donees. In addition, the IRS will no longer seek to defeat minority discounts by arguing for attribution between family members.

A separate "marketability discount" may also be available. This type of discount refers to an asset that would, as a practical matter, be difficult to market. In a recent case, a 15% marketability discount was allowed. See, e.g., *Estate of Bennett v. Commissioner*, 65 T.C.M. 1816 (CCH) (1993). For minority interests, both a minority discount and a lack of marketability discount will typically be allowed. See, e.g., *Estate of Bright v. United States*, 658 F.2d 999 (5th Cir. 1981); *Estate of Campbell v. Commissioner*, 62 T.C.M. 1514 (CCH) (1991). Thus, the total available discount for lack of marketability and minority position is approximately 40%.

182. The Health Insurance Association of America estimated that as of June 1990, 1.65 million long-term care policies had been sold by 134 insurers. *Long-Term Care Insurance: A Market Update*, HIAA RESEARCH BULLETIN (Jan., 1991).

183. The determination as to whether the client is underwritable will depend upon the client's age and physical condition.

184. In general, for younger individuals, insurance will be more freely available at a comparative low annual premium which can be "locked in" as long as the insurance is maintained (and as long as the insurer does not effect a rate increase). However, the amount of daily benefits selected is unlikely to be adequate if and when the client files for benefits. Consequently, a younger individual may wish to purchase an inflation protection rider. Practitioners must note that the proper policy is not a policy offering the most comprehensive benefits, but one that offers

feelings about Medicaid and asset preservation. If the client objects to receiving Medicaid benefits, then the leading alternative currently available is long-term insurance. Similarly, if the client assigns a high priority to preserving assets for inheritance, long-term care insurance is a worthwhile means to this end.¹⁸⁵ The amount of a client's assets that would be subject to depletion upon an application for Medicaid is also important. For example, if a particular client is married and all or nearly all of the individual's assets can be sheltered using various Medicaid planning techniques and available allowances, then long-term care insurance is not a high priority.¹⁸⁶

If, after careful evaluation, it is advisable for the client to purchase a long-term care insurance policy, planners should note that the long-term care policy need not provide "first dollar" coverage extending throughout a nursing home stay to satisfy the entire bill. One technique that can be used to make long-term care insurance more affordable includes having the purchaser accept a longer waiting period before policy benefits commence. The same effect can be obtained by having the client purchase a policy that pays a smaller indemnity amount or contains a shorter duration of benefits.

Perhaps the most cost effective way to use long-term care insurance in the overall Medicaid plan utilizes insurance to protect assets by financing the cost of care during the period of Medicaid ineligibility. For example, if a client makes transfers that would result in thirty-six months of ineligibility and the client's medical condition will permit the underwriting of a long-term care policy, it may be advisable to have the client purchase a policy with just under three years of benefits, planning instead to pay privately for the remaining amount if necessary. This procedure will allow the client to receive insurance benefits until the Medicaid benefits are available.¹⁸⁷

If a long-term care policy appears to be useful in a particular client's overall Medicaid plan, it is imperative to carefully evaluate the various types of long-term care insurance policies that are presently on the market. One of the major items which must be properly as-

the greatest cost effectiveness in providing the particular benefits that the client needs.

185. Conversely, if the client is quite willing to collect public benefits and assigns a low priority to inheritance, long-term care insurance may not be right for the client; provided, of course, that it seems likely that a Medicaid plan can be devised that will provide the client access to the necessary care.
186. California financial planner, James H. Braziel, suggested in 1989 that purchase of a long-term care policy is probably not appropriate for couples with a non-exempt asset level under \$150,000. See Linda Koco, *What Planners Look For in LTC Policies*, NAT'L UNDERWRITER, Sept. 11, 1989, at 9.
187. One side benefit of this approach is that it can allow senior citizens to maintain their autonomy for a longer time because transfers (and consequent loss of autonomy) can be deferred until illness strikes.

