

ASSET PROTECTION PLANNING FOR MEDICAID AND VETERANS BENEFITS

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ABOUT THE AUTHOR



Evan Farr, Certified Elder Law Attorney, is the creator of the **Living Trust Plus™ Asset Protection System** used by dozens of Estate Planning and Elder Law Attorneys around the country, and is widely recognized as one of the foremost experts in the Country in the field of Medicaid Asset Protection and related Trusts. Evan has been quoted or cited as an expert by numerous sources, including the *Washington Post*, *Newsweek Magazine*, *Northern Virginia Magazine*, *Trusts & Estates Magazine*, *The American Institute of Certified*

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SECTION 1. ASSESSING CLIENTS' NEEDS - WHEN TO START?

1.1. Does Your Client Have a Chronic Illness?

1.1.1. A chronic illness is a disease that is long-lasting or recurrent, and needs to be managed on a long-term basis.¹

1.1.1.1. According to various reports published by the Robert Wood Johnson Foundation, almost half of all Americans (roughly 150 million people²) live with chronic illness, and people with chronic illness account for 83 percent of health care spending.³

1.1.1.2. According to the National Center for Chronic Disease Prevention and Health Promotion, part of the Centers for Disease Control and Prevention, chronic diseases – such as heart disease, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the U.S., and chronic illnesses such as these cause approximately 70% of deaths in the United States.⁴

1.1.1.3. According to a 2004 report by the Bloomberg School of Public Health at The Johns Hopkins University (analyzing data from 1998), 85% of seniors (over age 65) have at least one chronic disease, and 62% of them have two or more chronic illnesses.⁵ According to that same report, of adults between the ages of 18

¹See http://en.wikipedia.org/wiki/Chronic_illness, <http://www.arthritistoday.org/glossary/glossary-c.php>, (both last visited December 20, 2011).

²According to the U.S. Census Bureau, the total U.S. population is nearly 313 million people as of December 20, 2011, <http://www.census.gov>.

³See, e.g., **Chronic Conditions: Making the Case for Ongoing Care**, prepared by Partnership for Solutions, a national program funded by the Robert Wood Johnson Foundation and based at Johns Hopkins University, <http://www.rwjf.org/qualityequality/product.jsp?id=14685> (September 2004 Update). See also **Making Health Systems Work for People With Chronic Conditions**, <http://www.rwjf.org/qualityequality/product.jsp?id=59588> (December 20, 2011).

⁴**Chronic Diseases and Health Promotion**, published by the Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), <http://www.cdc.gov/chronicdisease/overview/index.htm> (December 20, 2011).

⁵Gerard Anderson, PhD and Jane Horvath, MHA, **The Growing Burden of Chronic Disease in America**, Public Health Reports Volume 119, Bloomberg School of Public Health, The Johns Hopkins University (May–June 2004), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497638/pdf/15158105.pdf>

and 64, 45% have at least one chronic disease, and 20% have two or more chronic illnesses.⁶

1.2. How is Incapacity Planning Different for Clients With a Chronic Illness?

- 1.2.1. Incapacity Planning can be done separately from Estate Planning, but is most often done in connection with the overall Estate Planning process. For the purpose of this outline, we will discuss these two intertwined planning areas separately at this point.
- 1.2.2. From an Incapacity Planning perspective, a client suffering from a chronic illness obviously needs basic incapacity planning documents such as a General Power of Attorney and Advance Medical Directive, and this outline assumes that the reader already has a thorough understanding of these two documents.
- 1.2.3. Less understood by many estate planning attorneys is the importance of incorporating comprehensive “asset protection powers” into a General Power of Attorney, *e.g.*, powers allowing: unlimited gifting of assets in connection with Medicaid planning; the creation and funding of trusts – both revocable **and** irrevocable; and the revocation of trusts. These are all powers that are frequently missing or specifically barred from “regular” powers of attorney done by estate planners for healthy clients.
- 1.2.4. Also less understood by many estate planning attorneys is the fact that Advance Medical Directives are self-limiting in that they deal only with health care and medical issues that present themselves in a hospital setting, and ignore the often more important decisions that need to be made in a long-term care setting such as a nursing home. To address the issue of patient self-determination in the nursing home or other long-term care setting, all clients with chronic illness should have a Long-Term Care Directive which can much better guarantee that their wishes, lifestyles and desires are documented and will be communicated to their future caregivers, whether these be family members, private nurses, home health aides, or staff in a nursing home.

⁶*Id.*

1.3. How is Estate Planning Different for Clients With a Chronic Illness?

- 1.3.1. Since we have already discussed issues related specifically to incapacity planning in section 1.2, the term “Estate Planning” as used in this section is intended to refer primarily to the distribution of financial assets at death.
- 1.3.2. From an Estate Planning perspective, one of the most significant results of chronic illness is that it often predictably results in the need for long-term care,⁷ and in the United States, the most significant result of long-term care is that, for the majority of Americans, paying for such care is financially devastating.
- 1.3.3. The best estate plan in the world becomes utterly useless when a client, prior to death, has become financially impoverished due to the need for extended long-term care caused by a chronic illness.
- 1.3.4. As will be seen in Section 9, neither Medicare nor private health insurance covers long-term care services, whether such care is delivered at home, in a nursing home, or in a hospice setting. When a chronic illness results in the need for long-term care, Medicare and private health insurance companies discontinue their coverage.
- 1.3.5. Given the foreseeability and likelihood that chronic illness will result in the need for long-term care, estate planning attorneys dealing with clients who have chronic illnesses must be cognizant of some of the important legal and financial issues surrounding long-term care, especially:
 - 1.3.5.1. a basic understanding of the various methods clients can use to pay for long-term care;
 - 1.3.5.2. the basic eligibility rules for Medicaid, Veterans Aid and Attendance, and other public benefits that allow clients to receive government financial assistance in connection with long-term care; and

⁷See Family Caregiver Alliance, **Selected Long-Term Care Statistics**, http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440 (last visited December 20, 2011). See also **Understanding LTC –Definitions & Risks**, National Clearinghouse for Long-Term Care Information, U.S. Department of Health and Human Services, Administration on Aging, http://www.longtermcare.gov/LTC/Main_Site/Understanding/Index.aspx (last visited December 20, 2011).

- 1.3.5.3. an understanding of when and why to make appropriate referrals to Elder Law attorneys who specialize in assisting clients in the vital areas of long-term care planning and Senior-focused Asset Protection.

1.4. Why Your Clients Need to Understand the Risks of Long-Term Care.

1.4.1. Long-term care differs from health care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain and maintain an optimal level of functioning. Long-term care encompasses a wide array of medical, social, personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition.⁸

1.4.2. Long-term care encompasses a broad continuum of care:

1.4.2.1. May involve medical care or skilled nursing care.

1.4.2.2. Most often involves “intermediate care” or “custodial care” – assistance with “Activities of Daily Living” or “Instrumental Activities of Daily Living.”

1.4.2.2.1. ADLs: Toileting; Bathing; Dressing; Eating; Walking; Transferring

1.4.2.2.2. IADLs: Shopping; Cooking; Household Chores; Care of pets; Financial management

1.4.2.3. Often involves supervision due to Dementia.

1.5. Where is Long-Term Care Provided?

1.5.1. At Home

1.5.1.1. Home health care is provided in an individual's home (by family members or paid staff) and aims to keep the individual functioning at the highest possible level. Services range from basic assistance with household chores to skilled nursing services.

1.5.2. Assisted Living Facilities

⁸Special Committee on Aging. Developments in Aging: 1997 and 1998, Volume 1, Report 106-229. Washington, DC: United States Senate, 2000.

1.5.2.1. An Assisted Living Facility (ALF) typically provides apartment-style accommodations where services focus on providing assistance with ADLs and IADLs, including meals, housekeeping, medication assistance, laundry, and regular check-ins. Designed to bridge the gap between independent living and nursing home care.

1.5.3. Nursing Homes

1.5.3.1. A nursing home (also called a "skilled nursing facility" or "SNF") is a medical facility that provides 24-hour nursing care for people with serious illnesses or disabilities. SNFs must be state-licensed and care is provided by registered nurses, licensed practical nurses, and certified nurse aids. The vast majority of all nursing homes are for-profit entities, and many of these are large corporations with nursing facilities in multiple states. Nursing homes generally provide three levels of service:

1.5.3.1.1. rehabilitation for people who are injured, sick, or disabled;

1.5.3.1.2. skilled nursing and medical care;

1.5.3.1.3. custodial care (help with eating, dressing, bathing, toileting, and moving about).

1.5.3.1.4. According to the U.S. Department of Health and Human Services, National Center for Health Statistics,⁹ as of its latest study in 2013-14, there were 15,600 nursing homes in the country providing a total of 1,663,300 certified beds.

1.5.3.2. Alternative LTC Arrangements:

1.5.3.2.1. Adult Day Care

1.5.3.2.1.1 Adult day care programs provide meals and care services in a community setting during the day while a caregiver needs time off or must work.

⁹Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers, 2013–2014 (Chapter 3. National Profile of Long-Term Care Services Users). The document can be found online at https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf.

1.5.3.2.2. Out-patient Therapy

1.5.3.2.2.1 Many facilities offer the same therapies provided in a nursing home on an out-patient basis. For those choosing a home-based option, out-patient therapy may be a necessary professional service.

1.5.3.2.3. Continuing Care Retirement Communities (CCRC) or Life Care Communities (LCC)

1.5.3.2.3.1 Provide a continuum of care from independent living through skilled nursing. The facilities allow individuals to live within the same community as their needs progress through the spectrum of care.

SECTION 2. OVERVIEW OF THE SIX WAYS TO PAY FOR LONG-TERM CARE.

2.1. Private Pay.

2.1.1. This means paying for the cost of a nursing home out of your own pocket – from income and, if necessary, from assets. Unfortunately, with nursing home bills averaging over \$100,000 per year in many parts of the country, few people can afford to pay on their own for a long-term stay in a nursing home. Even those who can afford to do so often desire to explore other options — options that allow them to retain some or all of their assets for other important needs, while still permitting them to pay for nursing home care.

2.2. Traditional Long-term Care Insurance.

2.2.1. It is estimated that about 10% of the American population carries Traditional Long-term Care Insurance.¹⁰ Most people facing a nursing home stay do not have this type of coverage in place. Many people who would like to purchase this type of coverage find that they can not afford it and are unable to qualify medically. Many people who do purchase it eventually give it up because of huge premium increases. Many people who do purchase it also don't purchase enough coverage, or in some cases purchase too much coverage, because they fail to take Medicaid into account when determining how much insurance to purchase.

¹⁰ Fewer than 10% of Americans 65 and over carry long-term care insurance (<http://www.uscare.com/whytc.html>, quoting Wall St. Journal, 3/31/99), last visited 2-13-2011.

2.3. Hybrid Long-term Care Insurance.

2.3.1. Many clients who are rightly wary of traditional long-term-care insurance are increasingly purchase “hybrid” policies combining life insurance or an annuity product with long-term care benefits. For many, these products are a better way to manage the risk of catastrophic long-term-care costs. These policies come in many flavors:

2.3.1.1. Some hybrid policies attach a long-term care rider to a whole or universal life insurance policy. Consumers typically pay a single up-front premium, and if they never need long-term care, their heirs get the death benefit.

2.3.1.2. By paying a single premium or series of set premiums, your client avoids the risk of future premium increases – an issue that has plagued traditional long-term-care policies. Also, many clients hate the idea of the “use it or lose it” nature of traditional long-term care policies; the hybrid’s death benefit eliminates that concern.

2.3.1.3. Also, hybrid policies are much easier to qualify for, from a health standpoint, than traditional long-term care policies, and many can be purchased up to age 80.

2.4. Veterans Aid and Attendance.

2.4.1. The Veterans Administration (VA) pays for long-term care primarily through its “Aid and Attendance” payments, which is actually a veteran’s Special Pension with an add-on for Aid and Attendance.

2.4.2. Aid and Attendance qualification and eligibility will be discussed in greater detail later in these materials.

2.5. Medicaid.

2.5.1. This is a combined federally-funded and state-funded benefit program, administered by each state, that can pay for the cost of a nursing home if certain asset and income tests are met. According to AARP, about 70 percent of nursing home residents are supported, at least in part, by Medicaid.

2.5.2. Medicaid qualification and eligibility will be discussed in greater detail later in these materials.

SECTION 3. THE MEDICAID LOOKBACK PERIOD AND TRANSFER RULES.

3.1. The Medicaid Lookback Period.

3.1.1. All uncompensated transfers, regardless of whether they are made to individuals, trusts, charities, or other entities, are subject to a 5 year lookback.

3.1.2. Lookback Period Interplay with Penalty Period - don't confuse the Lookback Period with the Penalty Period. Medicaid penalty periods can exceed the duration of the Medicaid lookback period.

3.2. Uncompensated Transfers and Penalty Periods.

3.2.1. **Transfer Penalty.** An uncompensated transfer of assets results in a period of ineligibility for Medicaid, typically called a “penalty period.” The penalty period begins when (a) the person would be receiving an institutional level of care, (b) an application has been filed, and (c) a person is not in any other period of ineligibility. For most people this means at the time an application is filed and they are receiving care. The penalty is calculated as follows:

3.2.1.1. $\text{Amount of Transfer} \div \text{Penalty Divisor} = \text{Number of Months Penalty.}$

3.2.1.2. For example, in a state with a \$10,000 Penalty Divisor, if a person gave away a total of \$100,000 to his or her family during the 5-year lookback period, and then filed for Medicaid during that period, the period of ineligibility thus created would be 10 months ($\$100,000 \div 10,000$).

3.2.2. Penalty Beginning Date.

3.2.2.1. The beginning date for the penalty period for asset transfers is the later of the first day of the month in which the transfer was made or the date on which an individual is eligible for Medicaid benefits and would otherwise be receiving institutional level of care based on an approved application but for the application of a penalty period.

SECTION 4. MEDICAID ASSET PROTECTION PLANNING.

4.1. Types of Medicaid Planning. There are two general types of Medicaid Asset Protection Planning – Pre-Need Planning and Crisis Planning:

4.1.1. **Pre-Need Planning:** This is for clients doing Medicaid planning well in advance of the need for nursing home care, while they are still healthy and typically still living independently. These are typically clients who do not have long-term care insurance. For these clients, one of the primary planning options is the Living Trust Plus™ – a special type of irrevocable trust created by your author that protects a client’s assets from probate PLUS lawsuits PLUS Veterans benefit PLUS Medicaid. There are two versions of the Living Trust Plus™ – the most common one being the one where the Settlor does not retain any rights to any trust distributions, and the less common one where the Settlor retains the right to receive ordinary income from the trust (known generically as an Income Only Trust). The Living Trust Plus™ will be discussed in much greater detail later in this treatise.

4.2. Sample Crisis Planning Strategies.

4.2.1. Sample Asset Purchase Strategies Available in Most States¹¹:

- 4.2.1.1. Prepayment of legal or other services;
- 4.2.1.2. Payment for home improvements if home is exempt;
- 4.2.1.3. Purchase of household goods and personal effects;
- 4.2.1.4. Purchase of a more expensive home if the home is exempt;
- 4.2.1.5. Purchase life estate and reside for one year;
- 4.2.1.6. Purchase of pre-paid funeral arrangements;
- 4.2.1.7. Purchase of a new car;
- 4.2.1.8. Prepayment of taxes;
- 4.2.1.9. Payment of outstanding debts;
- 4.2.1.10. Purchase Medicaid-qualified annuity for Community Spouse.

¹¹Most of these strategies are based on federal law, but none of these strategies should be attempted without both (1) a comprehensive understanding of each strategy's specific rules and requirements in your state and (2) a thorough understanding of each strategy's Medicaid, estate planning and tax consequences (including income tax and capital gains tax).

4.2.2. Sample Asset Transfer Strategies Available in Most States¹²:

- 4.2.2.1. Transfer assets to blind or disabled child;
- 4.2.2.2. Transfer assets to a trust for the sole benefit of a blind or disabled child;
- 4.2.2.3. Transfer residence to caregiver child;
- 4.2.2.4. Transfer residence to sibling on title for more than a year;
- 4.2.2.5. Transfer residence subject to life estate;
- 4.2.2.6. Transfer residence subject to occupancy agreement;
- 4.2.2.7. Caregiver agreement between parent and child;
- 4.2.2.8. Transfer and Cure.

SECTION 5. OVERVIEW OF MEDICAID ELIGIBILITY CRITERIA.

5.1. Four Criteria

5.1.1. There are four separate but overlapping eligibility criteria for Medicaid, each of which is discussed below in detail:

- 5.1.1.1. *Medical Eligibility*;
- 5.1.1.2. *Resource Eligibility*;
- 5.1.1.3. *Income Eligibility*; and
- 5.1.1.4. *Transfer Eligibility*.

SECTION 6. MEDICAL ELIGIBILITY.

6.1. Medically Needy.

6.1.1. To be eligible for Medicaid long-term care assistance in most states, you must generally be “medically needy” – meaning in need of a nursing home level of care, though some states have expanded Medicaid to cover the assisted living level of care.

6.1.2. Determination of eligibility for long-term medical care is typically based on a comprehensive needs assessment, which must demonstrate that the proposed Medicaid recipient requires nursing facility services. This individual may have unstable medical, behavioral and/or cognitive conditions, one or more of which

¹²Most of these strategies are based on federal law, but none of these strategies should be attempted without both (1) a comprehensive understanding of each strategy's specific rules and requirements in your state and (2) a thorough understanding of each strategy's Medicaid, estate planning and tax consequences (including income tax and capital gains tax).

may require ongoing nursing assessment, intervention, and/or referrals to other disciplines for evaluations and appropriate treatment. Often adult nursing facility residents have severe cognitive impairments and related problems with memory deficits and problem-solving. These impairments and deficits severely compromise personal safety and, therefore, require a structured, therapeutic environment. Most nursing facility residents are also dependent on others in several Activities of Daily Living (walking; transferring; feeding; dressing; bathing; and toileting).

SECTION 7. MEDICAID RESOURCE ELIGIBILITY.

