

Estate Planning for the Elderly and Disabled: Organizing the Estate to Qualify for Federal Medical Extended Care Assistance

ROGER A. MCEOWEN*

NEIL E. HARL**

Perhaps the greatest fear of elderly Americans is the fear of becoming impoverished as a result of paying for their health care needs. This fear is not confined to a relatively small proportion of the population. Due to declining birth and mortality rates, the proportion of elderly in the population is expected to continue to grow.¹ In 1985, the eighty-five and over age group was twenty-two times larger than it was in 1900.² Thus, an increasing number of seniors are likely to experience frailty and disability in old age.

Even though the cost of nursing home care is high and individual patients are largely uninsurable,³ for many elderly persons, old age means time spent in a nursing home.⁴ Many feel that they are forced to enter

* B.S., Purdue University; M.S., Iowa State University; J.D., Drake University.

** Charles F. Curtiss Distinguished Professor in Agriculture and Professor of Economics, Iowa State University, Ames, Iowa; Member of the Iowa Bar.

1. Fertility in the United States has been below replacement level since 1972. See B. WATTENBERG, *THE BIRTH DEARTH* 7, 172 (1987). The proportion of elderly in the world population is also expected to continue to grow because the world-wide birth-rate is now falling faster than the mortality rate for the first time in recorded history. See Sherlock, *The Demographic Argument for Liberal Abortion Policies: Analysis of a Pseudo-Issue*, in *NEW PERSPECTIVES ON HUMAN ABORTION* 452 (T. Hilgers, D. Haran, & D. Hill ed. 1987).

2. AMERICAN ASSOCIATION OF RETIRED PERSONS, *A PROFILE OF OLDER AMERICANS* (Pamphlet No. D-996, 1986).

3. In 1986, the average annual nursing home cost was \$22,000. See J. CRICHTON, *THE AGE CARE SOURCEBOOK* 211 (1987). By 1988, the national average had risen to \$30,000. Norman, *Nursing-Home Insurance Out of Reach*, *Des Moines Register*, Jan. 23, 1990, at A1, col. 1. Approximately 80-85% of elderly Americans find private insurance for nursing home care prohibitively expensive. *Id.* However, this figure can be misleading. Long-term health care policies are not the answer for all elderly persons. For example, if an elderly person's parents or grandparents did not require long-term health care, the likelihood is greater that the elderly person will not require long-term health care. Similarly, the low income elderly are likely to be categorically eligible for Medicaid. See *infra* notes 15-16 and accompanying text.

4. According to the Department of Health and Human Services (HHS), 25% of Americans who live beyond the age of 65 will enter a nursing home. See Moorefield, *National Underwriter* 5 (Jan. 26, 1987). Currently, 25% of the population 85 and over live in nursing homes. See SUBCOMMITTEE ON HUMAN SERVICES OF THE HOUSE SELECT COMMITTEE ON AGING, 100TH CONG., 1ST SESS., *EXPLODING THE MYTHS: CAREGIVING IN AMERICA* 9 (Comm. Print 1987).

a nursing home once their personal and family finances have been depleted by providing in-home care to a spouse or they have outlived an income-producing or asset-owning spouse. Fewer than ten percent of nursing home residents have a child with an annual income over \$20,000, and seventy-five percent have no spouse to care for them at home.⁵ Thus, typical nursing home residents are elderly persons who have outlived their spouses and their financial resources.

Except for the most wealthy elderly, the cost of long-term health care quickly becomes unmanageable. Consequently, the federal government is involved in assisting the elderly in meeting their long-term health care needs. To a limited extent, Medicare covers nursing home care. For example, if a covered individual is hospitalized for at least three days and is admitted to a nursing home within thirty days of discharge, Medicare covers the nursing home bill for the first twenty days of residency.⁶ Between twenty and one hundred days, the resident pays the first \$74.00 each day and Medicare pays the balance.⁷ Medicare does not cover any part of nursing home care for residencies extending beyond one hundred days.⁸ The Medicaid program, on the other hand, is the primary source of public assistance for elderly persons living in nursing homes. Medicaid is a cooperative federal-state program designed to provide federal financial assistance to states choosing to reimburse certain costs of medical treatment for needy persons.⁹

The increased potential for an individual to experience costly long-term health care complicates estate planning. Estate maximization now includes structuring the estate so that eligibility for public benefit programs such as Medicaid may be established and maintained in light of the federal government's need to limit federal benefits to the truly needy. The purpose of this Article is to provide information about the Medicaid program's rules and regulations to those who counsel persons anticipating a need for Medicaid coverage so that maximum advantage can be taken of the Medicaid program's benefits and so that the possibility of adverse legal consequences can be reduced.

I. MEDICAID ELIGIBILITY

In 1965, Congress established the Medicaid program as Title XIX of the Social Security Act to provide federal financial assistance to states

5. K. DAVIS & D. ROWLAND, *MEDICARE POLICY* 62 (1986).

6. 42 U.S.C. § 1395d(a) (1988); 42 C.F.R. § 409.30 (1990).

7. 42 U.S.C. § 1395e(a)(3) (1988); 3 *Medicare & Medicaid Guide* (CCH) ¶ 13,010.80 (1990).

8. 42 U.S.C. § 1395d(a)(2)(A) (1988).

9. *Id.* §§ 1396, 1396a.

choosing to reimburse needy persons for certain medical treatment costs.¹⁰ State participation in the Medicaid program is voluntary, but participating states must follow federal guidelines including requirements imposed by the Act and regulations promulgated by the Secretary of the Department of Health and Human Services (Secretary).¹¹ In order to assure the public that Medicaid funds are used to provide medical services to the needy and are not fraudulently diverted to untrustworthy providers of medical services, participating states must protect the quality and value of services rendered to recipients of Medicaid funds.¹² States that establish programs meeting the federal Medicaid guidelines and obtain the Secretary's approval are entitled to federal matching funds. However, once the Secretary determines that a state Medicaid plan has failed to comply with federal guidelines, the Secretary is required to take action.¹³

To qualify for Medicaid assistance in a participating state, an applicant must meet three general tests: (1) the Medicaid applicant must be in a category of persons entitled to participate in the program;¹⁴ (2) the applicant's assets must be within specified levels; and (3) the applicant's available income must be less than a prescribed amount to avoid having any of the applicant's income used to pay medical expenses. Thus, the three tests that each Medicaid applicant must meet to qualify for Medicaid assistance in any participating state are: circumstances, assets, and income.

A. *Circumstances Test*

The circumstances test entitles certain categories of persons to Medicaid benefits. As originally enacted, Medicaid required participating states to provide medical assistance to individuals who were receiving cash

10. Title XIX of the Social Security Act, Pub. L. No. 89-97, § 121(a), 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. §§ 1396-1396s (1988)).

11. See 42 U.S.C. § 1396 (1988); *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981); *Illinois Hosp. Assoc. v. Illinois Dep't of Pub. Aid*, 576 F. Supp. 360, 360 (N.D. Ill. 1983). Participating states must also provide financial assistance for inpatient, outpatient, laboratory, X-ray, skilled nursing facility, and physicians' services. See *Weaver v. Reagen*, 886 F.2d 194, 197 (8th Cir. 1989).

12. *Medicon Diagnostic Laboratories, Inc. v. Perales*, 74 N.Y.2d 539, 545, 549 N.E.2d 124, 127, 549 N.Y.S.2d 933, 936 (1989).

13. 42 U.S.C. § 1396c (1988). The Secretary may waive the requirements of § 1396a when approving a state Medicaid demonstration program. See *id.* § 1315; *Phoenix Baptist Hosp. & Medical Center v. United States*, 728 F. Supp. 1423, 1426 (D. Ariz. 1989).

14. These persons generally include recipients of Supplemental Security Income (SSI) or Aid to Families with Dependent Children. 42 U.S.C. § 1396a(a)(10) (1988); 42 C.F.R. §§ 435.120-.136 (1990).

payments under any one of four welfare programs established in the Social Security Act.¹⁵ These persons were termed the "categorically needy," and all participating states were required to provide benefits to these persons.¹⁶

In addition, a state could provide benefits to the "medically needy." The medically needy are persons whose incomes are too high to qualify for one of the categorical programs, yet they meet all other categorical criteria.¹⁷ Medically needy persons are eligible for Medicaid when their combined assets and income are insufficient to meet the cost of necessary medical or remedial services.¹⁸ If a state chooses to provide benefits to both the categorically needy and the medically needy, the regulatory procedure employed in determining income and resource eligibility for medically needy applicants may be less restrictive, but no more restrictive than the procedure used to determine income and resource eligibility for categorically needy applicants.¹⁹ In general, categorical eligibility should not be a problem for most elderly persons living in states that cover the medically needy.