sessed concerns the type of care the policy actually covers.¹⁸⁸ For example, in *Dvorak v. Metropolitan Life Insurance Co.*,¹⁸⁹ the plaintiff's family was insured under the defendant's health and welfare benefit plan. The defendant's plan provided for convalescent nursing home benefits but excluded "principally custodial" care. The plaintiff's wife was placed in a nursing home where she required constant nursing attention as well as the administration of anti-psychotic drugs for the treatment of Wernicke-Korsakoff Syndrome. Due to the level and constant nature of such care, the court determined that the care was not "principally custodial" in nature and was, therefore, covered by the defendant's plan.¹⁹⁰

Long-term care insurance policies and the payment of premiums on such policies raise two important income tax considerations. The first issue regards the ability of the policy owner to deduct amounts paid for premiums as a medical expense deduction.¹⁹¹ Generally, amounts paid for medical expenses can be deducted if the reason for the expense is a medical necessity.¹⁹² Arguably, if a long-term care insurance policy is designed to assist with a medical need, even though the policy strictly covers custodial care, the premium should be deductible as a medical expense.¹⁹³ This argument is even stronger if benefits under the long-term care policy are triggered by a medical need certification.¹⁹⁴

A related tax issue concerns the treatment of benefits received under a long-term care insurance policy. Payments that a taxpayer receives under a health insurance policy for reimbursement of medical expenses are excluded from income.¹⁹⁵ If long-term care policies are treated the same as health care policies for purposes of premium de-

188. For instance, does the policy cover "skilled nursing care" or is it limited to "principally custodial care"? Other issues that practitioners should investigate include an analysis of how much will be paid for each level of care; how long benefits will be paid; whether the policy sets a maximum benefit level; whether benefits increase with inflation; a determination as to whether there is a waiting period before benefits become payable; and whether pre-existing conditions are covered. Also important in analyzing long-term care insurance policies is a determination of what the eligibility requirements are; whether Alzheimer's and/or Parkinson's disease (the two leading debilitating diseases of the elderly) are covered; whether the insurer can cancel the policy; whether the insurer has at least an "A" rating from a reporting agency; and what is the benefit trigger mechanism.

189. 965 F.2d 606 (8th Cir. 1992).

190. *Id.* at 610.

191. I.R.C. § 213 (West Supp. 1994) allows a taxpayer to take a deduction for certain amounts paid for medical expenses.

192. See, e.g., *Thoene v. Commissioner*, 33 T.C. 62 (1959).

193. See, e.g., Treas. Reg. § 1.213-1(e)(1)(v)(b) (1993)(amount of nursing home bill covering medical care furnished to the institutionalized person is deductible).

194. See, e.g., *Havey v. Commissioner*, 12 T.C. 409 (1949).

195. I.R.C. § 105(b) (West 1993).

ductibility, then payments received as reimbursements should likewise be excluded from income.¹⁹⁶

11. Medicaid Appeals Process

Another planning technique involves using the Medicaid appeals process to divert as much income as possible from the institutionalized spouse to the community spouse in order to bring the community spouse up to a specified minimum level of monthly income.¹⁹⁷ Utilizing the Medicaid appeals process to increase the Community Spouse Resource Allowance (CSRA) can be an invaluable tool for protecting family assets by diverting them to the community spouse.

State Medicaid agencies are required to grant upon request a "fair hearing" to any Medicaid applicant whose claim for services was denied or not acted upon with reasonable promptness or to any benefit recipient whose benefits have been terminated, discontinued, suspended, or reduced erroneously.¹⁹⁸ However, an individual has no right to a hearing if the only issue involved is a federal or state law requiring a change that adversely affects the claimant or other recipients.¹⁹⁹

Before filing an appeal, an applicant or an individual who is receiving Medicaid benefits must receive adequate written notice of the Medicaid agency's decision about the individual's benefits.²⁰⁰ In most cases, the agency must mail its notice at least ten days before reducing or discontinuing Medicaid benefits. This ten day period may be shortened to five days in case of fraud.²⁰¹

A hearing must be requested within ten days following the date of the agency's mailing of the notice in cases involving termination, discontinuance, suspension, or reduction of benefits.²⁰² In all other situations, an individual must be given a reasonable time, not exceeding ninety days, to request a hearing.²⁰³ If the request is filed within ten days after the agency has mailed the notice, the state may, but need not, reinstate benefits.²⁰⁴ Where benefits are continued or reinstated

196. The IRS' present position on this issue is unclear.

197. 42 U.S.C.A. § 1396r-5(e)(2)(c) (West Supp. 1994).