7.1. Countable Assets / Resources.

7.1.1. In every state, an individual applicant for Medicaid long-term care assistance may have no more than a small amount in "countable assets," also called "resources," in his or her name in order to be "resource eligible" for Medicaid. For example, in Virginia, this Individual Resource Allowance is \$2,000. A married couple both applying for Medicaid long-term care assistance may have no more than \$3,000 total Resources Allowance in their names in order to be resource eligible for Medicaid.

7.2. Exempt Assets and Countable Assets.

7.2.1. To qualify for Medicaid, applicants must pass some very strict tests on the type and amount of assets they can keep. To understand how Medicaid works, one first needs to learn to differentiate what are known as "exempt assets" from "countable" assets.

7.2.2. Exempt assets are those that Medicaid does not take into account. In most states, that includes:

7.2.2.1. The applicant's principal residence so long as the equity is under \$560,000 (\$840,000 in some states, including DC). However, in some states, such as Virginia, after the nursing home resident has been in the nursing home for a period of time (*e.g.* six months in Virginia), the resident's home will become a countable resource unless the resident's spouse or other dependent relatives live in the home. When the home is an exempt resource, that means the

Medicaid applicant can keep the home and still qualify for Medicaid. But it also means that the home will be part of the Medicaid recipient's estate at death and that the state can therefore exercise Estate Recovery (see section 7.4) against the home after death, thereby recovering from the sales proceeds of the home some or all of what Medicaid paid during the lifetime of the Medicaid recipient.

7.2.2.2. Personal possessions, such as clothing, furniture, and jewelry.

7.2.2.3. One motor vehicle, without regard to value.

7.2.2.4. Certain property used in a trade or business.

7.2.2.5. Certain prepaid burial arrangements.

7.2.2.6. Term life insurance policies with no cash value.

7.2.2.7. A life estate in real estate (however, the transfer rules on life estates are very complicated and must be carefully observed). Also, in some states, retention of a life estate means that the actuarial value of the life estate immediately prior to death will be considered to part of the Medicaid recipient's estate at death and that the state can therefore exercise Estate Recovery against the home after death, thereby recovering from the sales proceeds of the home some or all of what Medicaid paid during the lifetime of the Medicaid recipient.

7.2.2.8. Certain Special Needs Trusts; and

7.2.2.9. Certain assets that are considered inaccessible for one reason or another.

7.2.3. All other assets are generally “countable” assets, technically called “resources.” Basically all money and property, and any item that can be valued and turned into cash, is a countable asset unless it is specifically listed as exempt in your state's Medicaid Manual. This generally includes:

7.2.3.1. Cash, savings and checking accounts, credit union share and draft accounts;

7.2.3.2. Certificates of deposit;

- 7.2.3.3. Individual Retirement Accounts (IRAs), Keogh plans, 401(k) and 403(b) accounts (though some states exempt retirement accounts if they are in some sort of “payout” status, even though they have a cash value);
- 7.2.3.4. Nursing home accounts;
- 7.2.3.5. Prepaid funeral contracts that can be canceled;
- 7.2.3.6. Certain trusts (depending on the terms of the trust);
- 7.2.3.7. Real estate other than the primary residence;
- 7.2.3.8. Any additional motor vehicles;
- 7.2.3.9. Boats or recreational vehicles;
- 7.2.3.10. Stocks, bonds, or mutual funds; and
- 7.2.3.11. Land contracts or mortgages held on real estate.

7.3. Annuity Resource Rules.

- 7.3.1. An annuity purchased by or for an individual on or after February 8, 2006, using that individual’s assets will be considered an available resource unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. All annuities purchased by the institutionalized individual or a community spouse on or after February 8, 2006, must name the State as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.

7.4. Estate Recovery Rules.

- 7.4.1. Under federal regulations and state laws, the Medicaid agency of every state may make a claim against a deceased Medicaid recipient’s estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his/her behalf. This claim can be waived if there are surviving dependents.

SECTION 8. VETERANS AID AND ATTENDANCE - THE NEW RULES.

8.1. The New Rules Effective October 18, 2018

- 8.1.1. The Veterans Administration (VA) pays for long-term care primarily through its “Aid and Attendance” payments, which is actually a veteran’s Special Pension with an add-on for Aid and Attendance.
- 8.1.2. Prior to October 18, 2018:
 - 8.1.2.1. All transfers (trusts, annuities, gifting, etc.) prior to 10.18.18 are exempt from the look-back period.
 - 8.1.2.2. A Single Premium Annuity will not be a countable asset if it is purchased prior to 10.18.18.
 - 8.1.2.3. An IRA annuitized before 10.18.18 will not be countable as an asset because of the claimant’s inability to liquidate.
 - 8.1.2.4. An application does not need to be filed before 10.18.18 to maintain the exemption of pre-10.18.18 transfers.
- 8.1.3. **After October 18, 2018.** On January 23, 2015, proposed rule changes to amend the veterans pension application process were published by the VA in the Federal Register. These new rules are now scheduled to go into effect October 18, 2018. The new rule changes will have a significant effect on elder care planning for veterans, making asset protection trusts for veterans the primary planning tool, using the 3-year lookback period. The new rules mirror Medicaid rules in some ways, as they require a net worth determination and a look-back period, and impose penalties for asset transfers. Below is a brief summary of the key proposals that will go into effect on October 18, 2018:
- 8.1.4. **Net Worth.** The new rule imposes a net worth limit equal to the current maximum community spouse resource allowance for Medicaid purposes (\$123,600). Net worth will be determined by combining assets and annual income. A veteran’s assets are defined to include both the assets of the veteran and the assets of his or her spouse. A surviving spouse’s assets would only include the assets of that surviving spouse.

8.1.4.1. **Calculation of Net Worth:**

8.1.4.1.1. All Countable Assets + (Annual Gross Income - net Unreimbursed Medical Expenses).

8.1.4.1.2. Countable Assets include assets of Veteran as well as the assets of the spouse.

8.1.4.1.3. See 38 CFR 3.275 for Criteria for Evaluating Net Worth.

8.1.5. **Look-back on Asset Transfers**

8.1.5.1. Under old VA rules, there was NO transfer penalty. This meant that your clients could transfer excess assets and apply for VA benefits the next day. New Reg. § 2.276(e) now imposes a look-back and transfer penalties. The new rules establish a three-year look-back period for asset transfers for less than fair market value; Medicaid has a five-year look back period. The penalty period will be calculated based on the total assets transferred during the look-back period to the extent they would have exceeded a new net worth limit that the rules also establish.

8.1.6. **Exempt Assets - The Home?**

8.1.6.1. Under the new rules, the primary residence along with a lot size up to 2 acres (regardless of value), is exempt. Under the old rules, a residence and underlying/surrounding land “similar in size to other residential lots in the vicinity” were not countable. If most residences in the area were on a 20 acres, the applicant’s residence and surrounding land would not be countable.

8.1.6.2. The new rules impose a very worrisome 2 acre limit "unless the additional acreage is not marketable." The examples given with regard to nonmarketable acreage related to acreage "only slightly more than 2 acres," property that might be inaccessible (surrounded by other owners, perhaps) or property subject to zoning limits that could prevent a sale. It is unknown what other factors might make additional acreage "not marketable."

- 8.1.6.3. Example: Under the old rules, your client lives in his rural home on 12 acres of land, not uncommon for his county, where most people have lots of between 10 and 50 acres. Under the new rules, your client likely has 12 acres of countable real estate. Unless zoning laws or other "marketability issues" prohibit it, your client would most likely have to subdivide his property so that his lot is only 2 acres. This process, or course, could take several years, so it will, in almost all cases, be simpler to simply transfer the entire house and land into trust and wait out the 3-year lookback.
 - 8.1.6.3.1. It is important to note that the house is not an exempt asset for Medicaid in Virginia, and in most states where it is "exempt" in connection with Medicaid, it is not truly protected because of Estate Recovery "clawback," so houses must still be protected (generally using in a Living Trust Plus™ Total Protection Trust) because anyone who is in need of Veterans Aid and Attendance will most likely, at some point in the future, be in need of Medicaid.
- 8.1.6.4. Once the primary residence is sold, the residence is no longer exempt because it has been converted to money, and that money will be countable as of January 1 of the year following the year of sale. Another reason that houses need to be protected, preferably in a Living Trust Plus™ Total Protection Trust, prior to being sold.
- 8.1.6.5. Family transportation vehicles and personal items used on a regular basis.
 - 8.1.6.5.1. Note: Multiple vehicles are excluded so long as they are used for the veteran on a regular basis; not so with Medicaid, which exempts only one vehicle.
- 8.1.6.6. Pre-paid burials and burial plots.
- 8.1.6.7. Any asset that was transferred or gifted prior to 10.18.18.

8.1.7. Penalty Period

- 8.1.7.1. Under the new regulations, veterans or their surviving spouse who transfer assets within three years of applying for benefits will be subject to a penalty period that can last up to 5 years.
- 8.1.7.2. There is a complex calculation to determine the penalty period. Rule 3.276(e)(1) uses a single divisor for all claimants, which results in equal penalty periods for equal amounts of precluded asset transfers regardless of the type of claimant. The single divisor is the MAPR in effect on the date of the pension claim at the aid and attendance level for a veteran with one dependent, currently \$21,961 per year.
- 8.1.7.3. Only transfers of countable assets are penalized. Transfers of exempt (non-countable) assets are not penalized.
- 8.1.7.4. Transfers are only penalized if they adversely affect Net Worth (i.e., if the transfer reduces net worth to less than \$123,600).
- 8.1.7.5. Transfers to set up a SNT for a dependent child who was disabled before the age of 18 are not penalized.
- 8.1.7.6. There are exceptions to the penalty period for fraudulent transfers and for transfers to a trust for a child who is unable to provide “self-support.”
- 8.1.7.7. Under the new rules, the VA will determine a penalty period in months by dividing the amount transferred that would have put the applicant over the net worth limit by the maximum annual pension rate (MAPR) for a veteran with one dependent in need of aid and attendance. In 2018 that amount is approximately \$2,170. Actually, the MAPR for a veteran qualifying for the maximum Aid & Attendance benefit with one dependent is \$26,036 annually. The regulations say to divide that by 12 and drop the cents. Reg. § 3.276(e)(1). So technically in 2018 that amount is \$2,169 (\$26,036/12 = \$2,169.67).

- 8.1.7.8. It does not matter at whether the transfer penalty is being calculated for a single veteran, a married veteran, or a widow of a veteran. Always use the MAPR for a veteran with a dependent divided by 12.
- 8.1.7.9. For example, assume the current net worth limit of \$123,600 and an applicant has a net worth of \$115,000. The applicant transferred \$30,000 to a child during the look-back period.
- 8.1.7.9.1. If the applicant had not transferred the \$30,000, his net worth would have been \$145,000, which exceeds the net worth limit by \$21,400. The penalty period will therefore be calculated based on \$21,400, the amount the applicant transferred that put his assets over the net worth limit (\$145,000-\$123,600).
- 8.1.7.9.2. The transfer subject to penalty would be divided by the 2018 MAPR of \$2,170, resulting in a 9.86 month penalty (\$21,400 divided by \$2,169 = 9.86). The penalty begins to run on the first day of the month following the month of transfer.
- 8.1.7.10. A penalized transfer may be cured in whole or partially, *provided that it is done within 60 days of the notice of penalty and evidence of cure is received by the VA no later than 90 days from the date of notice.*

8.1.8. **Annual Gross Income**

- 8.1.8.1. All income from sources such as wages, salaries, earnings, bonuses, income from business, profession, investments and rents (list not inclusive).
- 8.1.8.2. Income of spouse also included.
- 8.1.8.3. Waived income is also included in annual gross income computation.
- 8.1.8.4. Exception for withdrawing a SS application after finding of entitlement to SS benefits.

- 8.1.8.5. See 38 CFR 3.262 for how income is evaluated.
- 8.1.8.6. See 38 CFR 3.271 for computation of income.
- 8.1.8.7. See 38 CFR 3.272 for exclusions from income.
- 8.1.8.8. Shall be counted during the 12-month annualization period in which received.

8.1.9. Unreimbursed Medical Expenses

- 8.1.9.1. Any amounts paid within the 12-month annualization period regardless of when the indebtedness was incurred.

- 8.1.9.1.1. See 38 CFR 3.278 for definition of what constitutes a medical expense.

8.1.10. Medical Expense Deductions from Income

- 8.1.10.1. Medical expenses are those that are either medically necessary or improve a disabled individual's functioning. These medical expenses are deducted from income. This becomes more complicated when the claimant is receiving home care or is in an independent or assisted living facility, as the new rules somewhat limit the circumstances under which room and board expenses may be counted, as well as the amount paid. There are very specific rules as to which services qualify as medical expenses and the claimant will have to be able to identify those in his/her application. Section (d)(3)(i)(B) now provides, in final paragraph (d)(3)(iv), that payments for meals and lodging, as well as payments for other facility expenses not directly related to health or custodial care, are medical expenses when either of the following are true: (A) the facility provides or contracts for health care or custodial care for the disabled individual; or (B) a physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that the individual must reside in the facility (or a similar facility) to separately contract with a third-party provider to receive health care or custodial care

or to receive (paid or unpaid) health care or custodial care from family or friends.

8.1.10.2. The proposed limited the hourly amount that can be paid to a home health care provider and based the amount on a national average, rather than local costs for care. The final rule does not include a limit to the hourly rate of in-home care.

8.1.10.3. Any veterans trust established before the effective date of the new regulations will, hopefully, not be subject to the new rules.

8.2. Veterans Half-Loaf Asset Protection Planning Under the New Rules

8.2.1. The fact that the penalty period will begin the first day of the month that follows the last asset transfer makes this new law similar to the old Medicaid gifting rules that were in effect prior to the Deficit Reduction Act of 2005 (“DRA”).

8.2.1.1. Under prior Medicaid law, someone already in a nursing home wanting to apply for Medicaid could give away half of his or her spend-down amount, immediately commencing the penalty period, and the nursing home resident would simply retain the other half to privately pay throughout the penalty period associated with the gift (as opposed to the Medicaid law since DRA, which says that the penalty period doesn’t start until someone has applied for Medicaid and is otherwise eligible “but for” the penalty period). This old Medicaid gifting strategy will now be available in connection with applications for the Veterans Pension. Below is an example of how this strategy works.

8.2.1.2. Let’s take John Jones, a single veteran. The net worth limit is \$123,600. Mr. Jones has assets of \$200,000 and annual income from Social Security of \$24,000 (\$2,000 per month) from Social Security. Adding his annual income to his assets produces a “net worth” of \$224,000, which exceeds the net worth limit by \$100,000, meaning that he has \$100,400 in assets to be protected. Let’s further assume that he lives in an Assisted Living Facility

and his monthly cost of care is \$6,000. Based on these assumptions, we can calculate his monthly shortfall as follows:

Assisted Living Facility Monthly Cost	\$6,000
Minus Monthly Income	\$2,000
Equals Monthly Assisted Living Shortfall	\$4,000

Now that we know his monthly shortfall, we can calculate how much of his assets can be transferred to the applicant’s children using the half-loaf strategy and how much must be retained and spent on Assisted Living Expenses to cover his monthly shortfall during the penalty period.

\$4,000.00	Monthly Assisted Living Shortfall	Penalty & Payout Period ▼	
\$100,400.00	Assets to be protected		
\$31,000.00	⇔ Amount to be Transferred to Children	Number of Resulting Penalty Months, rounded down ⇒	17
\$69,400.00	⇔ Amount to be Retained and Paid to ALF	Number of months that can be paid to ALF using the retained amount. ⇒	17

8.2.1.3. Result: After 17 months, \$31,000 out of the \$100,400 in unprotected funds has been protected, in addition to the \$123,600 that Mr. Jones is allowed to keep, and Mr. Jones can now apply for Aid and Attendance and begin receiving his VA pension amount of \$21,961 per year / \$1,830 per month, all while keeping \$154,600 out of the \$200,000 he started with.

8.3. Medicaid.

8.3.1. This is a combined federally-funded and state-funded benefit program, administered by each state, that can pay for the cost of a nursing home if certain

asset and income tests are met. According to AARP, about 70 percent of nursing home residents are supported, at least in part, by Medicaid.

8.3.2. Medicaid qualification and eligibility will be discussed in greater detail later in these materials.

SECTION 9. WHERE MEDICARE STOPS AND MEDICAID BEGINS.

9.1. What is Medicare?

9.1.1. Medicare is the national health insurance program primarily for people 65 years of age and older, those under age 65 who have been disabled for at least 24 months, and people with kidney failure. Medicare may provide limited coverage for up to 100 days in a nursing facility, provided the care required is deemed "skilled nursing care," but the patient must meet certain strict qualification rules, discussed below.

9.2. Does Medicare Pay for Long-Term Care?

9.2.1. No. Medicare simply does not cover long-term care. Long-term care is essentially synonymous with custodial care, and Medicare does not cover custodial care. At most, Medicare may in some situations cover short-term rehabilitative care, which often takes place in a nursing home, but this is not long-term care.

9.3. What Does Medicare Pay For?

9.3.1. **Part A**, free for qualified persons over 65, is hospital insurance and covers most costs billed by hospitals.

9.3.1.1. Note: it does not cover doctor costs, even if the doctor care is rendered in the hospital.

9.3.1.2. How much Part A pays depend on how many days of inpatient care during a "benefit period," or "spell of illness." The benefit period begins the day the patient enters the hospital or SNF as an inpatient and continues until the patient has been out for 60 consecutive days. If the patient is in and out of the hospital or SNF several times but has not remained out for 60 consecutive days, all inpatient bills for that time will be calculated as part of the same benefit period.