In 1972, Congress restructured the Social Security program and replaced three of the four welfare assistance programs with Supplemental Security Income (SSI) for the aged, blind, and disabled.²⁰ Under SSI, the federal government assumed responsibility for both the funding of payments and the setting of eligibility standards.²¹ Congress also retained the requirement that all recipients of categorical welfare assistance, including the new SSI program, are entitled to Medicaid.²² As a result of this statutory restructuring, however, the new SSI income eligibility limits became broader than some of the prior state-established criteria. Thus, the number of individuals eligible for Medicaid under the new SSI standards increased significantly in many states.²³

In 1974, Congress offered participating states the "section 209(b) option" because Congress feared that some states might withdraw from

15. See, e.g., *Herweg v. Ray*, 455 U.S. 265, 268 (1982). These programs included: Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, and Aid to the Permanently and Totally Disabled. *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 n.1 (1981).

16. 42 U.S.C. § 1396(e)(10) (1988). See also *Randall v. Lukhard*, 709 F.2d 257 (4th Cir. 1983), *modified*, 729 F.2d 966 (1984) (en banc).

17. 42 U.S.C. § 1396a(10)(C) (1988); 42 C.F.R. § 435.1(b)(3)(i) (1990).

18. See 42 C.F.R. §§ 438.800-.852.

19. 42 U.S.C. § 1396a(r)(2) (1988).

20. *Id.* §§ 1381-94. Aid to Families with Dependent Children (AFDC) was not federalized under SSI. See *id.* §§ 601-17.

21. See *id.* §§ 1381-94.

22. See *id.* § 1396(a)(10).

23. See, e.g., *Darling v. Bowen*, 878 F.2d 1069, 1071 (8th Cir. 1989), *cert. denied sub nom.* *Stangler v. Darling*, 110 S. Ct. 1782 (1990).

the Medicaid program rather than bear the extra costs associated with the restructuring.²⁴ Under section 209(b), participating states can opt out of the requirement of providing Medicaid assistance to persons who receive SSI, and may elect to provide Medicaid assistance only to those individuals who would have been eligible under the state's Medicaid plan in effect on January 1, 1972, provided that these eligibility criteria are more restrictive than the SSI criteria.²⁵ Therefore, SSI eligibility does not necessarily guarantee Medicaid eligibility in states electing the section 209(b) option. Thus, the section 209(b) option allows states to avoid the effect of the link between the SSI and Medicaid programs, and permits states to become either "section 209(b) states" or "SSI states."

If a state elects the section 209(b) option, its Medicaid eligibility requirements may be no more restrictive than the requirements in effect under the state's Medicaid plan on January 1, 1972.²⁶ Alternatively, each requirement may be no more liberal than that applied under SSI.²⁷ Thus, states may cover all SSI recipients or establish requirements that are more restrictive than SSI but that are no more restrictive than the requirements in effect under the particular state's plan on January 1, 1972. Coverage of the medically needy, however, is mandatory in section 209(b) states.²⁸

Section 209(b) states may use more restrictive definitions of blindness or disability than SSI states.²⁹ Section 209(b) states may also adopt disability determinations of the Social Security Administration (SSA), and are not required under federal law to make an independent determination of a Medicaid applicant's disability.³⁰ For example, in *Armstrong v. Palmer*,³¹ the plaintiff applied for SSI benefits, but failed to qualify due to an SSA finding that the plaintiff was not disabled. Although she did not have a change in physical condition, the plaintiff applied for Medicaid benefits under Iowa's Medicaid plan. The Iowa state agency denied the plaintiff's application based on the SSA's determination of nondisability. The Eighth Circuit Court of Appeals ruled for the Iowa agency, and stated that when the SSA has determined that an individual is not disabled, that determination settles the question of

24. Section 209(b) of the Social Security Act is set forth at 42 U.S.C. § 1396a(f) (1988).

25. 42 U.S.C. § 1396a(f) (1988); 42 C.F.R. § 435.121(6)(1) (1990).

26. 42 C.F.R. § 435.121(b)(1) (1990).

27. *Id.*

28. *See* 42 U.S.C. § 1396(a)(10) (1988); *Winter v. Miller*, 676 F.2d 276, 278 (7th Cir. 1982).

29. 42 C.F.R. § 435.121(a) (1990).

30. This reflects the Secretary's interpretation of 42 C.F.R. §§ 435.210 and 435.541.

31. 879 F.2d 437 (8th Cir. 1989).

SSI eligibility and consequently, Medicaid eligibility.³² The court emphasized that its ruling furthered Congress's desire to avoid spending limited public benefit funds to duplicate the eligibility determination work of the federal agency.³³

B. *Income Test*

1. *General Provisions.*—The income test serves the dual purpose of determining whether an applicant is eligible to receive Medicaid benefits and how much an applicant must contribute toward medical care from personal income. The income eligibility requirements for a particular Medicaid applicant depend upon two factors: (1) whether the applicant resides in an SSI state or a section 209(b) state and (2) whether the applicant is classified as categorically or medically needy.³⁴ A third factor to remember is that SSI states have the option of covering the medically needy, and those SSI states that do cover the medically needy may set higher income eligibility limits than those used in determining eligibility for other Social Security cash assistance programs.³⁵

For the medically needy, the income test is based upon monthly income limits that vary from state to state. While excess income does not bar Medicaid participation, it does require that the applicant incur medical bills equal to the excess of available income over the applicable income limit.³⁶ For example, assume that X lives alone, requires twenty-four hour medical care, and resides in either a section 209(b) state or an SSI state that covers the medically needy. X's only income is from Social Security in the amount of \$900 per month. If we assume that the monthly income limit for a one person household is \$386 (the Iowa limit), X's excess income is \$514. X is eligible for Medicaid if X's monthly medical bills average \$515. Although it would not be likely in this example, X will not be eligible for Medicaid if X's monthly income exceeds the per month cost of nursing home care.

2. *Available Income.*—The standards used in determining Medicaid eligibility provide in part that a state's plan for medical assistance must take into account only the income and resources that are "available"

32. *Id.* at 440.

33. *Id.*

34. The financial eligibility requirements for the categorically needy are set forth in 42 C.F.R. §§ 435.700-.740 (1990). The applicable financial eligibility requirements for categorically needy applicants residing in section 209(b) states are found in 42 C.F.R. §§ 435.731-.735. The financial requirements for medically needy applicants are specified in 42 C.F.R. §§ 435.800-.852.

35. 42 C.F.R. § 435.1(b)(3)(i) (1990).

36. Thus, medically needy persons become eligible for Medicaid when their medical bills make them categorically needy.

to the applicant.³⁷ The determination of available income has become an increasingly important Medicaid eligibility issue in recent years. An important point, however, is that from an estate planning standpoint, available income is a broadly defined concept. As a result, the determination of a particular applicant's available income may depend upon such factors as the income and resources of the applicant's spouse, the amount of monthly income received in the applicant's name, the applicant's countable income as opposed to actual income, and the amount of the applicant's income applied toward outstanding medical bills.³⁸

3. *Deeming.*—The income and resources of a Medicaid applicant's spouse can be considered available to the Medicaid applicant through the process of "deeming." The Secretary has promulgated regulations governing the administration of Medicaid benefits in both SSI states and section 209(b) states that describe the circumstances under which the income of a Medicaid applicant's spouse may be deemed available to the applicant. For example, SSI states are required to "consider the income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed."³⁹

The amount of a Medicaid applicant's available income may also depend upon the order in which federal medical assistance benefits are calculated if an applicant is applying for benefits under separate federal programs. For example, in *Mazza v. Secretary of Department of Health and Human Services*,⁴⁰ the claimant filed concurrent claims for Social Security Disability and Supplemental Security Income payments. The SSA calculated the disability benefits first and offset them against potential SSI payments. As a result, the claimant was saddled with a large debt for medical expenses, and was denied SSI and Medicaid benefits due to excess available income.⁴¹

The court cited favorably a congressional committee report discussing the Disability Benefits Reform Act of 1984 that stated that the overall purpose of the Act was "to clarify statutory guidelines for the deter-

37. See 42 U.S.C. § 1396a(a)(17) (1988). Additionally, an applicant's failure to provide the information that a state agency deems necessary to determine the applicant's eligibility may justify denying a Medicaid application. Likewise, the state agency, not the applicant's counsel, must make Medicaid eligibility determinations. *Badenhausen v. New York State Dep't of Social Servs.*, 151 A.D.2d 913, 914, 542 N.Y.S.2d 887, 887 (1989).

38. Likewise, courts have held that "available income" includes mandatory tax withholdings. *Heckler v. Turner*, 470 U.S. 184, 211 (1985). *Cf. Whitehouse v. Ives*, 736 F. Supp. 368, 379 (D. Me. 1990) (retirement payments included as income for determining Medicaid eligibility). Similarly, the cash value, rather than the face value, of an insurance policy is included in "available income" for purposes of calculating SSI eligibility. See *Wilczynski v. Harder*, 323 F. Supp. 509, 517 (D. Conn. 1971).

39. 42 C.F.R. § 435.723(b) (1990).

40. 903 F.2d 953 (3d Cir. 1990).