198. *Id.* § 1396a(a)(3).

199. 42 C.F.R. § 431.220(b) (1993).

200. *Id.* § 431.206(b). See also *Zellweger v. New York State Dep't of Social Serv.*, 547 N.E.2d 79 (N.Y. 1989).

201. 42 C.F.R. §§ 431.211, 431.214 (1993). Advance notice need not be given when a change in the level of medical care (*e.g.*, transfer from a skilled nursing facility to an intermediate care facility) is prescribed by the recipient's physician. See, *e.g.*, *Blum v. Yaretsky*, 457 U.S. 991 (1982).

202. 42 C.F.R. § 431.230(a) (1993).

203. *Id.* § 431.221(d).

204. *Id.* § 431.231(a).

upon timely request for a hearing, they must continue until a hearing decision is made.²⁰⁵

The request for a fair hearing should be filed on the appropriate agency form or in writing as stipulated by the agency.²⁰⁶ The request should include the following information:

- (1) the person requesting a hearing;
- (2) that the person is dissatisfied with the action the agency has decided to take on his or her application;
- (3) a request for an interpreter if the claimant does not speak English; and
- (4) a request that, if a hearing in the agency's office would burden the claimant, the hearing be held in the claimant's home, hospital, nursing home, or other convenient place.

Before the hearing, the claimant or the claimant's representative has the right to examine the claimant's case file at the agency in addition to all the documents and records to be used by the agency at the hearing.²⁰⁷ The hearing is to be conducted by a hearing officer who did not participate in the agency's decision,²⁰⁸ and the claimant or the claimant's representative may present witnesses, evidence, and arguments as well as confront and cross-examine adverse witnesses.²⁰⁹

The hearing officer's decision must be in writing and must be based solely on evidence introduced at the hearing.²¹⁰ The hearing officer's decision must summarize the facts, specify the reasons for the decisions, and identify the supporting evidence in regulations.²¹¹ The claimant must be notified in writing of the decision and the claimant's right to seek further administrative or judicial review.²¹²

An appeal from the hearing officer's decision must be taken to the state agencies within fifteen days from the mailing of the hearing decision to the individual.²¹³ The claimant must specifically request a de novo hearing.²¹⁴ Otherwise, the state Medicaid agency will review only the record of the hearing to see if the decision was supported by substantial evidence.²¹⁵ The claimant maintains the identical rights at the de novo hearing as he or she had at the earlier local hearing.²¹⁶

205. *Id.* §§ 431.230(a), 431.231(c). *See also Frank v. Kizer*, 261 Cal. Rptr. 882 (Ct. App. 1989).

206. 42 C.F.R. § 431.221(a) (1993).

207. *Id.* § 431.242(a).

208. *Id.* § 431.240(a)(3).

209. *Id.* § 431.242(b)-(e).

210. *Id.* §§ 431.244(a), 431.245.

211. *Id.* § 431.244(e).

212. *Id.* § 431.245.

213. *Id.* § 431.232(b).

214. *Id.* § 431.233(a).

215. *Id.*

216. *Id.* § 431.242(b)-(e).

Notice of the decision must be in writing, informing the claimant of any right to judicial review.²¹⁷ Judicial review may be sought in the state or federal courts, subject to the usual jurisdictional and filing requirements.

Perhaps the most useful manner in which to utilize the fair hearing process is to increase the Community Spouse Resource Allowance (CSRA).²¹⁸ This is a monetary sum that can be added to the community spouse's other income on a monthly basis to bring the community spouse up to a minimum specified level of monthly income. This process can be explained in the following manner.