- 9.3.1.3. Beyond 60 days, there is a daily coinsurance amount for hospital care, which increases depending on the length of the hospitalization.
- 9.3.1.4. About two-thirds of all Medicare recipients aged 65 or over also have private supplemental health coverage -- called medigap insurance, which typically covers this deductible.
- 9.3.2. **Part B**, for an optional monthly premium, pays some doctor and outpatient medical care costs. Part B generally pays 80 percent of most approved physicians' charges, after the patient pays the annual Part B deductible. For individuals with high monthly income, the Medicare Part B premium may be higher.
- 9.3.3. **Part D**, at an optional cost, covers some prescription drug costs, less a copay. The Medicare copay varies depending on the plan.
- 9.3.4. If a patient is enrolled in a traditional Medicare plan, has been in the hospital at least three days, and is admitted directly from the hospital into a SNF for rehabilitation and/or skilled nursing care, then Medicare may pay the full cost of the nursing home stay for the first 20 days, and may continue to pay part of the cost of the nursing home stay for the next 80 days — with a high per-day deductible that the patient must pay privately (although a Medigap policy will usually cover this deductible).
- 9.3.5. There is also a Medicare Managed Care Plan, for which the 3-day hospital stay may not be required, and for which the deductible for days 21 through 100 is waived, provided certain strict qualifying rules are met.
- 9.3.6. Whether the plan is traditional Medicare or Medicare Managed Care (MMC), the nursing home resident must need to be receiving daily "skilled nursing care." and generally must continue to "improve."
- 9.3.7. Medicare will not pay for treatment of all diseases or conditions. For example, if a long-term stay in a nursing home is due to a condition such as Alzheimer's or Parkinson's disease (which usually require custodial care, not "skilled care" and which do not "improve"), Medicare will not pay any benefits because

hospitalization for these conditions is termed a "custodial nursing stay," and Medicare simply does not pay for custodial nursing home stays.

- 9.3.8. In a "best case" scenario, traditional Medicare or MMC will provide some coverage for the hospital stay and convalescence of up to 100 days for each "spell of illness" (although in my experience coverage usually falls far short of the 100-day maximum). If the patient recovers sufficiently so as to not require a Medicare-covered benefit for 60 consecutive days, the patient may be eligible for another 100 days of Medicare coverage for the next "spell of illness," but the illness or disorder must not be a chronic degenerative condition from which the patient will not recover.

9.4. When Will Medicare Pay for Home Health Care?

- 9.4.1. Just as Medicare does not cover long-term care in a nursing home, Medicare also does not cover long-term care at home.
- 9.4.2. Medicare may cover some home health care (not long-term care) if:
- 9.4.2.1. The doctor decides the patient needs in-home medical care and makes a plan for in-home care (plan should specify the skilled services, frequency and duration of care needed); and
 - 9.4.2.2. The patient needs at least one of the following:
 - 9.4.2.2.1. intermittent (not full time) skilled nursing care, or
 - 9.4.2.2.2. physical therapy, or
 - 9.4.2.2.3. speech language pathology services, or
 - 9.4.2.2.4. occupational therapy, and
 - 9.4.2.3. The patient is homebound – i.e., unable to leave home or able to leave home but with a major effort.
- 9.4.3. The home health agency must be approved by the Medicare program.
- 9.4.4. Medicare covers up to a total of 35 hours a week of skilled nursing and home health aide services (note: home health aide services will not be covered without an accompanying skilled need).
- 9.4.5. The amount of care allowed in the plan of care depends upon the doctor's recommendations based on health status.

- 9.4.6. Realistically, most people can expect to receive about 10 hours per week of care at most.
- 9.4.7. Medicare covers 100% of all covered home health visits. Services and supplies approved in the plan of care are covered in full. Durable medical equipment is covered at 80 percent of the Medicare-approved amount.
- 9.4.8. While receiving home care the patient must continue to need those services at the covered level. This means that as the patient becomes more independent in self-care, the patient will longer be eligible to receive home care.

9.5. When Will Medicare Pay for Prescription Drug Benefits?

- 9.5.1. Anyone with Medicare Part A and/or Part B can join a Medicare prescription drug plan (Part D) offered in their area. Medicare Advantage Plans (similar to an HMO or PPO) also offer drug coverage.
- 9.5.2. Plans and costs vary greatly. In general, there is a monthly premium, a yearly deductible, and co-payments. Costs will vary depending on the plan chosen. Some plans offer greater coverage and additional drugs for a higher monthly premium.

9.6. When Will Medicare Pay for Hospice Care?

- 9.6.1. Patient must be certified by an attending physician and the hospice medical director to have an advanced illness with a life expectancy of six months or less.
- 9.6.2. Patient Consent in writing to choose palliative rather than curative care. Patient need not be in a severely deteriorated physical condition or in a medical crisis to qualify.
- 9.6.3. The services described in the Medicare-certified home health agency or hospice's plan of care are generally free to people with Medicare, with the exception of small co-payments for some supplies and equipment.
- 9.6.4. Medicare does not pay for services and supplies not covered by the plan of care.
- 9.6.5. Medicare does not pay for long-term care services.

SECTION 10. THE TEN MOST COMMON MEDICAID MYTHS.

10.1. Myth 1: "Greedy children want Medicaid Planning to protect their inheritance."

- 10.1.1. **Reality:** If I get the feeling that a child has unduly influenced his or her parent to come visit me in order to preserve an inheritance, I will send them packing. Most

Elder Law attorneys have a passion for protecting the dignity and quality of life of the Elder, which is what Elder Law is all about.

- 10.1.2. **Reality:** The expenses of long-term care caused by a chronic illness are often catastrophic because in the United States, citizens do not have a right to basic long-term care. Through Medicare, seniors have had virtually universal health insurance coverage for most chronic illnesses since 1965. For individuals under age 65, private health insurance has likewise always covered treatment, medication, and surgery for most chronic illnesses - such as heart disease, lung disease, kidney disease, and hundreds of other chronic medical conditions.
- 10.1.3. **Reality:** Our American health insurance system essentially discriminates against people suffering from certain types of chronic illnesses, i.e., chronic illnesses that routinely result in the need for long-term care, such as: Alzheimer's disease and other types of dementias; Parkinson's disease and other types of degenerative disorders of the central nervous system; Huntington's disease, Amyotrophic Lateral Sclerosis (ALS), and other progressive neurodegenerative disorders; and many genetic disorders such as Multiple Sclerosis, Muscular Dystrophy, and Cystic Fibrosis. So those Americans suffering the misfortune of one of these diseases must also suffer the misfortune of having the "wrong" disease according to our American health insurance system. Is it an ethical social policy that seemingly arbitrarily distinguishes among these different types of illnesses? Is it an ethical social policy that provides full coverage for most illnesses - whether chronic or acute - but forces Americans with certain chronic conditions (many of them elders) to become impoverished in order to gain access to the long-term care necessitated by their particular type of chronic illness? Is it a surprise that clients suffering the "wrong type" of chronic illness will want to look for legal ways to preserve the efforts of their lifetime in order to protect themselves from this unfair and arbitrary social policy?
- 10.1.4. **Reality:** Medicaid asset protection planning is not about "cheating" or "gaming" the system; it is about understanding and using existing laws that enable us to help our clients preserve their dignity and self-worth and avoid being financially destroyed by our unfair health care system.

10.2. Myth 2: "A nursing home resident must 'spend down' virtually all assets on nursing home care before qualifying for Medicaid."

10.2.1. **Reality:** Elder Law Attorneys who specialize in Medicaid Asset Protection legally help nursing home residents protect significant assets every day. For a married client, we can generally protect 100% of their assets, regardless of how the assets are titled, without forcing them to get divorced. For an unmarried client, we can generally protect 40% to 70% of the assets.

10.3. Myth 3: "It is illegal to transfer assets in the 5 years prior to applying for Medicaid."

10.3.1. **Reality:** Nothing is illegal about transferring your own assets, though there may be Medicaid consequences in doing so. Many legal and ethical asset protection strategies do involve transferring assets.

10.4. Myth 4: "Once someone is in a nursing home, it's too late to do any asset protection."

10.4.1. **Reality:** It's never too late to protect assets, even if you or a loved one is already in a nursing home facility.

10.5. Myth 5: "Someone on Medicaid gets lower quality care than someone paying privately."

10.5.1. **Reality:** Disparate treatment between Medicaid recipients and private pay residents is illegal. In fact, Medicaid recipients who have worked with a qualified Elder Law Attorney often get much better care than their private-pay counterparts because the money that has been protected is often used by a loving family member to help the elder obtain better quality care and to maintain dignity and quality of life.

10.6. Myth 6: "Medicare will pay for long-term care in a nursing home."

10.6.1. **Reality:** Medicare only pays for short-term rehabilitation, and only for a limited time and under limited circumstances. Medicare does not pay a single penny for long-term care.

10.7. Myth 7: "All Power of Attorney documents are basically the same."

10.7.1. **Reality:** Full gifting powers must be in a Power of Attorney in order to facilitate Medicaid Asset Protection planning. If you're an Estate Planning attorney or

General Practitioner who routinely limits gifting in your POAs, you need to reconsider this practice, which ultimately does a tremendous disservice to your clients.

10.8. Myth 8: "A revocable living trust will protect assets from Medicaid."

10.8.1. **Reality:** A regular living trust does not protect assets from Medicaid. For a detailed explanation of a living trust that does protect assets from Medicaid, while allowing the Settlor the ability to act as trustee and change beneficiaries, see the <http://www.livingtrustplus.com>.

10.9. Myth 9: "An irrevocable trust can never be changed or revoked."

10.9.1. **Reality:** An "irrevocable" trust is a trust that cannot be revoked by the settlor unilaterally. Modification and/or termination can occur by consent between all interested parties.

10.10. Myth 10: "A Client with over \$1 million won't ever need Medicaid."

10.10.1. **Reality:** Nursing homes nationally now average more than \$100,000 per year. A million dollars doesn't go as far as it used to. I've had clients that have spent over \$1 million on nursing home care before coming to see me. Long-term Care Medicaid is not a program for poor people with low income; it's an entitlement program for people who are able to legally qualify under the provisions of applicable laws, regulations, and policy.

SECTION 11. THE MORALITY OF MEDICAID PLANNING

11.1. "Hide" is a 4-Letter Word

11.1.1. Elder Law attorneys do not hide assets. Hide is literally a 4-letter word, and has no place in an Elder Law practice. Elder Law attorneys legally "protect" or "shelter" assets using the applicable laws that are available. Medicaid Asset Protection is absolutely ethical and moral; in fact, it is the "right" thing to do if a family is concerned about the long-term care of a loved one. From a moral and ethical standpoint, Medicaid planning is no different from income tax planning and estate planning.

11.2. Medicaid Planning is Just Like Income Tax Planning

11.2.1. Income tax planning involves trying to find all of the proper and legal deductions, credits, and other tax savings that you are entitled to - taking maximum advantage

of existing laws. Income tax planning also involves investing in tax-free bonds, retirement plans, or other tax-favored investment vehicles, all in an effort to minimize what you pay in income taxes and maximize the amount of money that remains in your control to be used to benefit you and your family.

11.3. Medicaid Planning is Just Like Estate Tax Planning

11.3.1. Estate planning involves trying to plan your estate to minimize the amount of estate taxes and probate taxes that your estate will have to pay to the government, again taking maximum advantage of the existing laws. Similar to income-tax planning, estate planning is a way to minimize what your estate pays in taxes and maximize the amount of money that remains in your estate to be used to benefit your family.

11.3.2. Similarly, Medicaid planning involves trying to find the best methods to transfer, shelter, and protect your assets in ways that take maximum advantage of existing laws, all in an effort to minimize what you pay and maximize the amount of money that remains in your control to be used to benefit you and your family.

11.3.3. Like income-tax planning and estate planning, Medicaid planning requires a great deal of extremely complex knowledge due in part to constantly-changing laws, so clients need to work with experienced Elder Law attorneys who know the rules and can give proper advice.

11.4. Just Like Long-Term Care Insurance.

11.4.1. For seniors over the age of 65, Medicaid has become equivalent to federally-subsidized long-term care insurance, just as Medicare is equivalent to federally-subsidized health insurance. Congress accepts the realities of Medicaid Planning through rules that protect spouses of nursing home residents, allow Medicaid Asset Protection via the purchase of qualified Long-Term Care Insurance policies, allow the exemption of certain types of assets, and permit individuals to qualify even after transferring assets to a spouse or to a disabled family members or to a caregiver child. To plan ahead and accelerate qualification for Medicaid is no different than planning to maximize your income tax deductions to receive the largest income tax refund allowable. It's no different

than taking advantage of tax-free municipal bonds. It's no different than planning your estate to avoid paying estate taxes.

11.5. Medicaid Planning Required to Overcome a Discriminatory Health Insurance System

- 11.5.1. One of the inherent tragedies of our American health insurance system is that it discriminates against people suffering from certain types of chronic illnesses, i.e., those that routinely result in the need for long-term care, such as Alzheimer's disease and other types of dementias; Parkinson's disease and other types of degenerative disorders of the central nervous system; Huntington's disease, Amyotrophic Lateral Sclerosis (ALS), and other progressive neurodegenerative disorders; and many genetic disorders such as Multiple Sclerosis and Muscular Dystrophy. Those Americans suffering the tragedy of one of these diseases must also suffer the tragedy of having the "wrong" disease according to our American health insurance system.
- 11.5.2. Why should someone with brain cancer – tumors in the brain that aren't supposed to be there – have all of his treatment (chemotherapy, radiation, and surgery) covered by health insurance, yet someone with Alzheimer's – plaques and tangles in the brain that aren't supposed to be there – must pay for his care out of pocket until he goes broke. In both cases, we are dealing with the care that someone needs because of the disease that person has. How is the differing result fair? It's not.
- 11.5.3. Is it an ethical social policy that seemingly arbitrarily distinguishes among these different types of illnesses? Is it an ethical social policy that provides full coverage for most illnesses - whether chronic or acute - but forces Americans with certain chronic conditions (many of them elders) to become impoverished in order to gain access to the long-term care necessitated by their particular type of chronic illness? Is it a surprise that Americans suffering the "wrong type" of chronic illness will want to look for legal ways to preserve the efforts of their lifetime in order to protect themselves from this unfair and seemingly arbitrary social policy?

SECTION 12. THE ETHICS OF MEDICAID PLANNING

12.1. Who is the Client?

12.1.1. Although family involvement may be very important in some elder law matters, above all, elder law attorneys seek to promote the dignity, self-determination, and quality of life of the elders we serve. Who is our client? Almost always the elder for whom we are doing work and drafting documents. The client is the person whose interests are most at stake in the legal planning or legal problem. The client is the one—the only one—to whom the lawyer has professional duties of competence, diligence, loyalty, and confidentiality. This is especially important in elder law, because family members may be very involved in the legal concerns of the older person, and may even have a stake in the outcome. It is possible, in some circumstances, for more than one family member to be clients of the same lawyer. This is common with married couples. However, in most of our cases, we will identify the elder or disabled person as our client. We will do this, of course, regardless of who is paying the bill.

12.2. Eliminating Conflicts of Interest when Someone Else Pays Your Client's Fee.

12.2.1. Occasionally a child or children of the parent or parents you are representing pay your fee. Anytime this happens, you need to make it clear in your verbal discussions and in your written Fee Agreement that regardless of who pays your fee, the elders are your clients, and that having someone else pay your fee will not interfere with your independence of professional judgment or with the client-lawyer relationship.

12.2.2. **ABA Model Rules of Professional Conduct Rule 1.8(f)** says that “A lawyer shall not accept compensation for representing a client from one other than the client unless:

- (1) the client gives informed consent;
- (2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
- (3) information relating to representation of a client is protected as required by Rule 1.6.

12.2.3. Suggested language to include in your written Fee Agreement with your client:
“You are our Client regardless of whether you, or someone else on your behalf, pays our fee.”

12.3. Handling Clients With Diminished Capacity

12.3.1. When dealing with elder law matters, it is very common to be dealing with a client who has diminished capacity. **ABA Model Rules of Professional Conduct Rule 1.14** addresses dealing with the **Client With Diminished Capacity**. It says:
“(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
“(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.
“(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.”

12.3.2. The relevant Comments to this rule state as follows:

“[3] The client may wish to have family members or other persons participate in discussions with the lawyer. When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (b), must look to the client, and not family members, to make decisions on the client's behalf.

12.3.3. Thus, it is acceptable under Rule 1.14 to meet with both the client and the client's family members so long the presence of such family members (normally adult children of the client) does not affect the applicability of the attorney-client evidentiary privilege.

12.3.4. Another relevant Comment to Rule 1.14 states as follows:

“[4] If a legal representative has already been appointed for the client, the lawyer should ordinarily look to the representative for decisions on behalf of the client.”

12.3.4.1. This means that if the client already has signed a comprehensive General Power of Attorney, then the elder law attorney may look to the Agent under that Power of Attorney for decisions on behalf of the client.

12.3.4.2. If the client has not yet signed a comprehensive General Power of Attorney, then the elder law attorney should consider whether the client is competent enough to sign, and desires to sign, a comprehensive General Power of Attorney allowing a loved one named by the client to make future legal decisions on behalf of the client.

12.3.5. Taking Protective Action

12.3.5.1. Another relevant Comment to Rule 1.14 states as follows:

[5] If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a normal client-lawyer relationship cannot be maintained as provided in paragraph (a) because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation, then paragraph (b) permits the lawyer to take protective measures deemed necessary. *Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decisionmaking tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client. In taking any protective action, the lawyer should be guided by such factors as the wishes and*

values of the client to the extent known, the client's best interests and the goals of intruding into the client's decision making autonomy to the least extent feasible, maximizing client capacities and respecting the client's family and social connections.

“[6] In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.

“[7] If a legal representative has not been appointed, the lawyer should consider whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests. Thus, if a client with diminished capacity has substantial property that should be sold for the client's benefit, effective completion of the transaction may require appointment of a legal representative. . . .*In many circumstances, however, appointment of a legal representative may be more expensive or traumatic for the client than circumstances in fact require.* Evaluation of such circumstances is a matter entrusted to the professional judgment of the lawyer. *In considering alternatives, however, the lawyer should be aware of any law that requires the lawyer to advocate the least restrictive action on behalf of the client.*” (emphasis added)

12.3.6. The Comments above make clear that it is desirable when possible to use voluntary surrogate decision making tools such as durable powers of attorney, which are much less expensive and much less traumatic than forcing the client to go through the financial and personal hardship of a guardianship and conservatorship hearing.

12.4. Eliminating Conflicts of Interest

12.4.1. **ABA Model Rules of Professional Conduct Rule 1.7 Conflict Of Interest: Current Clients** says

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

- (1) the representation of one client will be directly adverse to another client; or
- (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

- (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
- (2) the representation is not prohibited by law;
- (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
- (4) each affected client gives informed consent, confirmed in writing.