41. *Id.* at 955.

mination process to insure that no beneficiary loses eligibility for benefits as a result of careless or arbitrary decisionmaking by the Federal government."⁴² The court also recognized a long-standing practice in the courts of calculating SSI benefits and subtracting them from Title II disability benefits.⁴³ As a result, the *Mazza* court held that the agency's calculation, which offset disability benefits against potential SSI payments, was arbitrary and inconsistent with the overall objectives of the Social Security system.⁴⁴

When the applicant and his or her spouse cease living together, the spouse's income is disregarded unless actually contributed to the other spouse in or after the month of the separation unless both the spouse and the applicant apply or are otherwise eligible for Medicaid or SSI.⁴⁵ If both spouses apply or are eligible for Medicaid or SSI, the income of both the spouse and the applicant is considered available to each for six months following the month in which they were separated.⁴⁶

Section 209(b) states have greater authority to deem income available to a spouse. Section 209(b) states are required to deem income available to the extent required in SSI states, and have the option of deeming to the full extent of the requirements in effect under the state's Medicaid plan on January 1, 1972.⁴⁷ Additionally, income deemed available to a spouse may be considered unavailable to an applicant in a section 209(b) state when the spouse and the applicant reside in the same house and the Secretary determines that deeming would be inequitable.⁴⁸ Thus, the overall effect of deeming, in both SSI and section 209(b) states, is to reduce the number of Medicaid eligible persons and the amount of assistance paid to qualified applicants.

In *Schweiker v. Gray Panthers*,⁴⁹ the respondent argued that "'deeming' impermissibly uses an 'arbitrary formula' to impute a spouse's income to an institutionalized Medicaid applicant."⁵⁰ The respondent argued that the state must make a factual determination that the spouse's income is actually contributed to the applicant before calculating the applicant's benefits. The respondent also maintained that "deeming" was inconsistent with a regulation providing that only income "available"

42. *Id.* at 960 (citing H.R. REP. NO. 618, 98th Cong., 2d Sess. 2, reprinted in 1984 U.S. CODE CONG. & ADMIN. NEWS 3038, 3039).

43. *Id.* at 956.

44. *Id.* at 960.

45. 42 C.F.R. § 435.723(d) (1990).

46. *Id.* § 435.723(c)(1)(ii).

47. *Id.* § 435.734(a); *Schweiker v. Gray Panthers*, 453 U.S. 34, 40 (1981).

48. 42 C.F.R. § 435.734(b)(1), (2) (1990).

49. 453 U.S. 34 (1981).

50. *Id.* at 40.

to the applicant may be considered in establishing Medicaid eligibility. Specifically, the statute in question provided that in calculating benefits, state Medicaid plans must "not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan *unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or [in certain circumstances], is blind or permanently and totally disabled . . .*"⁵¹

The Court, noting that Congress gave the Secretary exceptionally broad authority to promulgate regulations for defining Medicaid eligibility, ruled that the Secretary's definition of "available income" was entitled to "legislative effect," and held that the deeming regulation at issue was consistent with the Medicaid statute.⁵² The Court also examined Medicaid's legislative history and determined that from its inception Congress has endorsed the concept of spousal deeming.⁵³ The Court also held that the administration of public assistance payments based on a formula was not inherently arbitrary because a requirement of individual need determinations would mandate costly fact-finding procedures that would deplete resources that could have been spent on the needy.⁵⁴

As mentioned above, deeming practices differ between SSI states and section 209(b) states.⁵⁵ In particular, deeming in section 209(b) states proceeds in a more direct manner. Typically, a section 209(b) state specifies a "maintenance" level of income and resources for the non-institutionalized spouse.⁵⁶ Any funds exceeding the prescribed amount are deemed available for the costs of institutionalization, and medical assistance is usually terminated if the noninstitutionalized spouse fails to contribute the excess amount.⁵⁷

Section 209(b) states must follow the federal regulations governing the treatment of income of institutionalized Medicaid recipients in these states. One regulation provides in part that "[t]he agency must reduce its payment to an institution, for services provided to an individual . . . by an amount that remains after deducting the amounts specified in paragraphs (c) and (d) . . . from the individual's total income . . ."⁵⁸ Similarly, state health care agencies in section 209(b) states must deduct

51. *Id.* at 44 (citing 42 U.S.C. § 1396a(a)(17)(D)) (emphasis in original).

52. *Id.* at 48.

53. *Id.* at 44.

54. *Id.* at 48.

55. *See supra* notes 47-48 and accompanying text.

56. *See, e.g.,* *Gray Panthers v. Administrator, Health Care Fin. Admin.*, 629 F.2d 180, 182 (D.C. Cir. 1980), *rev'd*, *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981).

57. *Id.*

58. 42 C.F.R. § 435.733(a) (1990).

certain amounts from a Medicaid recipient's total income, including sums that were disregarded in determining Medicaid eligibility. The pertinent federal regulation provides:

The agency must deduct the following amounts, in the following order, from the individual's total income . . .

(1) a personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution . . .

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but not exceed the higher of —

(i) The more restrictive income standard established under § 435.121; or

(ii) The medically needy standard for an individual.⁵⁹

Because section 209(b) states do not have a medically needy program, the spousal maintenance deduction may be no more restrictive than the requirements in effect under the particular state's Medicaid plan on January 1, 1972, and no more liberal than that applied under SSI.⁶⁰

In *Mattingly v. Heckler*,⁶¹ the spouse of an institutionalized Medicaid recipient brought suit challenging the procedures used for deeming spousal income in Indiana, which is a section 209(b) state. The Indiana regulations governing the income eligibility of institutionalized Medicaid recipients require the Indiana state Medicaid agency to deduct a prescribed sum from the recipient's monthly income for the recipient's personal needs and an additional sum as a monthly maintenance allowance for the recipient's noninstitutionalized spouse.⁶² Income remaining after these deductions is considered available to defray the Medicaid recipient's medical care costs.⁶³

59. *Id.* § 435.733(c)(1), (2)(ii).

60. *See id.* § 435.121(b)(1). In *Walsh v. Walsh*, 144 A.D.2d 947, 534 N.Y.S.2d 260 (1988), the Supreme Court Appellate Division reversed a lower court's holding that an institutionalized person without sufficient income to meet daily medical expenses is not responsible for contributing to the support of a noninstitutionalized spouse, and held that the income of a nursing home resident is available to support a noninstitutionalized spouse even though the person is a Medicaid recipient.

61. 784 F.2d 258 (7th Cir. 1986).

62. IND. CODE ANN. § 12-1-7-18.6 (West 1982 & Supp. 1990). At the time the case was decided, the monthly maintenance allowance was calculated by subtracting the noninstitutionalized spouse's income from \$325. Noninstitutionalized spouses with monthly incomes exceeding \$325 received no monthly maintenance allowance, and the excess was deemed available to the Medicaid applicant for application to the cost of medical care. *Heckler*, 784 F.2d at 263.

63. *Heckler*, 784 F.2d at 263.

The plaintiffs objected to the agency's mechanical subtraction of the monthly spousal maintenance allowance. Specifically, the plaintiffs claimed that the Indiana regulations were unconstitutional under the due process clauses of the fifth and fourteenth amendments because they failed to provide spouses of institutionalized Medicaid recipients an opportunity to demonstrate that the spouse's actual needs exceeded the prescribed monthly allowance. Thus, the plaintiffs argued that the Medicaid statute prohibited the use of a flat maintenance allowance that did not reflect the needs of a particular spouse.

The Seventh Circuit Court of Appeals rejected the plaintiffs' claims on three grounds. First, the court ruled that the applicable federal regulation⁶⁴ prevented the Medicaid program from granting more financial assistance to the noninstitutionalized spouse of a Medicaid recipient than the Medicaid program granted its own beneficiaries, and that it treated all recipients equally.⁶⁵ Second, the court held that the Indiana monthly maintenance allowance was within the federally prescribed range and was tied to the state SSI benefit rates (that is, the maximum monthly income that a single person may receive and still qualify for Medicaid benefits in Indiana).⁶⁶ Third, the court echoed the concern in *Schweiker* that requiring individual fact-finding procedures would dissipate funds that could have been spent on the needy.⁶⁷ Thus, the court held that the use of a flat rate maintenance allowance to provide for the needs of an institutionalized Medicaid recipient's spouse is not unconstitutional.⁶⁸

In recent years, Congress's attempts to reduce the federal budget deficit have led to a tightening of the eligibility standards for public welfare benefits. A primary concern is the impact that such attempts might have on the status of categorically needy persons who qualify for Medicaid benefits under a Medicaid related SSI program. For example, the Deficit Reduction Act of 1984 (DEFRA) amended the Aid to Families with Dependent Children (AFDC) financial eligibility requirements by deeming the income of siblings in the form of Social Security or child support benefits and the income of grandparents to be available to the AFDC filing unit.⁶⁹ As a result, DEFRA disqualified some AFDC family filing units from receiving further AFDC benefits.⁷⁰ Because AFDC and SSI benefit recipients are categorically eligible for Medicaid, the question

64. 42 C.F.R. § 435.733 (1990).

65. *Heckler*, 784 F.2d at 266 (construing 42 C.F.R. § 435.733).

66. *Id.* at 267.

67. *Id.* at 268.

68. *Id.* at 270.

69. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2640(38)(B), 98 Stat. 1145 (codified as amended at 42 U.S.C. § 602(a)(38) (1988)).

70. *See, e.g., Rosado v. Bowen*, 698 F. Supp. 1191 (D.N.J. 1982).

becomes whether individuals denied further AFDC or SSI benefits by DEFRA are also automatically disqualified from Medicaid benefits.