For married individuals at the time one spouse makes an application for Medicaid benefits, there is a one-time computation of the non-exempt resources of both spouses.²¹⁹ The total fair market value of those resources is considered to be available to the spouse that is applying for Medicaid benefits.²²⁰ A spousal share equivalent to one-half of the total value of the combined assets is also computed at the time of the initial Medicaid eligibility determination.²²¹ However, an exception to the one-half spousal attribution rule permits the community spouse to retain a spousal share of assets worth up to \$72,660 (as of January 1, 1994).²²² The community spouse's assets not exceeding \$72,660 will not be considered available to the institutionalized spouse for eligibility purposes.²²³ Medicaid eligibility is achieved for the spouse that is making an application when both spouses spend-down their asset shares to the applicable limit for each spouse.²²⁴

Additionally, the community spouse is entitled to divert as much income from the institutionalized spouse as is necessary to provide a minimum level of monthly income.²²⁵ Using the Medicaid appeals

217. *Id.* § 431.245.

218. *See, e.g.*, 42 U.S.C.A. § 1396r-5(e)(2)(C) (West Supp. 1994).

219. *Id.* § 1396r-5(c)(1)(A)(i).

220. *Id.* § 1396r-5(c)(2)(A).

221. *Id.* 1396r-5(c)(1)(A)(ii).

222. *Id.* § 1396r-5(f)(2)(A)(ii). However, for couples with a minimal amount of non-exempt assets, the floor spousal share is set at \$14,532. *Id.*

223. 42 U.S.C.A. § 1396r-5(c)(2)(B) (West Supp. 1994).

224. While the federal Medicaid law mandates income spend-down, it does *not* require resource spend-down (42 U.S.C.A. § 1396a(a)(17) (West Supp. 1994)). *See, e.g.*, *Harriman v. Commissioner*, No. 90-0046B-H, 1992 WL 133116 (D. Me. 1992) (holding that failure of state to permit resource spend-down, but to permit income spend-down does not violate equal protection clause); *Matarazzo v. Rowe*, 623 A.2d 470 (Conn. 1993) (holding that § 209(b) state only required to utilize resource spend-down if state utilized resource spend-down on Jan. 1, 1972); *Lieberman v. Connecticut Comm'r of Income Maintenance*, No. Cd-90-0438316-S, 1992 WL 294938 (Conn. Super. Ct. 1992) (stating that Connecticut law does not require resource spend-down); *Allen v. Utah Dep't of Health*, 850 P.2d 1267 (Utah 1993).

225. 42 U.S.C.A. § 1396r-5(e)(2)(C) (West Supp. 1994).

process to divert additional income from the institutionalized spouse to the community spouse is illustrated in the following example.

Assume Mr. and Mrs. Farmer retired from active participation in the family farming operation several years ago. At the time of retirement, the farming operation was sold to their four children who are the present operators. On the sale of the operation to the children, Mr. and Mrs. Farmer invested the bulk of the proceeds in stock and other securities. Mrs. Farmer is now suffering from the advanced stages of Alzheimer's disease; she has entered a nursing home and an application for Medicaid benefits has been made. Mr. and Mrs. Farmer list assets as follows:

Cash	\$ 425,000
Stock (publicly traded)	\$ 300,000
Securities	\$ 250,000
Bonds	\$ 258,000
Total	\$1,233,000

Under the procedure outlined above,²²⁶ each spouse would be considered to have \$616,500 worth of assets.²²⁷ Mr. Farmer would have to deplete his share down to \$72,660, and Mrs. Farmer would have to deplete her share down to \$6,000 before Medicaid benefits could be received.²²⁸

As mentioned above, the community spouse is entitled to a monthly income allowance consisting of a minimum maintenance needs allowance (MMNA) and an excess shelter allowance.²²⁹ Effective January 1, 1994, the maximum monthly income allowance is set at \$1,817.²³⁰ In addition, the base spousal income allowance is set at \$1,179 per month.²³¹ To this base amount is added the shelter allowance plus a standard utility allowance. From this base amount is subtracted the community spouse's actual income that is received on a monthly basis.²³² The difference between the maximum monthly income allowance and the income that the community spouse already receives is the amount of income that the community spouse can shift

226. See *supra* notes 219-24 and accompanying text.

227. 42 U.S.C.A. § 1396r-5(c)(1)(A)(ii) (West Supp. 1994).