12.4.2. Elder law attorneys, like all attorneys, have an ethical obligation to avoid conflicts of interest. This means that, in most situations, a lawyer may only represent one individual or a married couple with aligned interests. For example, when legal planning involves multi-generational property such as a family home in which several people have an interest, these interests are almost always actually or potentially conflicting. Sometimes joint representation is possible under ABA Model Rules of Professional Conduct Rule 1.7, even with potential conflicts of interest, but it is more likely that we will be representing only the older person or married couple whose interests are at stake. This is especially true when the older person wants to discuss a power of attorney, a will or trust, or planning for long-term care.

12.5. Eliminating Conflicts of Interest When Representing Married Couples

12.5.1. It is common for a husband and wife to employ the same lawyer or law firm to assist them in Medicaid Planning and/or Estate Planning. Comment 27 to Rule 1.7 states: “For example, conflict questions may arise in estate planning and estate

administration. A lawyer may be called upon to prepare wills for several family members, such as husband and wife, and, depending upon the circumstances, a conflict of interest may be present . . . In order to comply with conflict of interest rules, the lawyer should make clear the lawyer's relationship to the parties involved.” Sometimes this conflict can be avoided by representing just one spouse. But oftentimes it is essential to represent both spouses because you are preparing documents and performing services for both spouses.

12.5.1.1. When we represent a married couple, we include the following language in our Retainer Agreement as a way to comply with Rule 1.7 and eliminate any potential conflict of interest: “You have asked us to represent both of you in this planning, on a joint basis. It is important that you understand that, because we will be representing both of you, both of you will be considered our clients. Accordingly, matters that one Spouse might discuss with us must be disclosed to the other Spouse. Ethical considerations prohibit us from agreeing that either Spouse may withhold information from the other. In this regard, we will not give legal advice to either Spouse or make any changes to the Plan without mutual knowledge and consent from both Spouses. Of course, anything either Spouse discusses with us is privileged from disclosure to third parties except as otherwise indicated in this Legal Services Agreement. If and when one Spouse enters a nursing home, Medicaid laws and regulations currently offer certain protections to the Spouse remaining at home ("At-Home Spouse"). We understand that it is your desire to take full advantage of whatever techniques are available to protect the At-Home Spouse, if applicable. If either of you has children by a prior marriage, it is understood that some of these techniques may work to the disadvantage of those children. Nevertheless, you have instructed us to fully protect the At-Home Spouse, even at the expense of the children of a prior marriage, though we will always

encourage the protection of any children of a prior marriage. By executing this Legal Services Agreement, you indicate your consent to having us represent both of you. Any communications and information will be fully disclosed by us to both of you. We have explained to you the possibility of conflict that is raised by such multiple representation. Specifically, potential conflicts in this case include, but are not limited to, the following: how property should be titled; how property should be disposed of upon death; what persons should serve in fiduciary capacities (e.g., executors, trustees, guardians); and the possibility that an uncontested divorce proceeding between the two of you may be the best strategy to protect assets and secure Medicaid eligibility. Each of you may have different interests, goals, or perspectives regarding these or other matters. Each of you expressly consents to joint representation despite the possibility of conflict; however, we may withdraw from representing one or both of you if there is an actual conflict between your interests. If it is decided that an uncontested divorce proceeding is the best strategy to protect assets and secure Medicaid eligibility, then you both agree that the firm may represent the Medicaid applicant and help secure separate counsel for the non-applicant spouse, in which event the firm's ongoing representation of the non-applicant spouse will be deemed to be automatically terminated at such time.”

SECTION 13. OVERVIEW OF THE STATE MEDICAID PROGRAMS.

13.1. Applying for Medicaid - Why Clients Seek Legal Advice.

- 13.1.1. Sixteen years after the creation of Medicaid, the United States Supreme Court called the Medicaid laws "an aggravated assault on the English language, resistant to attempts to understand it." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).
- 13.1.2. Thirteen years later, in 1994, the United States Court of Appeals for the Fourth Circuit called the Medicaid Act one of the “most completely impenetrable texts within human experience” and “dense reading of the most tortuous kind.”

Rehabilitation Ass'n of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994).

Since then, it has only gotten worse.

- 13.1.3. Congress enacted the Deficit Reduction Act of 2005 on June 23, 2006, retroactive to February 8, 2006, the date of enactment, which rewrote much of the Medicaid law.
- 13.1.4. The actual Medicaid application process differs from state to state, but it typically involves filling out a lengthy and detailed application and also submitting appropriate verifications of income, assets, transfers, identity, and citizenship.
- 13.1.5. Due to tremendous complexity of the Medicaid laws, the Medicaid application process is also extremely complicated, and many persons who file for Medicaid without professional assistance will wind up with the application being rejected for a variety of reasons. Rejection often occurs due to financial issues — either excess resources, excess income, or improperly-timed gifts or transfers. Rejection in many cases is due to missing or incomplete information or verifications. Applications are also sometimes improperly rejected by an eligibility worker (most of whom are underpaid and overworked) who has not had the time to carefully and thoroughly review the application and verifications, or who has improperly applied the legal or financial requirements for eligibility.
- 13.1.6. Worse yet, an application that is filed at the wrong time can result not only in rejection, but in the imposition of significant penalties against the applicant that could have been avoided by a more timely filing. For these and many other reasons, an experienced elder law attorney should always be hired to represent the applicant through the entire Medicaid process — including planning for eligibility, preparing and filing the application, working with the local eligibility department during the application and verification process, filing an appeal when necessary, and representing the applicant in connection with any required hearings and appeals.
- 13.1.7. Medicaid is jointly funded by the federal government and the states. Each state administers its own program, and the federal Centers for Medicare and Medicaid Services (CMS) monitors the programs and sets general quality, funding, and

eligibility standards. However, states are allowed a certain degree of autonomy in implementing Medicaid regulations at the state level.

13.2. Relevant Federal Statutes.

13.2.1. Generally, see 42 USC § 1396 et seq.

13.2.2. 42 USC § 1396p (transfer of assets / estate recovery / trusts).

13.2.3. 42 USC § 1396r-5 (special rules applicable to an institutionalized spouse who has a "community spouse").

13.2.4. Deficit Reduction Act of 2005, Pub. L. No. 109-171 ("DRA"), was signed into law on February 8, 2006. DRA substantially changed a number of key provisions regarding eligibility for Medicaid long-term care, including asset transfer rules. The provisions of DRA dealing with the changes to eligibility for Medicaid long-term care are contained at §§ 6011 - 6021, and 6036 of the DRA.

SECTION 14. INCOME ELIGIBILITY FOR LONG-TERM CARE MEDICAID.

14.1. Basic Rule - Middle Class Medicaid.

14.1.1. The basic rule for income is that a Medicaid applicant can qualify so long as his gross income is less than the private pay cost of the nursing home care he is receiving. A Medicaid recipient must pay all of his or her income, less certain deductions, to the nursing home. The deductions include a small monthly personal needs allowance which ranges from around \$30 per month to \$100 per month depending on the state, a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance (called the Community Spouse Resource Allowance) he or she may possibly be able to pay to the spouse that continues to live at home. See section Section 15, 15.1.1 for more information about the Community Spouse Resource Allowance.

14.2. Medically Needy Rule.

14.2.1. Some states are "medically needy" states and some states are "income cap" states. In "income cap" states, a Medicaid applicant must have income lower than a specified "cap." However, in those states a special trust, called a *Miller Trust* (also called a *Qualifying Income Trust*, a *Qualified Income Trust*, and *Income Cap Trust* or and *Income Assignment Trust*) is needed if the Medicaid applicant's

income is above a certain level. The way the Miller Trust works is that after the trust is created, the patient assigns his or her right to receive social security and pension to the trust. In the eyes of the state Medicaid agency, if the Miller Trust is receiving income, the patient is not receiving that income, and thus the excess income “problem” is solved.

14.3. In providing Medicaid to disabled, low income individuals who are receiving SSI or deemed to be receiving SSI, States fall into one of three general categories:

- 14.3.1. **1634(a) States.** This terminology, referring to Section 1634 of the Social Security Act, means States have a contract with the Social Security Administration to determine eligibility for Medicaid at the same time a determination is made for receipt of SSI benefits. These 32 States and the District of Columbia also use the same Medicaid eligibility criteria for determining for their aged, blind and disabled SSI recipients as are used for the SSI program.
- 14.3.2. **SSI-criteria States.** This means States that use the same Medicaid eligibility criteria for their aged, blind, and disabled SSI recipients as are used for the SSI program, but require that these individuals apply to the State separately from their application for SSI to determine their Medicaid eligibility based upon that application. There are 7 States that are categorized as SSI-criteria States.
- 14.3.3. **209(b) States.** This means States that use more restrictive Medicaid eligibility criteria for their aged, blind and disabled recipients than are used in the SSI program in one or more eligibility areas and which were in place in the State's approved Medicaid plan as of January 1, 1972, although some §209(b) States do use SSI's definition of disability in determining the Medicaid eligibility of disabled individuals in their State. There are 11 States that are categorized as 209(b) States.¹³

SECTION 15. PROTECTIONS FOR THE COMMUNITY SPOUSE.

- 15.1.1. **CSRA:** All countable assets owned by the married couple as of the "snapshot date" (the first day of the first month that the Medicaid applicant enters a nursing home), regardless of whether titled jointly or in the name of just one spouse, are

¹³Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Virginia.

divided into equal halves. One-half of the countable assets (subject to a maximum under Federal Law of \$120,900 and minimum of \$24,180), is then allocated to the Community Spouse. This amount that is allocated to the community spouse is called the “Community Spouse Resource Allowance” or CSRA (sometimes called the Protected Resource Amount or PRA). The remaining assets are allocated to the nursing home spouse, and must be reduced until only the Individual Resource Allowance remains, at which time the nursing home spouse will then qualify for Medicaid. The examples below assume a state with a \$2,000 Individual Resource Allowance.

15.1.1.1. **Example 1:** John and Mary have \$100,000 in combined resources just prior to the date John enters the nursing home. John will be eligible for Medicaid once the couple's combined assets have been reduced to \$52,000 (\$2,000 Individual Resource Allowance for John plus \$50,000 for Mary as her Community Spouse Resource Allowance).

15.1.1.2. **Example 2:** Bill and Nancy have \$200,000 in combined resources just prior to the date Nancy enters the nursing home. Nancy will be eligible for Medicaid once the couple's combined assets have been reduced to \$102,000 (\$2,000 Individual Resource Allowance for Nancy plus \$100,000 for Bill as his Community Spouse Resource Allowance).

15.1.1.3. **Example 3:** Sam and Jane have \$300,000 in combined resources just prior to the date Sam enters the nursing home. Sam will be eligible for Medicaid once the couple's combined assets have been reduced to \$121,220 (\$2,000 for Sam plus the maximum of \$119,220 for Jane as her Community Spouse Resource Allowance).

15.1.2. **MMMNA:** Each state establishes a monthly income floor for the Community Spouse, called the Minimum Monthly Maintenance Need Allowance (MMMNA). Under Federal law, the MMMNA ranges from a low of \$2,030.00 per month to a

high of \$3,022.50 per month, and cannot exceed \$3,022.50 unless a court orders support in a greater amount. The MMMNA is calculated as follows:

15.1.2.1. \$2,030.00 plus

15.1.2.2. The Excess Shelter Allowance, which equals the amount by which the Community Spouse's shelter expenses exceed the state's "Excess Shelter Standard."

If the Community Spouse's income falls below his or her MMMNA, the shortfall can be made up from the nursing home spouse's income.

15.1.2.3. **Example of MMMNA Calculation:** Assume that Mary is the Community Spouse, that her sole source of income is \$800 per month in Social Security benefits, and that her actual shelter expenses are \$988. First we calculate the Excess Shelter Allowance as follows:

Actual Shelter Expenses	\$988.00
Minus "Excess Shelter Standard"	(\$581.63)
Equals Excess Shelter Allowance	\$406.37

Next, we calculate her MMMNA as follows:

Minimum income allowance	\$1,966.25
Plus Excess Shelter Allowance	\$406.37
Equals MMMNA	\$2,372.62

Since Mary is entitled to a monthly income of \$2,372.62, but only receives \$800, she is entitled to collect the shortfall every month from John's Social Security check.

MMMNA	\$2,372.62
Less actual income, from Social Security	\$-800.00
Equals the shortfall, which can be paid to Mary from John's income	\$1,572.62

The rest of John's income will be paid to the nursing home, to partially cover the cost of his care.

15.1.3. Annuity Transfer Rules:

15.1.3.1. An annuity purchased by an institutionalized individual or the community spouse will be treated as an uncompensated transfer if the state is not named as the remainder beneficiary (after the Community Spouse or a disabled child) for at least the total amount of medical assistance paid on behalf of the annuitant. A non-employment related annuity purchased by the institutionalized individual or Community Spouse will be considered an uncompensated transfer unless the annuity is irrevocable and non-assignable; actuarially sound; and provides for equal payments with no deferral and no balloon payments.

SECTION 16. MEDICAID PLANNING IN ADVANCE OF NEED.

16.1. Living Trust Plus

16.1.1. In the past few years, the Living Trust Plus™ as an asset protection tool has become increasingly popular for both pre-need Medicaid asset protection and traditional asset protection, in large part due to the research, publications, and teachings of your author, attorney Evan H. Farr, who has written several treatises and articles on this topic and taught numerous national Continuing Legal Education seminars on this topic – for groups such as the American Law Institute

- American Bar Association, the National Academy of Elder Law Attorneys, the National Business Institute, and Elder Law Answers.¹⁴

16.1.2. **Crisis Planning:** This is for clients where the family of the clients come to you shortly after a crisis in which a spouse or a parent has entered, or is about to enter, a nursing home and it is expected that the nursing home resident will not be able to return home. For these clients, there are dozens of asset protection strategies that can be used, and these strategies break down into two broad categories – Asset Purchase Strategies (also called “smart spenddown”) and Asset Transfer Strategies. A list of sample Asset Purchase Strategies and Asset Transfer Strategies are listed in section 4.2.

SECTION 17. IRREVOCABLE TRUSTS FOR MEDICAID AND VETERANS PLANNING

17.1. Pre-Need Medicaid Planning with Living Trust Plus™ .

17.1.1. Purpose of Using the Living Trust Plus™ for Medicaid.

17.1.1.1. **Asset Protection.** The **Living Trust Plus™** is a means by which clients can transfer assets they wish to protect to a trust rather than directly to their children. Clients rightfully view transfers to trusts as protection, whereas transfers to adult children are typically viewed as gifts. Trusts provide clients with a sense of dignity and security.¹⁵ Such transfers, whether to a **Living Trust Plus™** or

¹⁴ See, e.g., Farr, Nenno, Rothschild, Sullivan, and Terrill, *Planning and Defending Asset-Protection Trusts* (ALI-ABA 2009). Farr’s chapter of this book, entitled “Asset Protection For The Middle Class: Income-Only Trusts & Medicaid Asset Protection,” has quickly become the country’s leading treatise on the use and mechanics of IOTs. See also Farr, Frigon, Frolik, Sitchler, Whitenack, *Trusts for Senior Citizens: Cutting-Edge Tactics for Dealing with Medicaid Regulations and Medicare Set-Aside Trusts* (ALI-ABA 2009); Farr, *Using Income Only Trusts to Qualify for Public Benefits* (NAELA 2009); Farr, *Using Income Only Trusts For True Asset Protection*(NBI 2010).

¹⁵ Begley, Jr. & Hook, *Representing the Elderly or Disabled Client: Forms and Checklists with Commentary* ¶ 7.02 (WG&L 2007).

directly to a child, are subject to the Medicaid five-year lookback period.¹⁶

17.1.1.2. **Independence.** By transferring assets to the IOT version of the **Living Trust Plus™**, income is paid directly to the trust settlor rather than to her children, allowing the settlor to maintain greater financial independence. When real estate is transferred to the **Living Trust Plus™**, the Settlor retains the ability to live in the real estate or receive the rental income from the property (generally via a separate Occupancy Agreement between the trust and the Settlers).

17.1.1.3. **Risk-Avoidance.** If a parent transfers assets directly to his children, certain risks must be anticipated: creditors claims against a child; divorce of a child; bad habits of a child; need for financial aid; loss of step-up in basis.

17.1.1.3.1. A transfer to the **Living Trust Plus™** avoids all of these risks.¹⁷

¹⁶ See *supra*, section ?.

¹⁷ See *infra*, section 17.1.10, for an explanation of why a transfer to an IOT avoids the loss of step-up in basis.

17.1.2. Statutory Authorization for Medicaid.

17.1.2.1. Irrevocable trusts such as the **Living Trust Plus™** have been permitted under federal Medicaid law since OBRA '93,¹⁸ which states:

“In the case of an irrevocable trust . . . 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.”

17.1.2.2. Under OBRA '93, an individual is considered to have established a trust if the individual's assets were used to fund all or part of a trust and if the trust was established, other than by will,¹⁹ by any of the following: the individual, the individual's spouse, a person (including a court or administrative body) with legal authority to act on behalf of the individual or the individual's spouse, or a person (including a court or administrative body) acting at the direction or request of the individual or the individual's spouse.²⁰

17.1.2.3. Income-only trusts are also permitted under the CMS State Medicaid Manual, which states that:

¹⁸ 42 U.S.C. § 1396p(d)(3)(B).

¹⁹ The creation and funding of a testamentary trust is not a disqualifying transfer of assets. *See Skindzier v. Comm'r of Soc. Servs.*, 784 A2d 323 (Conn. 2001).

²⁰ 42 USCA § 1396p(d)(2).

“In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust . . . [t]he portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual.”²¹

17.1.2.4. The requirements were spelled out in a letter dated December 23, 1993, known as the Richardson letter.²² Under the Richardson letter:

17.1.2.4.1. “If there are any circumstances under which either income or trust corpus could be paid to the individual, then actual payments to the individual of either income or corpus are deemed ‘income’ for Medicaid eligibility purposes.

17.1.2.4.2. “If trust corpus could be paid to an individual but is not, such asset is deemed an available resource for Medicaid eligibility purposes.

17.1.2.4.3. “If no portion of the trust corpus may be distributed to an individual, i.e., an ‘income only trust,’ then no portion of

²¹ CMS State Medicaid Manual, Section 3259.6.B.