Numerous courts have decided the AFDC issue, and have held that DEFRA's "increased deeming" provisions do not operate to disqualify the categorically needy from further Medicaid benefits.⁷¹ Arguably, the same logic should be applied to reach a similar result in situations where an individual qualifies for Medicaid benefits under the SSI program.⁷²

A recent California case emphasizes the point that state Medicaid plans are prohibited from imposing financial responsibility for medical care on persons other than spouses and parents. In *Sneede ex rel. Thompson v. Kizer*,⁷³ the court invalidated California's Medicaid regulations that deemed income and resources of all persons in the family unit available to a family member seeking Medicaid benefits.⁷⁴ In invalidating the California plan, the court stated that the plain meaning of the Medicaid statute explicitly prohibited the deeming of income from persons other than a Medicaid applicant's spouse or from a parent in the case of a child who is under age twenty-one, blind, or permanently

71. A number of courts have held that the DEFRA regulations do not affect a Medicaid applicant's status. *See, e.g.,* Malloy v. Eichler, 860 F.2d 1179, 1185 (3d Cir. 1988) (Medicaid eligibility not derivative of or perfectly coextensive with AFDC eligibility); Mitchell v. Lipscomb, 851 F.2d 734, 736 (4th Cir. 1988) (Congress knew of limitations that Medicaid statute imposed on Secretary's authority when DEFRA was passed, and chose not to change Medicaid eligibility requirements); Georgia Dep't of Medical Assistance v. Bowen, 846 F.2d 708, 712 (11th Cir. 1988) (AFDC and Medicaid benefits are fundamentally different — AFDC benefits are shared by family members, whereas Medicaid benefits are for individual health care, and DEFRA contained no amendments specifically directed at § 1396a(a)(17)(D) of Medicaid statute); Childress v. Bowen, 833 F.2d 231, 233 (10th Cir. 1987) (Medicaid statute precludes Secretary from applying § 602(a)(38) of DEFRA to include sibling income in calculating family income for determining Medicaid benefits); Olson v. Norman, 830 F.2d 811, 818 (8th Cir. 1987) (DEFRA does not affect Medicaid eligibility); Rosado v. Bowen, 698 F. Supp. 1191, 1197 (D.N.J. 1987), *aff'd*, 860 F.2d 1179 (3rd Cir. 1988) (42 U.S.C. § 1396a(a)(17)(D) specifically prohibits deeming of sibling income as DEFRA requires); Gibson v. Puett, 630 F. Supp. 542, 544 (M.D. Tenn. 1985) (Medicaid must be provided to persons ineligible for AFDC solely because of sibling or nonparental caretaker income).

72. In *Massachusetts Association of Older Americans v. Sharp*, 700 F.2d 749 (1st Cir. 1983), the court held that states may not deny Medicaid benefits to persons who would be eligible for cash assistance but for their failure to satisfy requirements that are specifically prohibited under the Medicaid program. Additionally, upon receiving notice that an individual's SSI benefits have been terminated, the state agency must promptly determine *ex parte* the individual's eligibility for Medicaid independent of the individual's SSI eligibility, and pending the outcome of the determination, continue to furnish Medicaid benefits to the individual. *See also* Crippen v. Kheder, 741 F.2d 102, 107 (6th Cir. 1984) (Department of Social Services must determine Medicaid eligibility separate from SSI eligibility and must provide Medicaid benefits while the eligibility determination is made).

73. 728 F. Supp. 607 (N.D. Cal. 1990).

74. *Id.* at 612.

and totally disabled.⁷⁵ Thus, under current law, the Medicaid statute prevents the deeming of income and resources of any individual absent actual contribution, except from a spouse to a spouse or from a parent to a child.

4. *The "Name-on-the-Check" Rule.*—Another issue concerning available income, and closely related to the issue of deeming, involves the "name-on-the-check" rule. This rule "requires that a Medicaid applicant's eligibility for benefits be based on the amount of money that the applicant receives each month in his or her name."⁷⁶ The rule represents the Secretary's administrative interpretation of the word "income" in the pertinent Medicaid regulation,⁷⁷ and has no explicit basis in either the Medicaid statute or the Medicaid regulations.⁷⁸

Although the term "income" as used in federal statute and regulations is to be defined under state law,⁷⁹ the "name-on-the-check" rule does not consider the portion of a married applicant's monthly income that belongs to the applicant's spouse under state community property law.⁸⁰ As a result, applying the "name-on-the-check" rule in community

75. *Id.* at 610. See 42 U.S.C. § 1396a(a)(17)(D) (1988) (consideration of financial responsibility prohibited unless person is applicant's spouse, child under age 21, or is blind or disabled).

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

77. (b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the time periods specified below. After the appropriate time period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(1) If spouses cease to live together because of the institutionalization of one spouse —

(i) The agency must consider their income as available to each other through the month in which they cease to live together. Mutual consideration of income ceases with the month after the month in which separation occurs. . . .

(d) If only one spouse in a couple applies or is eligible, or both spouses apply and are not eligible as a couple, and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month in which they cease to live together.

42 C.F.R. § 435.723 (1990).

78. *Bowen*, 815 F.2d at 553.

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

80. In community property states, all marital property is owned in common by husband and wife, with each spouse having an undivided one-half interest by reason of their marital status. Thus, in community property states, one half of the earnings of each

property states may adversely affect the at-home spouse of an institutionalized Medicaid recipient if the spouse earning the income becomes institutionalized.⁸¹

For example, assume that an elderly couple resides in a community property state. Assume also that the couple receives \$1,000 per month in the husband's name and nothing in the wife's name. If the wife enters a nursing home, the "name-on-the-check" rule requires that her Medicaid eligibility be based exclusively on the income received in her name (zero), and allows the husband use of the full \$1,000 received in his name, subject to spousal deeming. Alternatively, if state community property law is applied, the wife's Medicaid income eligibility will be based on her one-half interest in her husband's income (\$500), and the husband will have use of the remaining \$500.

If, however, the husband becomes institutionalized, under the "name-on-the-check" rule, his Medicaid income eligibility will be based on the \$1,000 received in his name and his wife will be left to live at home entirely dependent on a spousal maintenance allowance. Under state community property law, the husband's eligibility will be based on \$500, leaving \$500 for the wife's use. Thus, the impact of the "name-on-the-check" rule is especially harsh on lower income at-home spouses of nursing home patients when it is applied in community property states. Conversely, the "name-on-the-check" rule favors those couples when the lower income-earning spouse must be institutionalized.

In *Washington Department of Social and Health Services v. Bowen*,⁸² the state of Washington submitted a Medicaid plan amendment for the Secretary's approval. Under the amendment, the eligibility of married applicants for benefits would be calculated under state community prop-

spouse are considered owned by the other spouse. Alternatively, under a common-law system, each spouse owns whatever he or she earns. Currently, there are nine states with community property systems. See ARIZ. REV. STAT. ANN. § 25-211 (1976 & Supp. 1990); CAL. CIV. CODE § 682 (West 1982 & Supp. 1990); IDAHO CODE § 32-906 (1983 & Supp. 1990); LA. REV. STAT. ANN. §§ 2325, 2327, 2338 (West 1979 & Supp. 1991); NEV. REV. STAT. ANN. §§ 123.225, 123.259 (Michie 1982); N.M. STAT. ANN. § 40-3-12 (1989); TEX. FAM. CODE ANN. §§ 5.01, 5.02 (1984 & Supp. 1990); WASH. REV. CODE ANN. § 26.16.030 (1986 & Supp. 1991); WIS. STAT. ANN. §§ 766.01-.82 (West 1987 & Supp. 1990). The remainder of the states are classified as common-law jurisdictions.

81. The effect on the at-home spouse may be particularly severe on elderly couples. Most elderly couples receive the majority of their income in the husband's name. See U.S. BUREAU OF THE CENSUS, CURRENT POPULATION REPORT (1985) (Ser. P-60, No. 146, Table 37). Furthermore, given any married couple, the husband is more likely to enter a nursing home than is the wife. See generally Mitchell, *Spousal Impoverishment: Medicaid Burdens on the At-Home Spouse of a Nursing Home Resident*, 20 CLEARINGHOUSE REV. 358 (1986).

82. 815 F.2d 549 (9th Cir. 1987).

erty law, rather than under the "name-on-the-check" rule.⁸³ The Ninth Circuit Court of Appeals reversed the Secretary's disapproval of the amendment on the ground that the states are free to devise their own reasonable standards for determining Medicaid eligibility.⁸⁴ Specifically, the court ruled that the term "available" in the Medicaid regulations must be read as a limiting term, and that "income" should be defined under state law in community property states.⁸⁵ The court noted that under the "name-on-the-check" rule, deeming would occur indefinitely, thereby violating the purpose of the Medicaid regulations.⁸⁶ Furthermore, the court stated that the DEFRA regulations barred the Secretary from disapproving less restrictive state plans during a moratorium period which was in effect when the Secretary disapproved Washington's plan amendment.⁸⁷ The court found Washington's plan amendment to be less restrictive than the Secretary's interpretation; therefore, it was protected from the Secretary's disapproval.⁸⁸

In a Minnesota case, *Rindahl v. St. Louis County Welfare Board*,⁸⁹ the court held that the "name-on-the-check" rule was not an overbroad interpretation of the Medicaid regulations requiring that state eligibility determinations take into account only income that is "available" to the applicant.⁹⁰ The plaintiff in *Rindahl* was afflicted with Parkinson's disease and entered a nursing home after ten years of in-home care. The plaintiff had a monthly income over \$1,500, but his wife had no independent source of income. The defendant used the "name-on-the-check" rule to determine Medicaid eligibility and attributed all of the couple's income to the plaintiff. The plaintiff brought suit claiming that his wife's monthly maintenance allowance was inadequate, and that even though Minnesota was a common-law property state, Minnesota's marital property division statutes should entitle her to one half of his income as a maintenance allowance.