228. Thus, there would be a total depletion of \$1,156,260.

229. Federal Medicaid law requires state Medicaid agencies to allow the community spouse "an amount adequate to provide . . . a minimum monthly maintenance needs allowance." 42 U.S.C.A. § 1396r-5(e)(2)(c) (West Supp. 1994).

230. Medicare Catastrophe Coverage Act of 1988, Pub. L. No. 100-360, § 301, 102 Stat. 683, 748 (1988) (codified as amended at 42 U.S.C. § 13964(p)(2)(A) (1988)).

231. *Id.* § 1924(d)(3)(B)(i-iii). As of July 1, 1994, the base figure will be \$1,230 per month.

232. 42 U.S.C.A. § 1396r-5(e)(2)(c) (West Supp. 1994).

from the institutionalized spouse on a monthly basis. The following example demonstrates this process.

Income-only approach:		
Base spousal income allowance		\$ 1,179.00
Plus shelter allowance:		
Mortgage principal plus interest	\$ 0.00	
Taxes and Insurance	<u>\$1,250.00</u>	\$ 1,250.00
Plus standard utility allowance:		\$ 175.00
Total		<u>\$ 1,425.00</u>
Less 30% of base:		\$ 353.70
		<u>\$ 1,071.30</u>
Monthly income allowance (actual)		\$ 2,250.30
Maximum monthly income allowance (maximum allowable)		\$ 1,817.00
Less: Community spouse income		\$ 1,000.00
Community spouse monthly income needed		\$ 817.00
Community spouse resource allowance (CSRA) needed to meet monthly income:		
	$\$ 817.00 + .04 =$	\$ 20,425.00
CRSA annualized:		\$245,100.00
Amount of assets available to meet annualized CSRA amount		\$616,500.00

Thus, Mr. Farmer, as the community spouse, will be entitled to retain an additional \$245,100 of his spouse's asset share. As a result, an additional \$245,100 worth of the family assets will be preserved from depletion paying for Mrs. Farmer's long-term health care.

Until recently, it was believed that the amount of the increase in the CSRA that was needed to meet the community spouse's MMNA was arrived at by applying a prevailing interest rate to the shortfall in monthly income in order to determine the amount of income generated by the underlying assets needed to increase the MMNA to the minimum level. With the decline in interest rates in recent years, the level of assets needed to generate a specific level of income has increased.²³³ Potentially, this can result in the shifting of a larger portion of the institutionalized spouse's asset share away from the institutionalized spouse.

A recent Iowa Supreme Court case has significantly reduced the opportunity to shift assets away from an institutionalized spouse in the era of low interest rates. In *Ford v. Iowa Department of Human Services*,²³⁴ the Iowa Medicaid agency used the cost of an annuity to measure the amount of the increase in the CSRA needed to meet the MMNA. This approach vastly reduced any increase in the CSRA. The

233. However, since President Clinton took office in January 1993, interest rates have risen approximately 25%. See, e.g., *Markets Diary*, WALL ST. J., May 10, 1994, at C1.

234. 500 N.W.2d 26 (Iowa 1993).

court reasoned that the return from principal is indistinguishable from interest earnings and should likewise be considered as income.²³⁵ In addition, the court held that the income-only approach was not mandated by federal law.²³⁶

IV. PROTECTING THE MEDICAID BENEFICIARY AND BENEFICIARY'S ESTATE FROM REIMBURSEMENT CLAIMS

Before OBRA '93, the Medicaid law contained a third party recovery provision which required state agencies administering Medicaid programs to "take all reasonable measures to ascertain the legal liability of third parties to pay for care and services under Medicaid."²³⁷ The purpose of this provision was to benefit both the federal and state governments.²³⁸