²² Letter from Sally K. Richardson, Director of Medicaid Bureau, Health Care Financing Administration, Dep’t of Health and Human Services, to Elice Fatoullah, Elder Law Report, Vol. V, No. 7, p. 2, Dec. 23, 1993.

the trust is deemed a resource of the individual for Medicaid eligibility purposes.

17.1.2.4.4. “If some portion of the irrevocable trust corpus could be paid to an individual, and assets are transferred from the trust to someone other than the individual, then the individual is subject to the Medicaid three-year lookback.”

17.1.2.5. This left open the issue of whether a lookback period applied for transfers to or from an income-only trust. Even the Health Care Finance Administration (HCFA) was not sure which interpretation was correct.²³ HCFA finally clarified the rules in a letter dated February 25, 1998, known as the Streimer letter.²⁴

17.1.2.5.1. The Streimer letter clarified the rules by stating as follows:

17.1.2.5.1.1 For Transfers To the Living Trust Plus™:

“Transfers to an irrevocable trust with retained income only interests are considered available only to the extent of the income earned. Otherwise, the assets are considered to have been transferred with a 5-year lookback period.”

17.1.2.5.1.2 For Transfers From the Living Trust Plus™:

²³ *Citing Q & A 83, Summary of Verbal Q & A's from HCFA Central to the Regions (Nov. 4, 1993).*

²⁴ Letter from Robert A. Streimer, Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operation, Health Care Finance Admin., Dep't of Health and Human Services, to Dana E. Rozansky, Elder Law Report, Vol. IX, No. 9, p. 9, Apr. 1998. Available at <http://www.sharinglaw.net/elder/Streimer.pdf>.

“[W]here assets in a trust can not be made available to the beneficiary, transfer of those assets to or for the benefit of someone other than the beneficiary does not incur a separate transfer penalty. Any penalty would have been assessed when the funds were placed in the trust.”

17.1.3. Principal Distribution Provision.

17.1.3.1. There can be absolutely no access to principal by either the settlor or the settlor’s spouse. If either spouse has direct access to principal, the trust is not an income-only trust, and the assets in the trust would be available to creditors and deemed “countable” for Medicaid eligibility purposes.²⁵

17.1.3.2. The trust should be designed to permit the trustee, or a third party, to make distributions to beneficiaries. Through this mechanism, the trustee can stop income payments to a settlor who will be requiring Medicaid and can avoid estate recovery in those states that use a broad definition of “estate.”²⁶ Through this mechanism, the beneficiaries could also, if they choose, make distributions of principal back to the Settlor or for the benefit of the Settlor.

²⁵ Begley, Jr. & Hook, *supra* § 7.02[7][b].

²⁶ *See supra*, section 7.4.

17.1.3.2.1. The disadvantage of distributing the assets from the income-only trust is that the opportunity for a “step- up” in basis will be lost.²⁷

17.1.3.2.2. It is VERY important, of course, that there be no collusion or appearance of collusion between the Settlor and the trust beneficiaries whereby the trust beneficiaries agree in advance to make principal distributions back to the Settlor or for the benefit of the Settlor.

17.1.4. **Leading Cases Supporting Use of the Living Trust Plus™ for Medicaid Asset Protection.**

17.1.4.1. **In the Matter of Irene Spetz v. New York State Department of Health, 190 Misc. 2d 297; 737 N.Y.S.2d 524; N.Y. Misc. LEXIS 29 (2002).** This case arose out of the Supreme Court of New York, and involved a claim by the State Medicaid Agency (“Agency”) that the assets of the applicant’s spouse’s irrevocable trust²⁸ were countable for purposes of Medicaid. The Agency challenged the trusts on several grounds:

17.1.4.1.1. Although the terms of the trust made it irrevocable, Mr. Spetz (the Medicaid applicant’s husband) reserved to himself the right to change the beneficiary. This right was

²⁷ Begley, Jr. & Hook, *supra* § 7.02[7][c].

²⁸ The trust at issue allowed distribution only to the beneficiaries. The trustees had no power to pay principal or income to or for the benefit of the Settlor or his spouse. Although this is slightly different from the typical income-only trust, which does allow income to the Settlor, the design of the this trust otherwise seems virtually identical to most income-only trusts, and the findings and conclusions of law in this case apply equally to income-only trusts..

limited, in that he was specifically prohibited from naming himself, his spouse, creditors of himself or his spouse, the estates of himself or his spouse or creditors of those estates. The Agency argued that because of this right, the trust assets were in the “control” of Mr. Spetz and, therefore, must be considered in determining the eligibility of Mrs. Spetz to receive Medicaid benefits. The Agency also argued that the trust assets were available to Mr. Spetz because he could control the trustees under threat of appointing different beneficiaries if they refuse to comply. They asserted that the retention of the right to change beneficiaries is equivalent to control over the corpus of the trust.

17.1.4.1.2. The Court held that although it was conceivable that Mr. Spetz could bring pressure on the beneficiaries to make payments to or for Mrs. Spetz’ benefit, the relevant law stated that the availability of assets, for Medicaid eligibility purposes, depends upon the “trustee’s authority, under the specific terms of the trust agreement.” The Court found that trustees of this trust had no such authority. The Court also stated that “[a]lthough the trustees and beneficiaries are currently the same people, that is not necessarily so under the terms of the trust, as respondents have pointed

out, and, in any event, their roles as trustees and beneficiaries must be considered as legally separate.”

17.1.4.1.3. The Agency also argued that under New York law (section 7-1.9 of the Estates, Powers and Trusts Law, which is similar to section 411 of the Uniform Trust Code), any trust can be revoked, provided that the beneficiaries consent, in writing, to the revocation. Thus, the Agency argued, the assets of the trust should be considered available to the Medicaid applicant because her husband could seek the consent of the trust’s beneficiaries to revoke the trust, thus placing the corpus of the trust back in his hands. This is especially true, the Agency argued, since Mr. Spetz could possibly use his power to change beneficiaries in collusion with someone willing to revoke the trust.

17.1.4.1.4. The Court held that the speculative possibility of a revocation pursuant to New York law did not render the corpus of the trust “potentially available” to the petitioner, as there was no evidence presented that the beneficiaries would consent to such a revocation. “To hold otherwise would eviscerate the federal and state statutes providing, in detail, for the protection of assets through the use of irrevocable trusts, since every trust would be presumed to be revocable under section 7-1.9.” The Court also found that the “claim that Mr. Spetz could somehow use his

power to change the beneficiary in collusion with someone willing to revoke the trust is entirely speculative.”

17.1.4.2. **Verdow v. Sutkowy, 209 F.R.D. 309 (N.D.N.Y. 2002).** In this case, a federal court faced with a similar fact pattern to *Spetz*, except in the form of a federal class action, six elderly nursing home residents in New York State who created irrevocable, income-only trusts were denied Medicaid benefits because the trusts contained provisions reserving a limited power of appointment. County and state Medicaid officials determined that a limited power of appointment makes the assets of a trust an available resource for purposes of determining Medicaid eligibility.

17.1.4.2.1. The plaintiffs brought a suit under 42 U.S.C. § 1983 for themselves and others similarly situated against county and state Medicaid officials, alleging that consideration of the trust assets as an available resource is unlawful because there are no circumstances under which they could be paid the assets. Just as in *Spetz*, Medicaid officials argued that the plaintiffs could utilize their retained power to change beneficiaries to individuals amenable to revoking an otherwise irrevocable trust.

17.1.4.2.2. The U.S. District Court for the Northern District of New York granted the plaintiffs’ motions for class certification and summary judgment, holding that “defendant’s denial

of plaintiffs' Medicaid benefits because they allegedly are potential beneficiaries of self-settled trusts containing limited powers of appointment exceeds the limits of federal law." The court further ruled that "absent evidence of bad faith or fraud, the decision of whether or not to provide Medicaid benefits should not be based upon the remote possibility of collusion."

17.1.4.3. **O'Leary v. Thorn, Massachusetts Superior Court, Civil Action No. WOCV2013-02013A (September 18, 2014).** This state court case arose out of the Superior Court of Massachusetts, and involved a claim by MassHealth, the State Medicaid Agency ("Agency") that the assets of the applicant's irrevocable trust were countable for purposes of Medicaid. The Agency challenged the trusts on several grounds. Although the terms of the trust clearly made it an irrevocable, income-only trust, the main issue was the interpretation of two seemingly ambiguous paragraphs in the applicable Trust.

17.1.4.3.1. Article Second read in part: "The Trustee shall pay to the Grantors in equal shares all of the net income of the Trust, quarterly or more often. After the death of the first Grantor to die, the Trustee shall pay to the surviving Grantor all of the net income of the Trust, quarterly or more often, **for the remainder of such Grantor's life.**"

B. Until the death of the last surviving Grantor the Trustee may distribute part or all of the principal of this Trust to any persons (**other than the Grantors**) otherwise entitled to the assets of the this Trust after the deaths of the Grantors" (Emphasis in original).

17.1.4.3.2. Article Seventh read in part: "The Trustee may apply any or all of the income or principal of any share or portion of the Trust to or for the benefit of any beneficiary and through such agencies as the Trustee deems advisable instead of paying it directly to the beneficiary or his or her guardian. "

17.1.4.3.3. The Medicaid Agency argued that Article Seven allowed the Trustee to transfer any portion of the income or principal of the trust at anytime for the benefit of a beneficiary, including the plaintiff.

17.1.4.3.4. The Medicaid applicant argued that MassHealth improperly predicated their denial on just one Trust provision and that a proper review of the entire Trust document establishes that the asset is not countable and that the Trustee had no powers to transfer any of the principle to the benefit of the plaintiff. The Court agreed with the Medicaid Applicant, stating that "when there are ambiguous/contradictory grants of power to the Trustee, it is necessary to use the established rules of interpretation. When interpreting Trust language, a court or agency is not to read words in isolation

and out of context. The purpose is to discern the settlor's intent from the trust instrument as a whole and from circumstances known to the settlor at the time the instrument was executed.”

17.1.4.3.5. The court held that it was “clear from a reading of the Trust that the grantors intended that only the income from the asset be available to them. Article Second could not be more clear in stating that the Trustee cannot distribute the principal to either of the grantors. The Trust takes great pains to ensure that there is no discretion to distribute principal to the grantors.”

17.1.4.3.6. The Medicaid Agency in this case also pointed to Article Nine of the trust to show another provision that the Agency argued justified the denial of the applicant’s Medicaid application. Article Nine allowed the plaintiff to substitute an asset in the trust for another asset of equal value, which the Agency argued was equivalent to having access to principal.

17.1.4.3.7. The Court, however, found that Article Nine did not expand the Trustee's powers of distribution, and held that any assets substituted into the Trust under this provision would still be bound by the restrictions listed in Article Two, discussed above.

17.1.4.4. **Cases Illustrating Prohibition of Retained Interest in Corpus.**

17.1.4.5. A trust in which the settlor or the settlor's spouse retains an interest in the corpus/principal is not a income-only trust. The following cases illustrate this point:²⁹

17.1.4.5.1. In both *United States v. Ritter* *United States v. Ritter*, 558 F.2d 1165, 1167 (4th Cir. 1977), and *Petty v. Moores Brook Sanitarium*, 110 Va. 815 (1910), the trust settlor retained the right to have the trust corpus returned to the settlor in the discretion of the Trustee. This retained power to return of the corpus was clearly a significant factor for both courts in concluding that the trust assets were not protected from the creditor of the settlor.

17.1.4.5.2. *In Re Robbins*, 826 F.2d 293 (4th Cir. 1987) is a case arising in Maryland that was decided on the basis of the settlor's retained interest in the corpus of the trust. The Fourth Circuit held that under the terms of the trust, the trustee was authorized to apply the entire corpus for the support and maintenance of the settlors, and thus the entire corpus was subject to the claim of their creditors. *Id.* at 294.

²⁹ Many of the cases cited in this section have been erroneously categorized by some commentators as income-only trusts, and therefore relied on to attempt to demonstrate that income-only trusts are not effective asset protection entities; however, as explained herein, none of the cases cited in this section were properly drafted as income-only trusts, as they all contained provisions allowing distribution of principal to the trust settlors.

- 17.1.4.5.3. In the Pennsylvania case of *In re Nolan*, 218 Pa. 135, 67 A. 52 (1907), the settlor retained the power to appoint the remainder and the trustee had the power to reconvey the property to the settlor. The Court held that no creditor protection was available.
- 17.1.4.5.4. In *Gayan v. Illinois Dept. of Human Services*, Ill. App. Ct., No. 3-02-0545 (Aug. 29, 2003), an irrevocable trust that allowed the trustee to distribute principal to pay for costs of custodial care not covered by Medicaid was found to be an available asset, the settlor's intent notwithstanding.
- 17.1.4.5.5. In *Balanda v. Ohio Dept of Job and Family Services*, 2008-Ohio-1946 (April 24, 2008), an Ohio appeals court ruled that assets held in an irrevocable trust were available to a Medicaid applicant because the trustee had the discretion to make payments of trust principal for the benefit of the applicant and the applicant's spouse.
- 17.1.4.5.6. In *Wisynski v. Wis. D.O.H. & Family Serv.*, Wis. App., Dist. 3, No. 2008AP1280 (Nov. 4, 2008), the irrevocable trust involved does not appear to have been written as an income-only trust, but the opinion is not clear on that issue, as it does not give any information about the trust other than to say that the Medicaid applicant named himself as a “beneficiary.” The opinion does not explain whether the applicant named himself as a beneficiary of income,

principal, or both. The use of the term “beneficiary” without further limiting the language would imply that the applicant was a beneficiary of both income and principal, properly resulting in the trust principal being found to be available.

17.1.4.5.7. *Clifford and Ruth Oyloe v. North Dakota Department of Human Services*, 2008 ND 67; 747 N.W.2d 106; N.D. LEXIS 66 (April 17, 2008). This case, from the Supreme Court of North Dakota, involved a claim by the State Medicaid Agency (“Agency”) that the assets of the applicant's irrevocable trust were countable for purposes of Medicaid.

17.1.4.5.7.1 The Agency challenged the trust the grounds of a drafting error involving the proceeds that were paid into the trust after the sale of real estate. The trust gave the trustee discretion to sell the Oyloes' home and distribute the proceeds if the Oyloes no longer resided there. Paragraph 2(b) of the trust provided:

“During the joint lifetime of the Grantors, if there ever comes a time when neither of the Grantors is living in the personal residence of the Grantors transferred into trust and it is unlikely to ever be occupied

by them again, the Trustee has the option to sell said personal residence and immediately distribute the proceeds from the sale in accordance with the terms of paragraph 1.(d) of this Agreement, subject only to the requirements of paragraph 4.”

17.1.4.5.7.2 The crucial drafting error was that the trust agreement did not contain a paragraph 1.(d). Accordingly, the Court found the sales proceeds from the house could possibly be given back to the Grantor, meaning that the trust was actually not an income-only trust, but rather one that allowed principal distributions to the Grantor.

17.1.4.5.7.3 Importantly, the Agency did not take the position that the other trust assets were countable assets for Medicaid purposes.

17.1.4.5.8. *Boruch v. Nebraska Dept. Of Health & Human Servs.*, 11 Neb. App. 713, 659 N.W.2d 848 (2003). This case, from the Nebraska Court of Appeals, involved the appeal of a Medicaid applicant (“Lambert Boruch”) of a determination by the State Medicaid Agency (“Agency”) that the assets of Boruch's irrevocable trust were countable for purposes of Medicaid. According to the Court, “Lambert [Boruch] was

the grantor and *beneficiary of the corpus* of the Trust, and his son, Ronald, was a co-successor trustee.” The Court goes on to explain that “[t]he Trust was established as an irrevocable instrument and provided that the beneficiary, Lambert, was entitled to the use and possession of the real property, as well as the annual net income derived therefrom, for his lifetime.” *Id.* at 714 (emphasis added). Clearly, this trust was not properly structured as an income-only trust, as the Court indicated that Boruch was the beneficiary of the corpus of the Trust, which is a feature that is absolutely prohibited in a properly-structured income-only trust such as the Living Trust Plus™ Income-Only Trust.

17.1.4.5.9. Although there is a disturbing interpretation of the law in *Boruch* (stating that “if an individual establishes an irrevocable trust with his or her funds and is the beneficiary of or can benefit from the trust under any circumstances, the trust corpus is counted in the determination of Medicaid eligibility” *Id.* at 719), this interpretation of federal Medicaid law³⁰ is entirely aberrational and is not supported by the law. In any event, this aberrational finding can

³⁰ 42 USC § 1396p(d)(3)(B).

arguably be considered dicta in that the trust in question was clearly not properly structured as an income-only trust.

17.1.4.5.9.1 The Court also indicated that the Medicaid applicant in *Boruch* was the “sole beneficiary” of the trust (*Id.* at 720), presumably meaning that there were no remainder beneficiaries of the trust, and in fact the Court's opinion gives no indication of any remainder beneficiaries named in the trust. An important feature of a properly-drafted income-only trust is that the corpus of the trust is immediately vested in the remainder beneficiaries (who therefore have the right to enforce the terms of the trust), while only the income interest is retained by the settlor. Even if the trust in *Boruch* had been a properly-structured income-only trust with the settlor ostensibly retaining no interest in the corpus, without any remainder beneficiaries there is no one to enforce the terms of the trust, and the trust is therefore analogous to a revocable trust whose assets are completely available for the purposes of Medicaid. Although this rationale was not articulated by the Court in *Boruch*, it is possible that this might have had an affect on the Court's decision.

17.1.5. Income Distribution Provisions.

17.1.5.1. Although neither the settlor nor the settlor's spouse can receive distributions from corpus, they can receive distributions of trust income. In this writer's opinion, and as defined in the Living Trust Plus™ Income-Only Trust, “income” means interest, ordinary dividends,³¹ rental income, royalties, and any other taxable income that does not qualify for capital gains treatment. The reason for excluding capital gains from the definition of income is that historically capital gains have been considered to be part of corpus/principal, and trustees were required to distribute only income to the income beneficiaries, retaining the principal/corpus and all capital gains realized by the trust for the ultimate benefit of the trust's remainder beneficiaries.³²

17.1.5.2. This view of what constitutes “income” for purposes of the Living Trust Plus™ Income-Only Trust is this writer's opinion based upon an abundance of caution developed over many years of dealing with Medicaid officials. It is also based on the desire of most clients to protect as much of their assets as possible using the Living Trust Plus™ Income-Only Trust, and defining capital gain as part of principal/corpus is consistent with this goal. Other

³¹ Perhaps also “qualified dividends,” but *see* n.20 for a further discussion of allowable distributions of income..