In holding that the "name-on-the-check" rule was a plausible method for attributing income, the court noted that indefinite deeming would not occur because the plaintiff's wife was not a wage earner to which

83. *Id.* at 551.

84. *Id.* at 553-54.

85. *Id.* at 554. See 42 C.F.R. § 435.723(b)-(d) (1990) (regulating when a spouse's income is available).

86. The court also opined that the Secretary's "name-on-the-check" rule would violate 42 C.F.R. § 435.723(c)(1)(i), (d). *Bowen*, 815 F.2d at 555.

87. *Id.* at 555-56 (discussing Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2373(c), 98 Stat. 1112).

88. *Id.* at 556.

89. 437 N.W.2d 686 (Minn. 1989).

90. *Id.* at 689 (discussing 42 U.S.C. § 1396a(a)(17)(B) (1988)).

deeming could apply.⁹¹ The court also held that the Minnesota marital property division statutes applied only to those situations involving annulment, dissolution of marriage, or legal separation.⁹²

Thus, in common-law property states such as Minnesota, the "name-on-the-check" rule appears to be an appropriate method for determining Medicaid financial eligibility for married couples when the primary wage earner is institutionalized. The question remains, however, whether the "name-on-the-check" rule will be used to determine Medicaid eligibility in common-law property states when the low income spouse is institutionalized and the high income spouse is not.

5. *Countable Income v. Actual Income.*—A Medicaid applicant's ability to satisfy the income test hinges on the level of the applicant's countable, as opposed to real, income.⁹³ Not all of an applicant's real income is necessarily considered to be "available income" for Medicaid eligibility purposes.⁹⁴ Only income that is received in cash or in kind *and* is available to meet the applicant's basic needs is considered to be income that counts toward inclusion in the income test for Medicaid eligibility.⁹⁵ Thus, an applicant's countable income is the income that is available to meet the applicant's needs.

Certain income amounts are not considered to be available to meet a person's basic needs. For example, assistance provided in cash or in kind under a federal, state, or local government program for the purpose of providing medical care or services is not considered to be countable income.⁹⁶ In *Mitson ex rel. Jones v. Coler*,⁹⁷ the court held that the portion of Veterans Administration (VA) pension benefits awarded to nursing home patients for reimbursed medical expenses does not constitute countable income for purposes of determining Medicaid eligibility.⁹⁸ The court concluded that the portion of the VA benefits at issue were reimbursement for the recipients' use of their non-VA income to pay for medical expenses.⁹⁹ Thus, because the recipients' non-VA income had already been diminished to pay medical expenses, the court reasoned

91. *Id.* at 690. See also *Washington Dep't of Social & Health Servs. v. Bowen*, 815 F.2d 549, 555 (9th Cir. 1987) (Medicaid regulations place time limit on "deeming").

92. *Rindahl*, 437 N.W.2d at 693.

93. See 20 C.F.R. § 416.1102 (1990) (income is anything received in cash or in kind).

94. *Id.* § 416.1103 (defining what is not income).

95. 42 U.S.C. § 1396a(a)(17)(B) (1988); 20 C.F.R. § 416.1102 (1990) (income is food, clothing, shelter, or something that can be used to obtain food, clothing, or shelter).

96. 20 C.F.R. § 416.1103(a)(3).

97. 674 F. Supp. 851 (S.D. Fla. 1987).

98. *Id.* at 856.

99. *Id.* at 854.

that the VA benefits did not generate additional resources which were available to meet the recipients' basic needs.¹⁰⁰

6. *Income Spend-down*.—Another issue concerning available income is the issue of income spend-down. States exercising the section 209(b) option must adopt a “spend-down” provision under which an individual whose income exceeds the applicable state standard can become eligible for Medicaid when that excess is spent on medical care.¹⁰¹ SSI states have the option of utilizing income spend-down.¹⁰² The purpose of spend-down provisions is to ensure the equitable treatment of the medically needy who may be as indigent as the categorically needy because of high medical expenses.¹⁰³

For example, in *Hession v. Illinois Department of Public Aid*,¹⁰⁴ the court held that the federal Medicaid law required the Illinois Department of Public Aid to offset an applicant's medical bills by the amount of the applicant's excess savings, and to provide medical assistance for the remaining balance.¹⁰⁵ The applicant had incurred \$38,000 in medical bills during a three-month hospital stay, which exceeded his financial resources of less than \$2,000 in personal savings. The plaintiff applied for medical assistance as categorically “disabled” under SSI. Upon finding that the plaintiff had \$400 worth of savings above the eligibility limit, the Illinois agency denied the plaintiff *any* financial assistance.

Ruling for the plaintiff, the court held that the Medicaid statute permits state plans to utilize resource spend-down in determining an applicant's eligibility for medical assistance.¹⁰⁶ Thus, when individuals have financial resources that do not cover the cost of their health care, but that exceed the applicable income eligibility limits, Medicaid eligibility can be obtained once their “excess” income is applied to their medical bills. In other words, Medicaid benefits can be received once excess income is “spent-down” to the income eligibility limits.¹⁰⁷

Similarly, in *Green v. Department of Public Aid*,¹⁰⁸ the plaintiff's application for medical assistance on behalf of her husband was denied

100. *Id.*

101. Section 209(b) states are required to provide benefits to the medically needy (i.e., persons with incomes that are too high to qualify them as categorically needy). See *supra* note 28 and accompanying text.

102. See 42 C.F.R. § 435.301(a)(1)(ii) (1990) (income spend-down is also known as resource spend-down).

103. See, e.g., ILL. REV. STAT. ch. 23, para. 5-1 (Smith-Hurd 1988 & Supp. 1990).

104. 163 Ill. App. 3d 553, 516 N.E.2d 820 (1987), *aff'd*, 129 Ill. 2d 535, 544 N.E.2d 751 (1988).

105. *Id.* at 560, 516 N.E.2d at 824.

106. *Id.* at 559, 516 N.E.2d at 824.

107. *Id.* at 558, 516 N.E.2d at 824.

108. 165 Ill. App. 3d 936, 520 N.E.2d 860 (1988).

because the couple's joint available income exceeded the applicable income limit by \$26.36. The plaintiff had outstanding medical bills equaling \$150,000. Although the Department had provisions designed to permit medical assistance applicants to qualify for assistance by applying their excess income to their medical bills, the plaintiff was unaware of the procedures necessary to comply with the provisions. The court, holding that the defendant's income reduction policy was applied in an unconstitutional manner, noted that in order to satisfy the constitutional requirements of due process and fundamental fairness, applicants must be advised of the provision's procedural requirements.¹⁰⁹

Likewise, in *Sipiora v. Illinois Department of Public Aid*,¹¹⁰ the court held that the defendant's failure to inform the plaintiff of the existing income reduction policy *at the time of the plaintiff's initial application* for benefits resulted in an improper denial of medical benefits.¹¹¹ Similarly, in *Johnson v. Department of Public Aid*,¹¹² the plaintiff was also denied medical assistance because of excess income. In reversing the lower court's denial of medical benefits and remanding for a re-determination of the plaintiff's eligibility, the court ruled that the defendant *must* employ an income spend-down procedure *or* consider an applicant's medical expenses when determining eligibility.¹¹³

7. *Income Transfers*.—As mentioned above, a Medicaid applicant with excess available income can become eligible for Medicaid when the excess income is spent on medical care.¹¹⁴ Conversely, persons with excess income cannot attain Medicaid eligibility by divesting themselves of the excess through voluntary transfers or gifts for the purpose of becoming eligible for Medicaid. Persons who transfer excess income within a specified time of applying for Medicaid raise a presumption that the transfer was made to obtain eligibility.¹¹⁵ These persons may rebut the presumption by providing convincing evidence that the transfer was not for the purpose of qualifying for Medicaid.¹¹⁶ Thus, it is important to understand the factors that can help a transferor overcome the presumption of a fraudulent conveyance.

In *Anson v. Kitchin*,¹¹⁷ the petitioner was hospitalized for three weeks. During this hospitalization, the petitioner instructed his mother

109. *Id.* at 941, 520 N.E.2d at 862-63.

110. 191 Ill. App. 3d 973, 548 N.E.2d 459 (1989).

111. *Id.* at 460.

112. 191 Ill. App. 3d 911, 548 N.E.2d 396 (1989).

113. *Id.* at 397.