Much of the litigation surrounding the old reimbursement provisions focused upon a state's right of obtaining reimbursement through subrogation, the ability of state Medicaid agencies to place liens on damage awards won by Medicaid recipients in court, and the ability of state Medicaid agencies to successfully seek reimbursement from trusts. For example, in *Kittle v. Icard*,²³⁹ the court held that the state Medicaid agency's right of reimbursement through subrogation was limited by principles of equity unless the state agency could demonstrate that it had a clear case of right and that no injustice would occur to any other individual.²⁴⁰ In *Meredith v. Schreiner Transport, Inc.*,²⁴¹ the court held that the Kansas state Medicaid agency's motion to intervene for payment of a lien on a judgment recovered by a Medicaid recipient had to be timely filed. Moreover, the lien claim must meet the jurisdictional amount in controversy requirement.²⁴² As to the issue of reimbursement from trusts, in *Society National Bank Ass'n v. Cayuga County*,²⁴³ the court held that the Ohio state Medicaid agency was not entitled to reimbursement for Medicaid assistance provided to a trust beneficiary where the trust was not in existence at the time of the application, and the spendthrift provisions of the trust did not give the beneficiary any legal interest in the trust.²⁴⁴

235. See, e.g., 42 U.S.C.A. 1382a(a)(2)(B) (West Supp. 1994).

236. *Ford v. Iowa Dep't of Human Serv.*, 500 N.W.2d 26, 31-32 (Iowa 1993).

237. 42 U.S.C. § 1396a(a)(25) (1988).

238. Thus, third party liability could not be sought from the federal government. *New York State Dep't of Social Serv. v. Bowen*, 684 F. Supp. 775 (E.D.N.Y. 1988).

239. 405 S.E.2d 456 (W. Va. 1991).

240. *Id.* at 464.

241. 814 F. Supp. 1001 (D. Kan. 1993).

242. *Id.* at 1003-04.

243. No. 13624, 1993 WL 65747 (Ohio App. 2d 1993).

244. *Id.* at 3-4.

Under the old law, reimbursement was also authorized from the estates of individuals over the age of sixty-five when benefits were received and from the sale proceeds of property subject to a lien imposed due to the payment of medical assistance benefits.²⁴⁵ Courts construed the definition of "estate" contained in this provision as limiting a state Medicaid agency's recovery to property that descended to a recipient's heir or beneficiaries of the recipient's will upon death.²⁴⁶ Thus, property held in joint tenancy with a Medicaid recipient was protected from a reimbursement claim upon the recipient's death.²⁴⁷ In addition, one federal appellate court has held that Medicaid recipients (and their estates) are not legally responsible for amounts not reimbursed to providers of medical services by state Medicaid agencies.²⁴⁸

Under OBRA '93, the states are required to adopt programs to recover Medicaid benefits from deceased recipients' estates dying on or after October 1, 1993 and any benefits paid on or after October 1, 1993.²⁴⁹ The states are directed to recover benefits paid to nursing facility services, home and community-based services, and related hospital and prescription drug services for anyone who at the time was fifty-five or older.²⁵⁰

Under the new law, the definition of estate has changed to include a decedent's probate estate under state law plus:

any other real and personal property and any other assets in which the individual had any legal title or interest at the time of death . . . including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy-in-common, survivorship, life estate, living trust or other arrangement.²⁵¹

A recent New York case has interpreted the estate recovery provisions of OBRA '93 as they apply to the possible reimbursement from the estate of an individual whose predeceased spouse had received Medicaid benefits. In *Estate of Craig*,²⁵² the state Medicaid agency paid the medical bill for an elderly individual and made no attempt to collect any portion of the bill from the decedent's spouse because the

245. 42 U.S.C. § 1396p(b)(1)(A-B) (1988).

246. See, e.g., *Citizen's Action League v. Kizer*, 887 F.2d 1003 (9th Cir. 1989).

247. Similarly, property held in tenancy-by-the-entirety was also likely to be protected. See, e.g., *Estate of Savage v. Pogue*, 650 S.W.2d 346 (Mo. Ct. App. 1983). This interpretation created an incentive for at-home care to be provided to a Medicaid recipient in exchange for the care-giver having a place to live, both during the provision of care and after the recipient's death.

248. *Banks v. Secretary of the Ind. Family & Social Serv. Admin.*, 997 F.2d 231 (7th Cir. 1993).

249. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13612, 107 Stat. 312, 627 (1993)(to be codified at 442 U.S.C. § 1396p(b)(1)).

250. *Id.*

251. *Id.* § 13612(c), 107 Stat. 312, 628.