³² *See* Barbara A. Sloan, T. Randolph Harris, and George L. Cushing, *When Income Isn't 'Income'—The Impact of the New Proposed Regulations Under Section 643*, Journal of Taxation (WG&L June 2001).

commentators do not distinguish between different types of income in the context of an income-only trust, and some drafters of income-only trusts have historically treated distributions of capital gains as income distributions. Unfortunately, this is a very complex area made even more difficult by the fact that the definition of income for tax purposes is different from the definition of income for Medicaid purposes.

17.1.5.3. The IRS definition of income in the context of trusts states that the term “*income*, when not preceded by the words *taxable*, *distributable net*, *undistributed net*, or *gross*, means the amount of income of an estate or trust for the taxable year determined under the terms of the governing instrument and applicable local law.” It further explains that “items such as dividends, interest, and rents are generally allocated to income and proceeds from the sale or exchange of trust assets are generally allocated to principal.”³³

17.1.5.4. The relevant Federal Medicaid law, OBRA ‘93,³⁴ states that the term “income” has the meaning given such term in 42 U.S.C. § 1382a, which in turn states, in the context of trusts, that income includes: “any earnings of, and additions to, the corpus of a trust established by an individual . . . and, in the case of an irrevocable trust, with respect to which circumstances exist under which a

³³ Treas. Reg. § 1.643(b)-1.

³⁴ 42 U.S.C. § 1396p(e)(2).

payment from the earnings or additions could be made to or for the benefit of the individual.”³⁵

17.1.6. Adjustments Between Principal and Income.

17.1.6.1. The trustee must be affirmatively prohibited from exercising any powers to adjust between income and principal, regardless of whether such powers are granted by common law or statute or both.

17.1.6.1.1. The Trustee must not have the power adjust between income and principal.³⁶

17.1.6.1.2. Likewise, the Trustee must not have the power to convert the trust to a total return unitrust.

17.1.6.2. The importance of the above rules is demonstrated by a 2009 Massachusetts case, *Doherty v. Director of the Office of Medicaid*, in which the Appeals Court of Massachusetts stated that “we take this opportunity to stress that we have no doubt that self-settled, irrevocable trusts may, if so structured, so insulate trust assets that those assets will be deemed unavailable to the settlor.” However, the trust reviewed by the Court in *Doherty*, through ostensibly written as an income only trust, was utterly defective in that it allowed distributions of principal via adjustments between income and principal. Although the trust explicitly provided that the

³⁵ 42 U.S.C. § 1382a(a)(2)(G).

³⁶ *Doherty v. Director of the Office of Medicaid*, 74 Mass. App. Ct. 439, 908 N.E.2d 390 (Mass. App., 2009).

trustee may “make no distributions of principal from the Trust, to or on behalf of” the settlor, the trust also gave the trustee the power to “determine all questions as between income and principal and to credit or charge to income or principal or to apportion between them any receipt or gain.”

17.1.6.3. Cases Supporting Use of Properly-Drafted Income-Only Trusts.

17.1.6.4. ***Ware v. Gulda*, 331 Mass. 68, 117 N.E. 2d 137 (1957)**. Held that where a settlor created for the settlor's own benefit a discretionary income-only trust (no principal distributions to the settlor were allowed), a creditor of the settlor could reach for satisfaction of a claim the maximum amount which the trustee could pay to the beneficiary or apply for the benefit thereof.

17.1.6.5. ***Paolozzi v. Commissioner*, 23 TC 182 (1954)**. In this Tax Court case, the petitioner, Ms. Paolozzi, created a trust for herself where the trustee had discretionary power to distribute income only to the settlor. No principal distributions to the settlor were allowed in the trust. The Tax Court referred to both the above-quoted Massachusetts Supreme Court case -- *Ware v. Gulda* -- and the above-quoted **Restatement of Trusts, Second** (section ?), in holding that the settlor's creditors could reach the maximum amount which, under the terms of the trust could be paid to the settlor. The Tax Court stated in its opinion:

The rule we apply is found in

Restatement: Trusts § 156 (2):

“Where a person creates for his own benefit a trust for support or a discretionary trust, his transferee or creditors can reach the maximum amount which the trustee under the terms of the trust could pay to him or apply for his benefit.” It has substantial support in authority.

Greenwich Trust Co. v. Tyson, 129

Conn. 211, 224, 27 A. 2d 166;

Warner v. Rice, 66 Md. 436, 8 A. 84;

Hay v. Price, 15 Pa. Dist. R. 144;

Menken Co. v. Brinkley, 94 Tenn.

721, 728-729, 31 S. W. 92; *Petty v.*

Moores Brook Sanitarium, 110 Va.

815, 817, 67 S. E. 355; 27 L. R. A.,

N. S., 800; *Scott, Trusts*, § 156.2;

Griswold, Spendthrift Trusts (2d ed.)

§ 481.

- 17.1.6.6. ***Estate of Uhl v. Commissioner*, 241 F. 2d 867 (7th Cir. 1957).** In this Federal case arising out of Indiana, the United States Court of Appeals for the Seventh Circuit examined a trust that the decedent created during lifetime which did not require the trustee to pay him income but from which the trustee could pay him the income. The

Seventh Circuit concluded that under Indiana law, which governed the trust, his creditors could not attach the trust assets.

17.1.7. Specific Features of the Living Trust Plus™ Income Only Trust.

17.1.7.1. **Retained General Powers Prohibited.**

17.1.7.1.1. When a person transfers property in trust for himself for life and reserves a general power to change the beneficiaries, the interest subject to such retained power (even if the power is not exercised), and the settlor's retained life interest, can both be subjected to the payment of the claims of creditors of such person and claims against his estate to whatever extent other available property is insufficient for that purpose. *United States v. Ritter*, 558 F.2d 1165, 1167 (4th Cir. 1977).

17.1.7.1.2. In *Petty v. Moores Brook Sanitarium*, 110 Va. 815 (1910), the decedent created a “spendthrift trust” for his own benefit and retained a general power of appointment over the remainder. In denying creditor protection to the trust, the Court stated that “[in all trusts there must be a *cestui que trust*, and it is manifest from the deed that [the decedent] was to have the sole beneficial use of the property conveyed, certainly during his life, with power to dispose of what remained at his death by will.” *Id.* at 817.

17.1.7.2. **Retained Limited Powers Essential.**

17.1.7.2.1. A trust settlors often retains a limited power to change beneficiaries for a variety of purposes:

17.1.7.2.1.1 To maintain the ability to respond to changing family circumstances;

17.1.7.2.1.2 To respond to changing financial needs;

17.1.7.2.1.3 To prevent the imposition of a gift tax;

17.1.7.2.1.4 To ensure a step-up in tax basis on his or her death.

17.1.7.2.2. As a matter of both common law doctrine and the practicalities of the situation, the donee of a limited power of appointment is not the owner of the appointive assets. The donee is in a fiduciary position with reference to the power and cannot derive personal benefit from its exercise. The donee's creditors have no more claim to the appointive assets than to property which the donee holds in trust. It is immaterial whether or not the donee exercises the power.³⁷

17.1.7.2.3. If the donee formerly owned the appointive assets covered by the non-general power *and transferred them in fraud of the donee's creditors*, reserving the non-general power, *the creditors can reach the appointive assets under the rules relating to fraudulent conveyances*. The fact that a non-general power was reserved by the donee in such

³⁷ REST 2d PROP-DT § 13.1(b), cmt. a.

fraudulent conveyance does not increase or decrease the ability of the creditors to reach the appointive assets.³⁸

17.1.7.2.4. **Illustration:** O by deed transfers property to T in trust. T is directed to pay the net income to O for life. In addition, T is directed “to distribute the trust property to, or hold the same for the benefit of, O's issue who are living from time to time, in such amounts and proportions and for such estates and interests and outright or upon such terms, trusts, conditions, and limitations as O shall appoint during O's lifetime; and on O's death, to the extent the trust property is not otherwise disposed of by an exercise of O's power to appoint, the trust property shall pass to O's issue then living, such issue to take *per stirpes*, and if no issue of O is then living, to the X charity.”³⁹

17.1.7.2.5. **Explanation:** O is both the donor and donee of O's non-general power to appoint. O's creditors can reach the life income interest under the trust which O owns. They can also reach the property that is subject to O's non-general power **if the transfer is in fraud of O's creditors under the governing law as to fraudulent conveyances.**⁴⁰

³⁸ REST 2d PROP-DT § 13.1(b).

³⁹ REST 2d PROP-DT § 13.1(b).

⁴⁰ REST 2d PROP-DT § 13.1(b).

Note that the rule of REST 2d PROP-DT §13.1 applies to non-general powers, i.e., powers that are not exercisable in favor of any one or more of the following: the donee of the power, the donee's creditors,

17.1.7.2.6. **Gift in Default of Appointment to Donee's Estate:** If the gift in default of appointment is to the donee's estate, the donee's power, though in form a non-general power, is in substance a general power, and is therefore not protected from the donee's creditors.⁴¹

17.1.7.2.7. **Supportive Case Law:** Commenting on the limited number of cases involving the point, the American Law of Property concludes that this is likely due to “a general acknowledgment of the rather obvious principle” that property under a non-general power is not available to creditors of the donee.⁴²

17.1.7.2.7.1 One of the few cases is *Egbert v. De Solms*, 218 Pa. 207, 67 A. 212 (1907). In that case a husband and wife executed a trust whereby the wife was to receive the income from the trust during her lifetime, to be followed after her death by a life interest for the husband, and at his death the principal to be divided among their issue in such shares as the husband should by will appoint. The

the donee's estate, or the creditors of the donee's estate. *See* Reporter's Note to § 13.1.

Note also that in bankruptcy law, where there has been a tendency to go further in allowing creditors access to property over which the debtor has a power of appointment than under the common law, property covered by a non-general power has never been subject to the claims of creditors. *See Drummond v. Cowles*, 278 F. Supp. 546 (D. Conn. 1968) and the Reporter's Note to REST 2d PROP-DT, § 13.6, item 3.

⁴¹ REST 2d PROP-DT §13.1(c).

⁴² REST 2d PROP-DT §13.1(c), citing 5 *American Law of Property* § 23.15 (A.J. Casner ed. 1952).

court held that while the income payable to the parents was subject to the payment of their debts, the issue's remainder estate could not be defeated. “Except as against existing creditors, or those in specific contemplation in the immediate future, the [settlers] could have conveyed a present absolute estate to their children; and *a fortiori* they could convey an estate in remainder.” *Id.* at 209, 67 A. at 212-13.

17.1.7.2.7.2 The fact that a donee exercises the power, while significant when dealing with a general power, makes no difference when the power is a limited one; creditors cannot reach the appointive property in either case.

17.1.7.2.8. In *Prescott v. Wordell*, 319 Mass. 118, 65 N.E.2d 19 (1946), the executors contended that, because the donee exercised her non-general power in her will, the will had the effect of making the appointed property assets of her estate in so far as her creditors were concerned. The court, pointing to § 326 of the first Restatement of Property, held that since the donee had no power to appoint to her own estate or for the benefit of her creditors, her exercise of the power did not subject the appointed property to the payment of her debts.

17.1.7.3. The Maryland high court in *Price v. Cherbonnier*, 103 Md. 107, 63 A. 209 (1906), held invalid an attempted testamentary appointment to certain creditors since they were not objects of the donee's non-general power. Further, the attempted exercise did not render the property assets of the estate subject to the claims of creditors. Dictum to the same effect (that ineffectively appointed property under a non-general power cannot be reached by the donee's creditors) appears in *Fiduciary Trust Co. v. First National Bank of Colorado Springs*, 344 Mass. 1, 7, 181 N.E.2d 6, 10 (1962).

17.1.7.3.1. In a more recent Maryland case, the Court held that a settlor's retained limited power of appointment is not sufficient to allow the creditor to seize trust assets. In *United States v. Baldwin*, 283 Md. 586, 391 A.2d 844 (1978), Baldwin had transferred property to a trust, reserving to himself the right to receive the income from the trust property for life and a power of appointment by will to designate those persons who would receive and enjoy the remainder after his death. The Maryland Court of Appeals held in *Baldwin* that the power of appointment, under Maryland law, was a special or limited power which did not permit Baldwin to appoint the corpus to his own estate or to his creditors. Such a limited power of appointment of the corpus, coupled with the life estate, did

not give Baldwin such a property interest in the corpus as to subject it to the claims of his creditors. *Id.*

- 17.1.7.4. The Connecticut case of *Ahern v. Thomas*, 248 Conn. 708, 739, 733 A.2d 756, 775 (1999) involved a nursing-home resident who appealed denial of her Medicaid application following administrative determination that the principal of the trust she had established was an available resource for purpose of calculating her Medicaid eligibility. The trial court reversed. Affirming, the Connecticut high court held that because the trust instrument did not provide trustees with authority or discretion to distribute trust principal to settlors, the principal of the trust was not an available resource.
- 17.1.7.5. In another Connecticut case, after a dissolution of marriage was granted, a Connecticut intermediate appeals court reversed and remanded, holding that no portion of the husband's spendthrift trust assets could be included in the marital estate and awarded to the wife, as the husband had only a limited power of appointment and no interest in the appointive assets of the trust. *Cooley v. Cooley*, 32 Conn. App. 152, 161, 628 A.2d 608, 614, *cert. denied* 228 Conn. 901, 634 A.2d 295 (1993).
- 17.1.7.6. In a Georgia case, *Avera v. Avera*, 253 Ga. 16, 315 S.E.2d 883 (1984), a settlors created a trust whereby he would receive the income of the trust while retaining a limited power of appointment. The trustee could invade the corpus of the trust for the settlor's

benefit, but that power was subject to an ascertainable standard. The Supreme Court of Georgia held that principal of the trust could not be invaded to satisfy a claim against the settlors arising out of a divorce since the trustee's discretion to make distributions to the settlors was limited by an ascertainable standard. The court so held even though the settlors retained a limited power of appointment. The court also noted that there was always one other beneficiary of the trust, even though the settlors could change that beneficiary.⁴³

17.1.7.7. The New York case of *Spetz*⁴⁴ and the New York federal case of *Sutkowy*,⁴⁵ both previously discussed, were Medicaid cases involving irrevocable trusts with retained lifetime limited powers of appointment. The Medicaid Agency in both cases claimed that the settlors could use their retained lifetime limited power to change the beneficiaries to individuals willing to revoke the trust. Both courts, relying on the same logic, rejected this argument as being entirely speculative, holding that denial of Medicaid benefits could not be based upon a remote possibility of collusion absent bad faith or fraud.⁴⁶

⁴³ REST 2d PROP-DT §13.1© (also citing *DiMaria v. Bank of Cal. Nat'l Ass'n*, 237 Cal. App. 2d 254, 46 Cal. Rptr. 924 (1965) (self-settled trust could not be reached where trustee's power to invade and distribute to settlor/beneficiary was limited by an ascertainable standard)).

⁴⁴ *See supra*, section 17.1.4.1.

⁴⁵ *See supra*, section 17.1.4.2

⁴⁶ *Supra*, sections 17.1.4.1 and 17.1.4.2.

17.1.7.8. Cautionary Case Law.

17.1.7.8.1. In the Pennsylvania case of *In re Nolan*, 218 Pa. 135, 67 A. 52 (1907) (*see supra* Section 17.1.4.4), the settlors retained the power to appoint the remainder and the trustee had the power to reconvey the property to the settlors. In holding that no creditor protection was available, the court unfortunately did not specifically refer to the trustee's power to reconvey the property to the settlors. The Court stated:

“It is against public policy, and not consonant with natural justice and fair dealing as between debtor and creditor, that a settlors should be permitted to play fast and loose with his property, in such a manner as to have the use of the income during life, and the right to disposing of the principal by will at any subsequent time he chooses to exercise the power, thus giving him all of the substantial benefits arising from the ownership thereof while he has safely put his property beyond the reach of creditors.”⁴⁷

⁴⁷ Spero, *Asset Protection: Legal Planning, Strategies and Forms* ¶13.10[3]. Note that the *In re Nolan* Court did not mention in its holding that the trustee had the power to reconvey the property to the settlors. This writer presumes that it was the trustee's power to reconvey the property to the settlors, in addition to

17.1.7.8.2. Similarly, in *First National Bank v. Schwab*, 194 So. 307, 309 (1940), the settlors transferred property to a trust while retaining a life estate, and the power to change the trustee and beneficiary. The court held that these retained powers established that he did not intend to place property out of his control and that the transfer was a mere contrivance that was not effective with regard to his creditors.⁴⁸

17.1.7.8.3. In *Doherty v. Dir. of the Office of Medicaid* (74 Mass.App.Ct. 439, 441, 908 N.E.2d 390, 2009) the court held that if an irrevocable trust allows the Medicaid applicant to use and occupy the home, then home is an 'available' asset. This is why in the Living Trust Plus™ we never have the trust permit the settlors to reside in the property. But more importantly, in *Doherty*, the Appeals Court concluded the trust's principal was a countable asset because the trust, despite some language restricting the grantor's access to the principal, allowed the trustees to invade the trust's principal and income when necessary to ensure the grantor's "quality of life," "comfort," and "respond to her changing life needs."

the limited power of appointment, that irked the Court and resulted in this anomalous holding.

⁴⁸ In the *Schwab* case, the settlor not only retained a limited power of appointment, but also the trustee was given the power to reconvey the property to the settlor. This writer presumes that it was the trustee's power to reconvey the property to the settlors, in addition to the retained limited power of appointment, that particularly irked the Court and resulted in this anomalous holding.