114. *See supra* note 101 and accompanying text.

115. 20 C.F.R. § 416.1246(e) (1990).

116. *Id.*

117. 64 A.D.2d 752, 406 N.Y.S.2d 916 (1978).

to withdraw \$3,000 from his savings account and to use approximately \$1,600 of the withdrawn funds to pay an outstanding credit card bill. The petitioner instructed his mother to retain the balance as repayment for money advanced to him for repairs he was to make to his mother's home, but that he had never made. A few days later, the petitioner instructed his mother to apply for medical assistance on his behalf. The state agency determined that the entire \$3,000 was income available to the petitioner for medical expenses, and approved the petitioner's application only to the extent that his medical expenses exceeded the excess amount including the \$3,000.

In reviewing the agency's determination, the court noted that the applicant bears the burden of proving that an otherwise prohibited transfer was not made for the purpose of attaining eligibility, and that the purpose of creating such presumptions was to prevent fraudulent transfers.¹¹⁸ The court reasoned that the petitioner could overcome the presumption of fraud by showing that the transfer was for value or was for repayment of an antecedent debt.¹¹⁹ Applying this reasoning, the court held that the credit card debt was a valid debt incurred before hospitalization; therefore, the money used to pay it was not income available to the petitioner for medical expenses.¹²⁰ The court held, however, that the money initially advanced to the petitioner for repairs to his mother's home was merely a loan and was not a debt to perform work on her home.¹²¹ Thus, the court included the amount of the loan in the computation for determining the income available for medical expenses.¹²²

In *Downer v. Department of Human Resources*,¹²³ the plaintiff's ninety-year-old father transferred \$1,250 to the plaintiff and her husband to repay them for taking care of him and to help make repairs to their trailer. At the time of the transfer, the plaintiff's father was hospitalized and was facing imminent death. The plaintiff's father survived, however, and was placed in a nursing home.

Ten days after the transfer, the plaintiff filed for Medicaid benefits on her father's behalf under the Nevada Medicaid plan. The state agency denied the requested Medicaid benefits on the basis that the evidence was insufficient to rebut the presumption that the transfer was for the sole purpose of obtaining Medicaid eligibility, and the district court affirmed.

118. *Id.* at 753, 406 N.Y.S.2d at 918.

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. 101 Nev. 398, 705 P.2d 144 (1985).

The Nevada Supreme Court reversed the district court on two grounds. First, the court opined that because the plaintiff's father believed his death was imminent, he could not have anticipated at the time of the transfer that an application for Medicaid benefits would be filed on his behalf.¹²⁴ Second, the court noted that at the time of her father's death, the plaintiff and her husband had applied the entire amount of the transferred funds toward the decedent's medical bills.¹²⁵ The court thus remanded the case to the district court with instructions to recalculate the proper level of Medicaid benefits and to distribute them to the plaintiff and her husband.¹²⁶

Similarly, the plaintiffs in *Rizzuto v. Blum*¹²⁷ closed a joint savings account containing almost \$15,000 and gave the funds to their sons, allegedly in consideration for the sons' performance of past services. Twenty days later, the plaintiffs applied for Medicaid. Upon discovering the former account's existence, which the plaintiffs had failed to indicate on their application, the state agency rejected the plaintiffs' request for benefits.

Unlike *Downer*, however, the *Rizzuto* court affirmed the state agency's denial of benefits.¹²⁸ Although the sons had applied part of the funds toward the plaintiffs' medical expenses, the court noted that excess income remained.¹²⁹ Furthermore, the court held that the excess income was available to the plaintiffs because they had retained control over the amount given to their sons.¹³⁰

Similarly, in *Mitsch v. Perales*,¹³¹ the state agency denied the petitioners' application for medical assistance on the ground that they had transferred \$30,000 to their son and daughter-in-law without compensation and within two years of the application date. The petitioners argued that the transfer was made pursuant to an oral agreement with their son to compensate him for the cost of building an extension onto the home where the petitioners would reside.

The court affirmed the state agency's denial of benefits even though the son completed the work. The petitioners moved into the addition, and were not in need of nursing home care at the time of the transfer. The court focused on the time lag between the date the son completed

124. *Id.* at 399, 705 P.2d at 145.

125. *Id.*

126. *Id.*

127. 101 A.D.2d 699, 475 N.Y.S.2d 680 (1984).

128. *Id.* at 699, 475 N.Y.S.2d at 682.

129. *Id.* at 699, 475 N.Y.S.2d at 681.

130. *Id.* at 699, 475 N.Y.S.2d at 682.

131. 114 A.D.2d 369, 493 N.Y.S.2d 887 (1985).

the work and the transfer date, and ruled that a delay of approximately seven months colored the transfer as a gift.¹³²

In *Bregola-Sorrentino v. Illinois Department of Public Aid*,¹³³ the plaintiff received a \$7,000 gift from her son-in-law to be used for her hip replacement surgery. The plaintiff used \$2,000 of the gift to pay for her surgery, with the balance remaining in her son-in-law's checking account. Due to a subsequent hip infection, the plaintiff was hospitalized a second time and applied for financial assistance to help defray her \$15,000 in outstanding medical bills. The county department denied the plaintiff's application because the plaintiff's available income, which included the \$7,000 gift, exceeded the Illinois income limit for single persons.

The court agreed with the county department's determination that the funds were income available to the plaintiff for payment of medical expenses, and noted that the son-in-law's testimony indicated that he intended to provide the balance of the gift to his mother-in-law only if no other funds were available to pay her medical expenses.¹³⁴ However, the court reversed the county department's decision to deny benefits because the department failed to notify the plaintiff of her opportunity to apply her excess income to her outstanding medical bills which would consequently qualify her for assistance once the excess was reduced to the applicable income limit.¹³⁵

In *Probate of Marcus v. Department of Income Maintenance*,¹³⁶ two conservators applied for Medicaid benefits on their ward's behalf after making a series of gifts that totally depleted the ward's \$600,000 estate. The Department of Human Resources petitioned the probate court for an accounting of the estate's management, whereupon the probate court disallowed the gifts under Connecticut law. The Department of Income Maintenance adopted the probate court's decision, and disallowed the conservators' application.

The Connecticut Supreme Court affirmed the probate court's disallowance of the gifts for two reasons. First, in Connecticut, the probate court is responsible for the care and management of the ward's estate, whereas the conservator merely acts under the probate court's supervision and control as an agent of the court.¹³⁷ Thus, lacking a statute to

132. *Id.*

133. 129 Ill. App. 3d 566, 472 N.E.2d 877 (1984).

134. *Id.* at 571, 472 N.E.2d at 880.

135. *Id.* at 573, 472 N.E.2d at 882.

136. 199 Conn. 524, 509 A.2d 1 (1986) (holding that probate court properly disallowed gifts for mother's estate because they were "actually available" to her).

137. *Id.* at 529, 509 A.2d at 2.

authorize the conservators' gifts, the probate court was forced to disallow them.¹³⁸ Second, the probate court disallowed the gifts because at the time of the gift, Connecticut did not follow the doctrine of substituted judgment.¹³⁹ The doctrine of substituted judgment permits the probate court to authorize gifts from a ward's estate for the sole purpose of avoiding unnecessary inheritance taxes or administrative expenses when it appears that the ward, if sane and reasonably prudent, would have made such gifts and when the gifts were made in accordance with the ward's testamentary intent.¹⁴⁰ Additionally, the effect of the probate court's disallowance of the gifts under Connecticut law was to impose personal responsibility on the conservators for the return of the unauthorized gifts to the estate.¹⁴¹

Marcus raises interesting questions for estate planners. For instance, planners must determine how broad a conservator's powers are in their state and whether their state follows the doctrine of substituted judgment. Similarly, planners must understand the potential impact that a probate court's decision might have on predecision acts of the conservator in their state.

In summary, excess income cannot be transferred or given as a gift to qualify for Medicaid benefits. If such a transfer occurs *within* a specified time before the transferor's application for Medicaid benefits, a presumption will be raised that the transfer was made to obtain Medicaid eligibility. A transferor can overcome the presumption if the transfer was made to pay a valid antecedent debt, the transferor relinquished control over the transferred funds, the excess transferred funds have been applied to medical expenses, or if the transfer was for full compensation, thus becoming payment for a valid debt due and owing. Similarly, if the transfer was made for services rendered, a significant and unreasonable time lag between performance and compensation must not exist. Transfers made in contemplation of death where the transferor lives and later applies for benefits are also likely to overcome the presumption of fraud.

A transferor will be unable to overcome the presumption of fraud if the transfer is for less than full compensation or if the transferee neither expected nor requested repayment. Likewise, a transferor will be ineligible for Medicaid if a transferee applies transferred funds to the transferor's medical expenses, but applies less than an amount necessary to eliminate all excess income. Also, retaining control over transferred funds tends to turn those funds into income available for the payment

138. *Id.* at 527, 509 A.2d at 4.

139. *Id.* at 528, 509 A.2d at 4.

140. *Id.* at 530, 509 A.2d at 4. *See also* UNIF. PROBATE CODE § 5-408 (1977).