252. 604 N.Y.S.2d 908 (1993).

surviving spouse lacked "sufficient means" to be considered a financially responsible relative at the time of the decedent's death.²⁵³

Before the surviving spouse died six years after the decedent's death, the surviving spouse had also received Medicaid benefits. At the time of the surviving spouse's death, the total Medicaid bill paid by the state for the surviving spouse and the predeceased spouse were less than the total value of the surviving spouse's estate at the time of the surviving spouse's death. Upon the surviving spouse's death, the state Medicaid agency attempted to recover the total amount of Medicaid payments for both spouses from the surviving spouse's estate. The surviving spouse's estate reimbursed the state Medicaid agency for the assistance paid to the surviving spouse but refused to pay the claim representing the amount of Medicaid benefits the predeceased spouse received.²⁵⁴

The state Medicaid agency argued that the "sufficient means test" as set forth in the state Medicaid law had no application after both spouses were deceased. Thus, the state argued that it should be entitled to full reimbursement for Medicaid benefits paid on behalf of both spouses, once both spouses are deceased.²⁵⁵

The court disagreed with the state Medicaid agency, holding that Medicaid assistance paid on behalf of the predeceased spouse may not be recouped from the surviving spouse's estate where the surviving spouse did not have sufficient means to be considered a responsible relative at the time payments were made on behalf of the predeceased spouse.²⁵⁶ In essence, the court held that a surviving spouse must have sufficient means at the time of the predeceased spouse's death to be considered a financially responsible relative. In addition, the court also commented on OBRA '93, stating that it had no bearing on the case.²⁵⁷ Under OBRA '93, states may only seek reimbursement against the recipient's assets that were conveyed through joint tenancy and other specified forms for survivorship. In *Craig*, the predeceased spouse died intestate.

OBRA '93 also directs the Secretary to establish standards and criteria for states to follow in setting procedures for waiver of estate recovery in cases of undue hardship.²⁵⁸ Apparently, Congress wants the hardship provision to be used, providing in the new law for specific instances when the hardship waiver should be granted. These instances include income producing property such as a family farm or

253. *Id.* at 909.

254. *Id.*

255. *Id.* at 910.

256. *Id.* at 911.

257. *Id.*

258. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13612, 107 Stat. 312, 628 (to be codified at 44 U.S.C. § 1396p(b)(1)).

other family businesses involved, a homestead of modest value, or other compelling circumstances.²⁵⁹ Further, the new law contains exceptions to the estate and recovery provisions for any individuals receiving benefits under long-term care insurance.²⁶⁰

V. CONCLUSION

The possibility for long-term health care must be factored into the overall estate plan. Failure to account for potential long-term health care needs early in the estate planning process can lead to undesirable results for the client. As a result, preserving the largest amount of assets for the heirs necessitates a knowledge of the federal Medicaid law and the applicable state laws governing public assistance benefits and how qualification for those particular benefits can be achieved.

The federal Medicaid statute is complex and requires a great deal of time to gain a working knowledge of its intricacies. However, even a rudimentary knowledge of the Medicaid law can be extremely useful for the representation of many elderly clients. An awareness of the Medicaid law's estate planning opportunities addressed in this Article are necessary to properly advise elderly or disabled clients.

While the estate planning opportunities have been significantly foreclosed by OBRA '93, some estate planning techniques remain viable options. In addition, the overall Medicaid appeals process and the ability to use the fair hearing process to increase the CSRA remains intact, even if to a smaller extent. While much of the benefit of trust planning has been foreclosed by OBRA '93, the treatment of GRITs remains uncertain. If the treatment of corpus and income of a GRIT is resolved in favor of Medicaid applicants, such trusts will remain a viable estate planning tool. Moreover, if the client is an owner of a closely held business, utilizing a series of lifetime gifting to work the client into a minority position before a Medicaid application is made can prove invaluable.

While the financial cost of long-term health care can be devastating, practitioners who counsel their clients to responsibly manage their financial resources and who have a general understanding of the Medicaid law's requirements and estate planning possibilities will remain a cut above many estate planners.

259. *Id.*

260. *Id.*