17.1.7.8.3.1 Clearly these latter provisions are inconsistent with a Medicaid Asset Protection Trust.

17.1.7.8.4. In a more problematic Massachusetts case, *Daley v. Sudders* (Mass. Super. Ct., No. 15–CV–0188–D, Dec. 24, 2015), a Massachusetts trial court recently made a very bad ruling that a Medicaid applicant's irrevocable trust was an available asset because the applicant retained a life estate in the condominium owned by the trust. In December 2007, Mr. and Mrs. Daley transferred their condominium into an irrevocable trust naming their son and daughter as trustees. The deed retained a life estate for Mr. and Mrs. Daley permitting them to live in the condominium, which they did for six years, when Mr. Daley had to move to a nursing home in December 2013. His application for Medicaid benefits was subsequently denied because the trust was considered a countable asset. On appeal, the Court upheld Medicaid's denial, citing the above decision in *Doherty v. Dir. of the Office of Medicaid* (74 Mass.App.Ct. 439, 441, 908 N.E.2d 390, 2009) to the effect that: "If a Medicaid applicant can use and occupy her home as a life tenant, then her home is 'available.'" According to prominent Massachusetts Elder Law Attorney Harry Margolis,⁴⁹

⁴⁹ <http://www.margolis.com/our-blog/court-rejects-income-only-trust-created-by-masshealth-applicant>

"While this is a misunderstanding of the Doherty decision, the court then makes the leap that would seem to invalidate all life estate deeds, which MassHealth has never in fact challenged to date." The court concluded that Mr. and Mrs. Daley's condominium was available to them because they retained life estates under the deed, and continued to use and live in it after establishing the Trust. "In other words," according to Margolis, "the Court here takes a provision in the deed retaining property rights for Mr. and Mrs. Daley to invalidate a trust which apparently does not give them the right to use and occupy the condominium. This is unlike the Doherty trust in which the right to use and occupy the property was in the trust rather than the deed."

17.1.7.8.4.1 However, and this may be the real point of the case, the Court then reviews certain provisions in the trust which permit the trustees to use income and principal to pay certain trust expenses -- taxes, insurance premiums -- and a right of substitution, to conclude that "the Daleys had access to both the Trust principal and income." The right of substitution is fatal in this author's opinion, because the right to substitute assets of equal or greater value clearly (in the warped mind of Medicaid

eligibility workers) allows the Settlers to "obtain principal" from the trust, even though it is by way of substitution and our lawyer minds rebel sharply against this concept.

17.1.7.8.5. We do have one recent good Massachussets case. In **Heyn v. Director of the Office of Medicaid** (Mass. App. Ct., No. 15-P-166, April 15, 2016), the Massachusetts Court of Appeals ruled that the state Medicaid agency erred when it determined that the assets in an irrevocable income-only trust were countable because, in the agency's opinion, the trustee's ability to purchase an annuity with trust assets allowed the trustee to distribute trust principal to the beneficiary. The court found that "[o]ut of each annuity payment, only the investment income portion would be available for distribution to the grantor from the trust; that portion of each payment representing a return of capital would be required by the trust instrument to be retained in the trust. The income portion available for distribution in such circumstances would be no different in character than interest earned on a certificate of deposit . . . In all events, the trust principal is preserved in the trust, and is not available for distribution to the grantor under the governing provisions of the trust."

17.1.7.8.6. Another cautionary case came from New Hampshire's highest court on July 12, 2016 (*Estate of Thea Braiterman, N.H., No. 2015-0395*), ruling that a Medicaid applicant's irrevocable trust was an available asset, even though the applicant was not a beneficiary of the trust, because the applicant supposedly retained a degree of discretionary authority over the trust assets. Ms. Braiterman created an irrevocable trust in 1994, naming herself and her son as trustees and her children as beneficiaries. In 2008, Ms. Braiterman resigned as trustee, but the trust authorized her to appoint additional and successor trustees, including appointing herself. The trust also gave Ms. Braiterman the ability to appoint any part of the income of the trust to any of the beneficiaries and, as interpreted by the court, *did not limit her ability to impose conditions on the appointment of principal to the beneficiaries*. Ms. Braiterman entered a nursing home and applied for Medicaid. The state determined that the trust assets were countable resources and denied her benefits. After a hearing, Ms. Braiterman appealed the agency's decision to court. The New Hampshire Supreme Court affirmed the denial of benefits, holding that the trust was an available asset because the court believed that Ms. Braiterman retained a degree of discretionary authority over the trust. The court correctly

pointed out that an irrevocable trust is a countable asset if there are *any* circumstances in which payment can be made to the applicant. The court rules that there was nothing in the trust "to preclude [Ms. Braiterman] from requiring her children, as a condition of their receipt of the Trust principal, to use those funds for her benefit."

17.1.7.8.6.1 The *Braiterman* court specifically addressed the *Verdow* and *Spetz* cases cited herein. However, the *Braiterman* court pointed out that, unlike the grantors in *Verdow* and *Spetz*, the applicant in this case retained broad powers over the Trust, in her capacity both as donor and as Trustee, including the power to make a distribution to a legatee conditioned upon that legatee using the distribution for the applicant's benefit. In addition, the *Braiterman* court stated that "although there is no evidence of collusion in this case, collusion is arguably encouraged by Clause 4.1.1, which provides that, in the event that the Trust's existence disqualifies the applicant for Medicaid benefits, the applicant 'suggests' that the Trust be terminated and that the Legatees (her children) use Trust assets 'to supplement the income and . . . governmental benefits and services to which [she] may be

entitled.’ By virtue of these provisions and others, the circumstances under which payments from the Trust could be made to benefit the applicant in this case are not ‘entirely speculative,’ *Verdow*, 209 F.R.D. at 316, but, rather, are specifically anticipated under the Trust Agreement.”

17.1.8. Taxation of Income-Only Trusts.

17.1.8.1. Income Tax.

17.1.8.1.1. Because all trust income flows through the trust to the Settlor, the income-only trust is considered by the IRS to be a “grantor trust.”⁵⁰ Through use of an income-only trust, the ordinary income of the trust is paid directly to the settlor/grantor and the tax will be paid at the settlor’s tax rate, rather than by the trust at the compressed trust tax rates.

17.1.8.2. Income Tax Reporting.

17.1.8.2.1. If the Settlor of a grantor trust is also a trustee or co-trustee, a separate taxpayer identification number is not required and a separate tax return (Form 1041) need not be filed by the trustee.⁵¹

⁵⁰ IRC § 677 and Treas. Reg. §1.671-2.

⁵¹ See IRS Instructions for Form 1041, “Optional Method 1” under “Special Filing Instructions for Grantor Type Trusts.”

17.1.8.2.2. However, for asset protection purposes, it is preferable for the trust to obtain a separate tax identification number so that potential creditors, including Medicaid, will clearly see the trust as a separate entity.

17.1.8.2.3. The Rules for reporting income are contained in the Instructions for Form 1041, under the section entitled “Grantor Type Trusts.” The trustee does not show any dollar amounts on the form itself dollar; amounts are shown only on an attachment to the form (typically called a Grantor Trust Statement) that the trustee or tax preparer files. The trustee should not use Schedule K-1 as the attachment nor issue a 1099.

17.1.8.3. Gift Tax.

17.1.8.3.1. Because the income-only trust is typically designed so that the settlor retains a limited power of appointment in the trust corpus, transfers to an income-only trust are not considered completed gifts for gift tax purposes.⁵²

17.1.8.3.1.1 When a donor transfers property to another in trust to pay the income to the donor or accumulate it in the discretion of the trustee, and the donor retains a testamentary power to appoint the remainder among

⁵² Treas. Reg. § 25.2511-2(b).

his descendants, no portion of the transfer is a completed gift.⁵³

17.1.8.3.1.2 A gift is incomplete if and to the extent that a reserved power gives the donor the power to name new beneficiaries or to change the interests of the beneficiaries as between themselves.⁵⁴

17.1.8.4. Gift Tax Reporting.

17.1.8.4.1. Even though the transfer of assets into the trust is not considered a taxable gift, pursuant to Treas. Reg § 25.6019-3 a Form 709, U.S. Gift (and Generation Skipping Transfer) Tax Return should still be filed in the year of the initial transfer into the trust.⁵⁵ On the Form 709, the transaction should be shown on the return for the year of the initial transfer and evidence showing all relevant facts, including a copy of the instrument(s) of transfer and a copy of the trust, should be submitted with the return.⁵⁶ The penalty for not filing a gift tax return is based on the amount of gift tax due, so if there is no amount due there

⁵³ Treas. Reg. § 25.2511-2(b).

⁵⁴ Treas. Reg. § 25.2511-2(b).

⁵⁵ See Treas. Reg § 25.6019-3, which states that “[i]f a donor contends that his retained power over property renders the gift incomplete . . . and hence not subject to tax . . . , the transaction should be disclosed in the return for the . . . calendar year of the initial transfer and evidence showing all relevant facts, including a copy of the instrument of transfer, shall be submitted with the return. . . [along with] additional documents the donor may desire to submit.”

⁵⁶ Treas. Reg § 25.6019-3.

should be no penalty for failure to file. Nevertheless, a gift tax return should be filed pursuant to Treas. Reg § 25.6019-3. Additionally, the filing of a gift tax return could provide additional evidence to future creditors, including Medicaid, that a completed transfer was in fact made despite the fact that the transfer was not considered by the IRS to be a completed gift for tax purposes.

17.1.8.4.2. Neither Treas. Reg § 25.6019-3 nor the IRS Form 709 Instructions reveal how to report an incomplete gift. However, Treas. Reg § 301.6501(c)-1(f)(2) provides in relevant part as follows:

“A transfer will be adequately disclosed on the return only if it is reported in a manner adequate to apprise the Internal Revenue Service of the nature of the gift and the basis for the value so reported. Transfers reported on the gift tax return as transfers of property by gift will be considered adequately disclosed under this paragraph (f)(2) if the return (or a statement attached to the return) provides the following information—

- (i) A description of the transferred property and any consideration received by the transferor;

(ii) The identity of, and relationship between, the transferor and each transferee;

(iii) If the property is transferred in trust, the trust's tax identification number and a brief description of the terms of the trust, or in lieu of a brief description of the trust terms, a copy of the trust instrument.”

17.1.8.4.3. Although the transfer to the trust is an incomplete gift for gift tax purposes, if the trustee later distributes corpus from the trust to one or more of the beneficiaries, the tax result of such distribution is that a completed gift has now been made from the trust settlor to the beneficiary. Accordingly, a gift tax return should be filed by the settlor for the tax year of such distribution if the amount of such distribution exceeds the annual exemption amount.

17.1.8.4.3.1 Annual Exclusion Gifts. For 2018, the IOT can make an unlimited number of gifts to individuals of up to \$15,000 per recipient, per year, and the settlor will not need to file a gift tax return.

17.1.8.4.3.2 Tuition and Medical Gifts. The IOT can make additional unlimited gifts by paying tuition costs or medical expenses for a child or grandchild (assuming they are named as remainder

beneficiaries) directly to the provider, and the Settlor will not need to file a gift tax return.

17.1.8.4.3.3 Charitable Gifts. The IOT can make unlimited charitable contributions, or gifts to political organizations, and the Settlor will not need to file a gift tax return.

17.1.8.5. **Estate Tax.**

17.1.8.5.1. The corpus of the trust is taxable in the Settlor's estate upon death under IRC Section 2036, which says that "[t]he value of the gross estate shall include the value of all property to the extent of any interest therein of which the decedent has at any time made a transfer . . . under which he has retained for his life . . . the possession or enjoyment of, or the right to the income from, the property"⁵⁷

17.1.8.5.2. If the Settlor retains a limited power of appointment in the trust corpus, the entire value of the estate is included in the settlor's estate for estate-tax purposes.⁵⁸

17.1.9. **Step Up in Basis.**

17.1.9.1. Because an income-only trust is designed so that assets are included in the estate of the Settlor, the trust beneficiaries will

⁵⁷ IRC § 2036 and Treas. Reg. §20.2036-1

⁵⁸ Begley, Jr. & Hook, *supra* at § 7.20[6][c]

receive a step up in tax basis as to trust assets to the fair market value of the assets as of the Settlor's death.⁵⁹

17.1.10. **Capital Gains Exclusion for Sale of Principal Residence.**

17.1.10.1. If a taxpayer is considered the owner of the entire Trust (including the residence) under the Grantor Trust rules,⁶⁰ the taxpayer will be treated as the owner of the residence for purposes of satisfying the ownership requirements of § 121 of the Internal Revenue Code.⁶¹

17.1.10.2. Accordingly, by transferring a residence to an income-only trust in which the settlor retains a testamentary limited power of appointment, the exclusion from capital gains on the sale of a principal residence is maintained.⁶²

SECTION 18. SSI AND SSDI

18.1. What's the Difference?

18.1.1. Both SSI and SSDI offer cash benefits for persons with disabilities. Both programs are overseen and managed by the Social Security Administration. Medical eligibility for disability is determined in the same manner for both programs. However the eligibility requirements are quite different.

18.1.2. The most significant difference between Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) is the fact that SSDI is only available to workers who have accumulated a sufficient number of work credits, while SSI

⁵⁹ IRC § 1014(b)(9). See also IRC § 1014(b)(3), Treas. Reg. §§ 1.1014-2(a)(3), 1.1014-2(b)

⁶⁰ IRC §§ 671-679

⁶¹ See Rev. Rul. 85-45 (1985) and PLR 199912026 .

⁶² Begley, Jr. & Hook, *supra* at § 7.20[6][e].

benefits are available to low-income individuals who have either never worked or who haven't earned enough work credits to qualify for SSDI.

18.2. What Is SSI?

18.2.1. Supplemental Security Income is a program that is needs-based, for disabled persons with very low income and almost no assets. SSI is funded by general fund taxes (not from the Social Security trust fund). SSI is called a "means-tested program," meaning it has nothing to do with work history, but strictly with financial need. The maximum benefit paid by SSI in 2018 is \$750 per month for individuals and \$1,125 for couples (this increases annually if there is a Social Security cost-of-living adjustment).

18.2.2. Many disabled clients and family members of disabled clients don't know if they're receiving SSI or SSDI; all they know is they get a check from Social Security. A good way to determine is to ask them the amount of the check. If it's an individual and he or she is receiving \$750 per month, it's a pretty safe bet that person is on SSI.

18.2.3. To meet the SSI income requirements, a disabled person must have less than \$2,000 in assets (or \$3,000 for a married couple) and a very limited income. In many states, a person with a disability who is eligible under the income requirements for SSI is also able to receive Medicaid. Most people who qualify for SSI will also qualify for food stamps, and the amount an eligible person will receive is dependent on where they live and the amount of regular, monthly income they have.

18.3. What is SSDI?

18.3.1. Social Security Disability Insurance is funded through payroll taxes. SSDI recipients are considered "insured" because they have earned at least 40 "credits" by working for at least 40 "quarters" and making contributions to the Social Security trust fund in the form of FICA Social Security taxes.

18.3.2. Only persons who become disabled before age 65 can obtain SSDI.

18.3.3. After receiving SSDI for two years, a disabled person will become eligible for Medicare.

18.3.4. Under SSDI, the person who is disabled and his or her spouse and children dependents are eligible to receive partial dependent benefits, called auxiliary benefits. However, only adults over the age of 18 can receive the SSDI disability benefit.

18.3.5. There is a five-month waiting period for benefits, meaning that the SSA won't pay an applicant benefits for the first five months after becoming disabled.

18.3.6. The amount of the monthly benefit after the waiting period is over depends on the applicant's earnings record, much like the Social Security retirement benefit, so the monthly SSDI benefit is typically significantly larger than the monthly SSI benefit.

SECTION 19. HELPING CLIENTS MAXIMIZE SOCIAL SECURITY BENEFITS

19.1. Social Security Retirement Income.

19.1.1. On Aug. 14, 1935, then-President Franklin D. Roosevelt signed the Social Security Act into law, with the intention of providing a guaranteed monthly benefit to aged workers during retirement. These payouts officially began on Jan. 1, 1940, and they've continued for the past 78 years. Currently, there are around

62.5 million people receiving a monthly benefit check, including 43.1 million retired workers.

19.1.2. If you have a client who is nearing eligibility age, of course you'd like to help them get as much as possible out of the program and enjoy a more financially secure retirement. To assist you, I will address some of the most common concerns about the program.

19.2. How Much Your Benefits Will Be:

19.2.1. Unfortunately, Social Security benefits aren't likely to be nearly as generous as most of us would like – but on a positive note, they're still likely to make up a good portion of your retirement income. The average monthly Social Security retirement benefit was recently \$1,365, which amounts to \$16,380 per year. If your earnings have been above average, you'll collect more than that — up to the maximum monthly Social Security benefit of \$2,687 for those retiring at their full retirement age (that's about \$32,000 for the whole year). You can get an estimate of your expected Social Security benefits by setting up a “my Social Security” account with the SSA.

19.3. Qualifying for Benefits Even For Clients Who Didn't Work.

19.3.1. Many people whose “job” was being a homemaker and full-time parent think that they don't qualify for any benefits. However, they may be pleasantly surprised to learn that even if they've worked mostly in the home, without receiving paychecks, or didn't have much or any taxable income, they may still qualify for Social Security benefits. That's because if you're married, divorced, or widowed, you may be able to claim benefits based on your current, ex-, or deceased spouse's earnings record — generally receiving between 50% to 100% of the

spouse's benefit (divorced claimants will need to have been married for at least 10 years and not have remarried.)

19.4. Knowing When to Collect.

19.4.1. Many people think that they need to start collecting benefits at age 65, but that's not necessarily the case. The normal (or "full") retirement age used to be 65, but it has been increased for many of us. For those born in 1937 or earlier, it's 65, and for those born in 1960 or later, it's 67. For those born between 1937 and 1960, it's somewhere in between.

19.4.2. Despite that, though, you can start receiving benefits as early as age 62 and as late as age 70, but you need to be careful—starting to collect benefits too early or too late can be a costly mistake.

19.4.3. By starting at age 62, your Social Security benefits may be about 30% smaller than they would have been had you started at your full retirement age. That's not necessarily a mistake, though, because the system is designed so that total benefits received are about the same for people with average life spans no matter when they start collecting.

19.4.4. If you opt to begin receiving benefits at age 62, the amount will be considerably smaller, but you'll receive many more monthly payments if you live to your projected life expectancy.