141. *Marcus*, 199 Conn. at 524, 509 A.2d at 5.

of medical expenses. Additionally, conservators who transfer or make gifts of estate funds in states that grant limited powers to conservators or that decline to follow the doctrine of substituted judgment are not likely to obtain Medicaid benefits for the ward.

8. *The Medicare Catastrophic Coverage Act of 1988 (MCCA).*— In 1988, Congress amended portions of the Medicaid statute, thereby affecting Medicaid financial eligibility requirements.¹⁴² These amendments only apply when an institutionalized spouse is married to a spouse in the community (the community spouse).¹⁴³ They also contain separate provisions regarding income and assets.¹⁴⁴ Thus, the new amendments should be of concern to couples facing an anticipated or potential institutionalization of one of the spouses.¹⁴⁵

The MCCA income provisions became effective September 30, 1989, and apply to individuals institutionalized on or after that date, including institutionalized individuals currently receiving Medicaid.¹⁴⁶ The income provisions provide that except for the potential attribution of joint income, none of the community spouse's income is deemed available to the spouse during any month in which that spouse is in an institution.¹⁴⁷ Yet, whether money held in a savings account in the community spouse's name will remain income unavailable to the Medicaid applicant is unclear.¹⁴⁸

The MCCA sets forth attribution rules for two types of income: nontrust income and income without an instrument establishing ownership.¹⁴⁹ With respect to nontrust income, the "name-on-the-check" rule

142. The Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 748 [hereinafter MCCA].

143. *Id.*

144. *Id.*

145. Under the MCCA, an institutionalized spouse is defined as:

an individual who (A) is in a medical institution or nursing facility or who (at the option of the State) is described in § 1902(a)(10)(A)(ii)(VI), and (B) is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

42 U.S.C. § 1396r-5(h)(1)(A) (1988). The term "community spouse" remains unchanged, and means the spouse of an institutionalized spouse. *Id.* § 1396r-5(h)(2).

146. *Id.* § 1396r-5(b)(2)(A)(ii).

147. *Id.* § 1396r-5.

148. Income held in a *joint* savings account will generally be classified as income available to the Medicaid applicant. Upon creation of a joint account, the joint tenants are presumed to be one-half owners of the deposited funds. The presumption is effective upon creation of the account, and the burden is upon the party challenging it to rebut the presumption. See *Zagoreos v. Zagoreos*, 81 A.D.2d 890, 891, 439 N.Y.S.2d 155, 156 (1981).

149. 42 U.S.C. § 1396r-5(h)(2)(A) (1988).

applies.¹⁵⁰ Thus, income is attributed solely to the spouse in whose name the income is received.¹⁵¹ Similarly, one-half of all joint income is considered available to each spouse.¹⁵² Likewise, any income made payable to both spouses and to any other person is considered available to each spouse in proportion to the spouse's interest.¹⁵³ Regarding any income a couple receives that is not made payable to any particular person, one-half of such income is considered available to both the institutionalized spouse and the community spouse.¹⁵⁴ These income attribution rules apply regardless of any state community property or marital division laws,¹⁵⁵ and are rebuttable if an institutionalized spouse can establish by a preponderance of the evidence that his or her ownership interests differ from the provisions.¹⁵⁶

The MCCA also provides that when possible, the community spouse is to receive income of at least: (1) 122% of the federal poverty level for a couple effective September 30, 1989; (2) 133% of the federal poverty level for a couple effective July 1, 1991; or (3) 150% of the federal poverty level for a couple effective July 1, 1992.¹⁵⁷ Community spouses may also be entitled to an excess shelter allowance.¹⁵⁸ Additionally, a community spouse is entitled, subject to adjustment, to a monthly maintenance allowance from the institutionalized spouse of not more than \$1,500 per month if the money is needed to permit the community spouse to maintain the level of income he or she is to receive.¹⁵⁹

The MCCA also requires states to honor court orders for support of the community spouse, and these court orders are not subject to the monthly maintenance allowance limit of \$1,500.¹⁶⁰ The amount of money that a court orders for spousal maintenance, however, will not be deducted from a medically needy applicant's total income.¹⁶¹ In *Clark v. Commissioner of Income Maintenance*,¹⁶² the plaintiff applied to the probate court for a monthly allowance from her husband's estate. The probate court granted her a monthly allowance exceeding her request,

150. *See id.* § 1396r-5(b)(2)(A)(i).

151. *Id.*

152. *Id.* § 1396r-5(b)(2)(A)(ii).

153. *Id.* § 1396r-5(b)(2)(A)(iii).

154. *Id.* § 1396r-5(b)(2)(A)(ii).

155. *Id.* § 1396r-5(c)(2).

156. *Id.* § 1396r-5(b)(2)(D).

157. *Id.* § 1396r-5(d)(3)(B)(i)-(iii).

158. *Id.* § 1396r-5(d)(4).

159. *Id.* § 1396r-5(d)(3)(C).

160. *Id.* § 1396r-5(d)(5).

161. *See infra* note 164 and accompanying text.

162. 209 Conn. 390, 551 A.2d 729 (1988).

but did not deduct this amount from the computation of her husband's available income. The plaintiff appealed the probate court's determination, arguing that the monthly allowance was not "available" to the husband because the court order obligated the husband to pay the amount to a third party. The trial court ruled for the plaintiff, and the state appealed.

The Connecticut Supreme Court reversed the trial court, holding that the state agency could not consider a probate court order for spousal support in determining a Medicaid applicant's eligibility for Medicaid.¹⁶³ In reaching this decision, the court noted that the applicable federal regulation specifically listed four amounts that a state agency may deduct from a medically needy applicant's total income, and that these enumerated amounts did not include court orders for spousal support.¹⁶⁴ The court concluded that because the Secretary's regulations already provided for an agency-determined spousal support exclusion, the court-ordered amount of support was properly included in the computation of the husband's available income.¹⁶⁵

C. Asset Test

1. *General provisions.*—To qualify for Medicaid, an applicant may possess only a limited amount of assets. Each participating state sets its own asset limit and determines which assets are counted toward this limit. If an applicant possesses assets exceeding the applicable asset limit, the applicant will be required to spend-down the excess income before he or she will be eligible for Medicaid.

The 1988 MCCA amendments made critical changes to the federal Medicaid statute concerning the computation of an applicant's available assets and restrictions on asset transfers.¹⁶⁶ These changes are the basis for present and future planning, and have the greatest impact on married couples when one spouse is receiving long-term institutional care in a nursing home and the other spouse remains in the community.

163. *Id.* at 397, 551 A.2d at 732-33.

164. *Id.* at 398-402, 551 A.2d at 733. A state agency may deduct the following amounts from a medically needy applicant's total income: (1) a personal needs allowance; (2) an at-home spousal allowance; (3) an at-home family allowance; and (4) medical or remedial expenses not paid by third parties. 42 C.F.R. § 435.832(c) (1990).

165. *Clark*, 209 Conn. at 404, 551 A.2d at 736. Similarly, in *Johnson v. Flanagan*, 179 Ga. App. 708, 347 S.E.2d 643 (1986), the court ruled that court-ordered alimony payments may not be deducted from the computation of a Medicaid applicant's available income.

166. The MCCA regulations apply only to those persons beginning a continuous period of institutionalization on or after September 30, 1989. 42 U.S.C. § 1396r-5(d)(3)(B)(i) (1988).

2. *Computing an Applicant's Available Assets.*—At the time of an initial Medicaid eligibility determination, the MCCA provides for a one-time computation of the nonexempt assets of both the institutionalized spouse and the community spouse.¹⁶⁷ The total fair market value of these assets is considered available to the institutionalized spouse for eligibility purposes, regardless of any state laws relating to community property or the division of marital property.¹⁶⁸ A spousal share equivalent to one-half of the total value of the combined assets is also computed at the time of the initial Medicaid eligibility determination.¹⁶⁹ During the continuous period of institutionalization and after the month in which the institutionalized spouse is determined to be eligible for Medicaid, none of the community spouse's assets are deemed available to the institutionalized spouse.¹⁷⁰

While the combined value of both spouses' assets is deemed available to the institutionalized spouse for Medicaid eligibility purposes, an exception to this rule permits the community spouse to retain a spousal share of assets worth up to \$60,000.¹⁷¹ The community spouse's assets that do not exceed the prescribed amount at the time the institutionalized spouse applies for Medicaid will not be considered to be available to the institutionalized spouse for eligibility purposes.¹⁷² Thus, under the exception, the institutionalized spouse must deplete his or her own spousal share down to the nonexempt asset limit, and the community spouse must deplete his or her spousal share down to the spousal share asset limit before the institutionalized spouse can receive Medicaid benefits.

For example, assume X and Y are an older farm couple with nonexempt assets consisting of land, machinery, buildings, and livestock totalling \$2,000,000. X is afflicted with Parkinson's Disease and will require institutionalization within a year. Under the MCCA, both X and Y are considered to have a spousal share of \$1,000,000 regardless of how the assets are divided between X and Y. X must exhaust all but \$1,600 (the nonexempt asset limit) of X's assets, and Y must exhaust all but \$60,000 before X becomes eligible for Medicaid.¹⁷³

If the total combined value of the assets is such that the spousal share is less than \$12,000, the MCCA permits the institutionalized spouse to transfer assets to the community spouse to allow the community

167. *Id.* § 1396r-5(c)(1)(A)(i).