19.4.5. For those who expect to have enough income at 62 and perhaps for a few more years, and people in your family tend to live very long lives, you might want to start collecting later. By delaying when you start collecting Social Security, you can make your benefit checks bigger.

19.4.6. For every year beyond your full retirement age that you delay — until age 70 — you'll increase your monthly benefit by about 8%. So, delaying from age 67 to 70 can leave you with checks about 24% bigger. Remember, though, that it will still be a wash, if you live an average life span. So, it's up to you, considering your personal situation, to decide when to start collecting. There's no one-age-fits-all answer.

19.5. Should You Collect Social Security Earlier for a “Happier Retirement?”

19.5.1. For years, Social Security experts were suggesting that seniors wait as long as they could to collect their Social Security benefits. But the tide is turning, and now, some experts are saying to go ahead and collect your benefits earlier, rather than waiting.

19.5.2. The full retirement age is going through a slow change. However, the range when you can claim Social Security will remain the same for the foreseeable future: from as early as 62 to as late as 70. For many, it clearly makes sense to wait until your 70th birthday to claim benefits for maximum payouts. But many Americans are claiming Social Security early, with 38% of men and 44% of women filing for benefits as soon as they become eligible.

19.6. The “Leisure in Retirement: Beyond the Bucket List” Study:

19.6.1. Recently, Merrill Lynch and Age Wave launched the “Leisure in Retirement: Beyond the Bucket List” study to understand the priorities, experiences, and challenges of leisure in retirement, and the topic of when to collect Social Security was addressed. According to study results, the best reason to claim Social Security early is because even if the payout is less, you can use the money earlier to make your day-to-day experience of retired life happier. This study is

based on a nationally representative survey of more than 3,700 respondents, nationally representative of age, gender, ethnicity, income, and geography.

19.6.2. Unless you're truly in love with your job, there's something that the added income of Social Security can buy you that nothing else can: free time. If you have extra income from working, you can buy things like a nice car, vacations, fancy gadgets etc. This is called material affluence. What many of us don't consider is time affluence, or the time we spend enjoying our retirement. Knowing that the added income of Social Security can give you the freedom you need to live your golden years the way you want, it's important to maximize these years, and sometimes that means taking less money, but taking it a lot sooner.

19.7. Taking Social Security Administration Mortality Rates into Account

19.7.1. According to the Social Security Administration, a 62-year-old man has on average another 20 years to live, while a 62-year-old woman has 23 years. If you waited until you were 70 to collect Social Security, as a man you would have on average, 10 more years, and as a female, 13 more years (Remember, this is an average. A lot of us are living much longer!) Taking these numbers into account, do you want to enjoy less extra income ten years sooner, or wait to get more ten years later?

19.8. Why Many Retirees Are Taking Social Security Earlier

19.8.1. Retirees who collect Social Security earlier are using the extra income to enjoy more freedom, more fun, new beginnings, and greater emotional wellbeing than at any other point in their lives. According to the Merrill Lynch/Age Wave survey:

19.8.1.1. **Greater freedom:** 92% of retirees say retirement gives them greater freedom and flexibility to do whatever they

want—regardless of how much money they have. Between ages 61-75, retirees reach the “freedom zone,” where they enjoy the greatest balance of health, free time, fun, and emotional wellbeing.

- 19.8.1.2. **More fun:** Despite popular media portrayals of fun as primarily the domain of youth, it turns out that the experience of fun rises in midlife and peaks in retirement.
- 19.8.1.3. **Greater emotional wellbeing:** Lifetime emotional wellbeing peaks in retirement. Feelings of happiness, contentment, and relaxation soar, while anxiety seems to plummet.
- 19.8.1.4. **More experiences rather than things:** Most retirees (95%) say they would prefer to have more enjoyable experiences rather than buy more things. Retirees enjoy two types of leisure: “everyday leisure,” where most seek to de-stress and improve their health and “special occasion leisure,” where retirees seek unique or rare peak experiences that give them lasting memories. 81% of retirees say they want a retirement filled with many peak experiences.
- 19.8.1.5. **More time with family and friends:** Retirees tell us who they spend time with (61%) is far more important than what they do (39%), and that’s even more true for women than men.

19.9. Coordinate with Your Spouse.

19.9.1. Married couples have many more ways to strategize about Social Security than single and never-married people do. For example, a couple might start collecting the benefits of the spouse with the lower lifetime earnings record on time or early, while delaying starting to collect the benefits of the higher-earning spouse. That

way, the couple does get some income earlier, and when the higher earner hits 70, they can collect extra-large checks. Also, should that higher-earning spouse die first, the spouse with the smaller earnings history can collect a portion of those bigger benefit checks.

19.10. Social Security is Still Going Strong

19.10.1. Based on media coverage, you might be assuming that the Social Security program is on its last legs at 83-years old. But, things are not quite so bad! Here's why:

19.10.1.1. The Social Security trust funds have been running a surplus in every year since 1982, taking in more from taxes and interest earned on taxes than they pay out in benefits.

19.10.1.2. Social Security trust fund surpluses are likely to stop around 2019, at which point the Social Security system can rely on incoming interest payments to make up the deficit — for a while.

19.10.1.3. According to several government estimates, if no changes are made, Social Security funds are likely to be depleted by 2034. If that happens, payment checks won't disappear, but they could shrink by about 25%, leaving beneficiaries with about 75% of what they were expecting, which is certainly better than nothing.

19.10.1.4. Fortunately, there's a decent chance that the system will be shored up, one way or another. There are many possible fixes, though politicians don't agree on them. Congress could theoretically fix the problem by simply appropriating other funds to supplement the Social Security trust fund. Another option — it's been

estimated that 77% of the trust funds' shortfall could be eliminated by increasing the Social Security tax rate for employers and employees from its current 6.2% to 7.2% in 2022 and 8.2% in 2052.

19.10.1.5. The more you know about Social Security and the more you can help you clients strategize about it, the more money you'll likely be able to help your clients get out of the system.

19.10.1.6. It's important for your clients to consider their options when filing for Social Security benefits. It is also important to keep in mind what could happen if you are living on Social Security alone and you or a loved one becomes incapacitated. You must take this into account when planning for retirement.

SECTION 20. HELPING CLIENTS MAXIMIZE PRIVATE RETIREMENT BENEFITS.

20.1. What is Retirement Planning?

20.1.1. Whether your clients' retirement is coming up soon or many years away, it is important to help them protect their hard work in their golden years with effective retirement planning and long-term care financial planning. Every adult over the age of 65 or retired needs to have a legal and financial retirement plan in place. Retirement Planning goes hand-in-hand with Estate Planning and Elder Law, which is why besides being a Certified Elder Law Attorney, your author is also an experienced retirement planning advisor and long-term care financial advisor through his financial services company, Lifecare Financial Services, LLC (in business since 2006) and is highly knowledgeable about using fixed indexed annuities to provide safe retirement income, and also helping to pay for long-term

care (especially home care and assisted living, which Medicaid doesn't cover) using hybrid insurance policies and asset-based policies that combine life insurance or an annuity product (or both) with a long-term care benefit.

SECTION 21. TAX-FREE MONEY TO PAY FOR LONG-TERM CARE.

21.1. Leveraging Retirement Accounts.

21.1.1. One great way to leverage a retirement account to use tax-deferred money (money in your client's IRA, 401(k), 403(b), or Thrift Savings Plan) is to use this tax-deferred money to help pay for long-term care. One of the main ways to do this is through a patented type of policy that combines a qualified annuity with life insurance and long-term care coverage.

21.1.2. State Life Insurance Company Group is part of OneAmerica, an A.M. Best A+ rated, 140-year-old company. The State Life Asset Care III is a Combination Life and Long Term Care Insurance policy funded with mostly pre-tax and some after-tax dollars.

21.1.3. With Traditional LTC policies, premiums can be increased and you may not receive any benefits if you do not need LTC. With Combination LTC policies, the benefits and premiums are guaranteed. The insurance company either:

21.1.3.1. pays you if you need LTC;

21.1.3.2. pays your heirs if you do not need LTC;

21.1.3.3. pays you and your heirs if you need a modest amount of LTC; or

21.1.3.4. pays you a refund if you cancel the policy.

21.1.4. State Life Asset-Care III is unique because it can be paid with retirement account funds and can be designed to provide **lifetime** benefits.

21.1.5. For many savers, their largest asset is their retirement account. State Life Asset Care III allows your client to rollover a portion of your retirement account, such as an IRA or 401(k), to an IRA deferred annuity. Then, from that qualified plan, a withdrawal is taken annually to fund a 20-pay Combination Life and Long Term Care policy. These annual withdrawals defer taxes and still meet your Required Minimum Distributions (RMDs).

21.1.6. Asset Care III can insure a married couple using just one of their retirement accounts.

21.1.7. For more information, please see a great article here:

<http://skloff.com/state-life-asset-care-iii-combination-life-and-long-term-care-insurance-review-long-term-care-university-101517>

SECTION 22. UTILIZING SPECIAL NEEDS TRUSTS AND ABLE ACCOUNTS.

22.1. What is a Special Needs Trust?

22.1.1. A special needs trust is an essential tool to protect a disabled individual's financial future. Also known as "a supplemental needs trust," this type of trust preserves eligibility for federal and state benefits by keeping assets out of the disabled person's name. Special Needs Trusts fall generally into two main categories:

22.1.1.1. Third-Party SNTs that one person creates and funds for the benefit of someone else.

22.1.1.2. First-Party SNTs (also called d4a trusts) that are created for the person with special needs using that person's own money.

22.1.2. A special needs trust is often designed to restrict payment for food and shelter, but can typically pay for the following special needs: dental care; plastic or

cosmetic surgery or other non-necessary medical procedures; psychological support services; recreation; transportation; telephone equipment and service; television equipment and service; music sound systems; smart home devices; computer equipment; internet access; electric wheelchairs; mechanical beds; companions for travel, driving, and cultural experiences; reading material; audio books; hair and nail care; stamps and writing supplies; private rehabilitative training; outings, cultural experiences, and vacations; medical/dental expenses; annual checkups; transportation and vehicle purchase; training programs; education; insurance premiums; rehabilitation not covered by health insurance; home health aides or private nursing home sitters; differentials in cost between shared rooms and private rooms; special nursing care and similar care which assistance programs may not otherwise provide; in some states, food and housing if absolutely necessary (though this will cause an approximate 1/3 reduction in the amount of SSI benefits paid if the person is also receiving SSI).

22.1.3. Third-Party Special Needs Trusts

22.1.3.1. A trust that is created and funded by someone for the benefit of a person with special needs is often called a “third party SNT.” This type of trust can be created while your client is alive by using a revocable or irrevocable living trust, or can be created upon your client's death through a living trust or Last Will and Testament.

22.1.3.2. If you create and fund a third-party SNT during your lifetime, you can place assets into the SNT while you are alive and/or upon your death. This type of third-party SNT can also be used to receive any inheritance that may come from a grandparent or other family

member, provided the other family member properly names the SNT that you created.

22.1.3.3. Because the SNT will own the assets, the beneficiary will not become ineligible for government benefits. On the contrary, the SNT allows the beneficiary to receive vital public benefits, while the funds in the SNT can be used for the special needs beneficiary to improve care and quality of life until his or her own death, at which time any assets left in trust can pass to whoever you name in the trust document.

22.1.3.4. Elder law firms work with clients to determine the exact provisions to include in each SNT. To be considered: information about each client and the beneficiary with a disability and how the clients wants the trust funds used; the beneficiary's age; what benefits the beneficiary is receiving or is likely to receive in the future; the eligibility requirements for benefits; and the kind and amount of assets planned to fund the trust.

22.1.4. Funding The Third-Party Special Needs Trust

22.1.4.1. A number of issues arise with respect to the question of how much to put into a third-party SNT. First, how much will your child with special needs require over her life? Second, should you leave the same portion of your estate to all of your children, no matter their need? Third, how will you assure that there's enough money?

22.1.4.2. The first question is a difficult one. It depends on what assumptions you make about your child's needs and the

availability of other resources to fulfill those needs. A financial planner or life care planner with experience in this area can help make projections to assist with this determination.

22.1.4.3. It's generally better to err on the side of more money rather than less. You can't be certain current programs will continue. And you have to factor in paying for services, such as case management, that you provide free-of-charge today.

22.1.4.4. If these assumptions mean that your child with special needs will require a large percentage of your estate, how will your other children feel if they receive less than their pro rata share? After all, your estate may already be smaller than it would be otherwise due to the time and money spent providing for the child with special needs. And your other children may have received less of your attention growing up than they would have otherwise had they not had a child with special needs.

22.1.4.5. One solution to the question of fairness and to the challenge of assuring that there are enough funds is life insurance. You could divide your estate equally among your children, but supplement the amount going to the special needs trust with life insurance. The younger you are when you start, the more affordable the premiums will be. If you are married, the premiums can often be lower if you purchase a policy that pays out only when the second parent dies.

22.1.5. First-Party Special Needs Trusts

- 22.1.5.1. The above discussion involves estate planning by parents or grandparents for money they plan to leave their child with special needs. However, a third-party special needs trust cannot hold funds belonging to the disabled individual himself. Unexpected events may trigger money being paid directly to a person with special needs.
- 22.1.5.2. This may happen, for example, through an inheritance from a family member, life insurance proceeds, or a personal injury settlement.
- 22.1.5.3. If a person is about to receive money or property in an amount that will cause him or her lose benefits, a First-Party SNT – often called a “(d)(4)(A)” trust, so-named after the U.S. Code section that authorizes this type of trust – is a planning option that can help set aside some or all of the money for supplemental needs and still allow the person to stay on public benefits without any period of disqualification.
- 22.1.5.4. If a person has already received money or property in an amount that has caused him or her lose benefits, the First-Party SNT can still be used as a tool to set aside some or all of the money for supplemental needs and allow the person to re-obtain public benefits.
- 22.1.5.5. A (d)(4)(A) trust must be created while the disabled individual is under age 65 and can be established by the disabled individual or by his or her parent, grandparent, legal guardian, or by a court. A

(d)(4)(A) trust also must provide that at the beneficiary's death any remaining trust funds will first be used to reimburse the state for Medicaid paid on the beneficiary's behalf.

22.1.5.6. Because of this payback provision, this type of trust is sometimes called a "payback trust." The Virginia Office of the Attorney General must approve all payback trusts to make sure that they meet the standards in the law. After the state is paid back, any assets left in the trust can pass to the people chosen by the grantor and named in the trust instrument.

22.1.6. Choosing the Trustee for Your Special Needs Trust

22.1.6.1. Choosing a trustee is one of the most difficult parts of planning for a person with special needs. The trustee of a special needs trust must be able to fulfill all of the normal functions of a trustee – accounting, investments, tax returns and distributions – and also be able to meet the needs of the special beneficiary.

22.1.6.2. The latter often means having an understanding of the various public benefits programs, having sensitivity to the needs of the beneficiary, and having knowledge of special services that may be available. There are a number of possible solutions, including professional trustees such as banks, trust companies, and law firms who work with special needs trust.

22.1.6.3. Often parents choose to appoint co-trustees – for example a trust company or law firm as a professional trustee along with a healthy child as a family trustee. Working together, the co-trustees can

provide the necessary experience to meet the needs of the child with special needs. Unfortunately, in many cases such a combination is not available. Some professional trustees require a minimum amount of funds in the trust. In other situations, there is no appropriate family member to appoint as a co-trustee.

22.1.6.4. Where the size of the trust is insufficient to justify hiring a professional trustee, two other solutions are possible. The first option is simply to have a family member trustee who would hire accountants, attorneys and investment advisors to help with administering the trust. Where no appropriate family member is available to serve as co-trustee, the parent may direct the professional trustee to consult with specific individuals who know and can care for the child with special needs.

22.1.6.5. These could be family members who are not appropriate trustees, but who can serve in an advisory role. Or they may be social workers or care managers or others who have both personal and professional knowledge of the beneficiary. This role may be formalized in the trust document as a “Care Committee” or “Advisory Committee.” The second option is to use a pooled trust.

22.1.7. When To Use Pooled Special Needs Trusts

22.1.7.1. A pooled SNT is a special type of SNT that is created by a nonprofit organization. The nonprofit organization may act as the trustee of the pooled SNT, or it may select the trustee. Individuals have separate accounts in the pooled SNT, but all the money is

pooled together and invested by the trustee. Individual beneficiaries get the services of a professional trustee and more investment options because there is more money overall. A third-party pooled trust provides a way to benefit from a special needs trust without having to create one yourself.

22.1.7.2. Just as with single-beneficiary trusts discussed above, there are both “third-party” pooled SNTs (which you can use to give money during life, or leave money upon death, for a special needs beneficiary) and “first-party” pooled SNTs – also called “(d)(4)(C)” trusts – used to protect money that belongs to the special needs beneficiary. A pooled trust account, just like a (d)(4)(A), can must be established by the person who is disabled or by his or her parent, grandparent, legal guardian, or by a court. In addition, at the beneficiary’s death the state does not have to be repaid for Medicaid expenses so long as the funds are retained in the trust for the benefit of other disabled beneficiaries.

22.1.8. Microboards

22.1.8.1. A Microboard is usually a small, non-profit corporation, established by the family of a disabled child or adult, that is established to provide for the ongoing special needs of a disabled person.

22.1.8.2. A Microboard serves as a support structure for a person with special needs. When the parents or other primary caregivers are no

longer able to assist the person with special needs, a Microboard can be in place to help ensure that person's ongoing needs are met.

22.1.8.3. A Microboard is typically set up as a nonprofit corporation. The Elder Law Attorney would normally prepare the Articles of Incorporation and the ByLaws, and there must be Board Members who actually hold regular board meetings. These can be family members, friends, social workers, or anyone else willing to be formally involved in the life of the person with special needs.

22.1.8.4. One of the main advantages of a Microboard is the ability of the organization to accept loans from the State Housing Authority for the purchase of a home for the disabled person for whom the Microboard has been created.

SECTION 23. PRACTICE TOOLS.

23.1. Living Trust Plus™ Asset Protection System - <http://www.LivingTrustPlus.com>

23.2. Elder Counsel® – <http://www.eldercounsel.com/>

23.3. Elder Law Planning™ – <https://www.interactivelegal.com>