168. *Id.* § 1396r-5(c)(2)(A).

169. *Id.* § 1396r-5(c)(1)(A)(ii).

170. *Id.* § 1396r-5(c)(4).

171. *Id.* § 1396r-5(f)(2)(A)(ii).

172. *Id.* § 1396r-5(c)(2)(B).

173. If Y subsequently acquires or inherits assets in Y's name, Y will be permitted to keep the assets and will not be required to contribute toward X's medical care.

spouse to hold at least \$12,000 in nonexempt assets.¹⁷⁴ At their discretion, participating states may permit transfers allowing the community spouse to hold up to \$60,000, but the community spouse is guaranteed a spousal asset share worth \$12,000.¹⁷⁵ Additionally, an affected person who believes that the determination of the spousal share or resource attribution is incorrect, or who believes that the community spouse resource allowance is inadequate to raise the community spouse's income to the applicable limit, may request a hearing.¹⁷⁶

3. *Asset Transfers*.—Because the cost of long-term institutional care is high, persons anticipating a need for long-term care may face a strong temptation to transfer or to give away excess assets to qualify for Medicaid benefits.¹⁷⁷ In an attempt to prevent potential Medicaid applicants from deliberately divesting themselves of excess assets in order to qualify for Medicaid benefits, participating states have enacted statutes and regulations that deny benefits to applicants who transfer assets during a specified time period with the intent of qualifying for Medicaid. Yet, because the federal government partially funds state Medicaid benefits, the applicable governing federal Medicaid laws, combined with the constitutional constraints of due process and equal protection, limit the participating states' power to regulate asset transfers.

Before 1980, a federal regulation permitted the categorically needy to transfer assets that, if retained, would have disqualified them from receiving cash assistance and hence, Medicaid benefits.¹⁷⁸ Similarly, categorically needy individuals could give away or sell assets for less than adequate consideration and remain eligible for SSI. No similar federal regulation applied to the medically needy. Rather, various state rules denied Medicaid benefits to medically needy applicants who divested themselves of assets within a specified time before applying for Medicaid. This divergence between the federal rule and state rules culminated in the Social Security Amendments of 1980, commonly known as the Boren-Long Amendment (Amendment).¹⁷⁹

The Amendment created a presumption that any asset owned by an

174. 42 U.S.C. § 1396r-5(f)(2)(A)(i) (1988).

175. *Id.* § 1396r-5(f)(1), (2).

176. *Id.* § 1396r-5(e)(2)(A).

177. To the extent that divesting occurs, the costs of the Medicaid program are increased because public funds are paying for medical expenses that could have been met from the individual's assets.

178. 20 C.F.R. § 416.1240 (1990). *See, e.g.,* Sinclair v. Department of Health & Social Servs., 77 Wis. 2d 322, 253 N.W.2d 245, 250 (1977) (categorically needy persons applying for Medicaid are not ineligible if they sell their assets within two years of their application for benefits).

179. Pub. L. No. 96-611, § 5, 94 Stat. 3567 (1980).

applicant or an applicant's spouse that was disposed of for less than its fair market value within two years of an application for SSI is included in the applicant's resources if the asset was disposed of in order to establish eligibility for SSI.¹⁸⁰ The Amendment specifies that the amount included in the applicant's resources is to be the asset's fair market value at the time of the transfer, less any compensation received.¹⁸¹ An applicant can overcome the presumption with convincing evidence that the transfer was made exclusively for a purpose other than to establish eligibility.¹⁸²

The Amendment also expressly allows state Medicaid plans to apply similar rules to Medicaid recipients, including both the categorically needy and the medically needy.¹⁸³ Additionally, the Amendment specifies that state procedures for determining Medicaid eligibility may be no more restrictive than the federally mandated SSI procedure, subject to one exception. The exception permits states to delay eligibility for more than two years if the transferred asset's fair market value at the time of the transfer less compensation received exceeds \$12,000.¹⁸⁴

The MCCA applies to transfers completed on or after July 1, 1988 and changes the prior twenty-four-month rule regarding asset transfers for less than fair market value to a thirty-month rule.¹⁸⁵ Specifically, the MCCA provides that an institutionalized Medicaid *applicant* who, at any time during the thirty-month period immediately preceding the individual's application, disposes of assets for less than fair market value is subject to a period of ineligibility.¹⁸⁶ The period of ineligibility is defined as the period of time up to thirty months that is needed to

180. *Id.* § 5(a)(c)(1), (2). For example, assets transferred in order to qualify for Medicaid are "available" to the transferor. *See Harrison v. Commissioner*, 204 Conn. 672, 529 A.2d 188, 192 (1987). Similarly, unauthorized gifts by a conservator are "available" to the ward. *See Probate of Marcus v. Department of Income Maintenance*, 199 Conn. 524, 509 A.2d 1 (1986).

181. Pub. L. No. 96-611, § 5(a)(c)(3).

182. *Id.* § 5(a)(c)(2).

183. *Id.* § 5(a)(c)(3).

184. *Id.* § 5(a)(c)(3)(b)(2).

185. 42 U.S.C. § 1396p(c)(1)(A) (1988).

186. *Id.* One may query whether the MCCA permits the *community* spouse to transfer the couple's assets for less than fair market value within 30 months of the institutionalized spouse's Medicaid application. Additionally, because assets acquired by the community spouse after the institutionalized spouse has established Medicaid eligibility will not be considered, the MCCA appears to permit asset transfers to a third party more than 30 months before the initial Medicaid application. The assets are then transferred back to the community spouse after Medicaid eligibility has been established for the institutionalized spouse. On the other hand, assets held by a child or other third party arguably would be treated as being held in constructive trust for the community spouse.

spend the uncompensated value of the transferred assets on nursing home care in the applicant's state or community.¹⁸⁷

Like the previous law, the MCCA provides that transfers of non-exempt assets occurring within the thirty-month period will be excused if a satisfactory showing is made that the applicant intended to dispose of the assets either at fair market value or for other valuable consideration, or that the assets were transferred exclusively for a purpose other than to qualify for medical assistance.¹⁸⁸ Likewise, an otherwise prohibited transfer will be set aside if the state determines that denying eligibility will cause undue hardship.¹⁸⁹ Unlike previous law, however, otherwise prohibited transfers of assets to or for the sole benefit of the community spouse will not result in the transferor-applicant's ineligibility.¹⁹⁰

For courts deciding whether an applicant is ineligible for benefits due to asset transfers or whether an applicant has excess available assets, the circumstances giving rise to the applicant's present inability to meet medical expenses are the determinative factor. Similar to the income transfer cases, important factors for a court's consideration are the transferor-applicant's knowledge at the time of the transfer that future medical assistance would be required, whether assets were transferred to a relative or a nonrelative, and the amount of consideration received for any transferred assets.¹⁹¹ Alternatively, transfers of exempt assets are not prohibited,¹⁹² but planners must recognize that the list of exempt assets varies from state to state.¹⁹³

187. *Id.* § 1396p(c)(1)(B).

188. Thus, nonexempt assets may be transferred within the 30-month period for less than fair market value without making the transferor ineligible for Medicaid benefits if the transferor can show that the assets were not transferred "in contemplation of Medicaid." *Id.* § 1396p(c)(2)(C).

189. *Id.* § 1396p(c)(2)(C), (D).

190. *Id.* § 1396p(b)(c)(2)(B).

191. *Id.*

192. *See, e.g.,* *Beltran v. Myers*, 677 F.2d 1317 (9th Cir. 1982); *Brown v. Toia*, 59 A.D.2d 1044, 399 N.Y.S.2d 796 (1978) (applicant who transferred home to children without consideration is eligible for Medicaid).

193. Planners must also note that the proceeds from the sale of exempt assets may be included in the computation of a Medicaid applicant's available income. For example, the court in *Moran v. Lascaris*, 61 A.D.2d 405, 402 N.Y.S.2d 486 (1978) held that the proceeds from the sale of an exempt homestead, when the sale is to an unrelated third party for valuable consideration, constitutes an available resource relevant to the recipient's continued medical assistance eligibility. Similarly, in *McManus v. D'Elia*, 66 A.D.2d 783, 410 N.Y.S.2d 655 (1978), the petitioner conveyed her home to a third party for \$30,000. While the court noted that other courts have held that a transfer made to satisfy an antecedent debt owing to the grantee rebuts the presumption that the transfer was made for the purpose of qualifying for medical benefits, it also noted that the petitioner received

In *Saviola v. Toia*,¹⁹⁴ an applicant for medical assistance successfully overcame the presumption that a transfer of assets was made for the purpose of attaining eligibility. The court held that the applicant provided sufficient evidence that the transfer was made when the applicant was in good health and did not contemplate a future need for assistance.¹⁹⁵

Similarly, in *Yiotis v. D'Elia*,¹⁹⁶ the court held that the petitioner presented sufficient evidence to rebut the presumption that the \$4,200 in assets she transferred within a year of her initial application for medical assistance was for the purpose of qualifying for medical assistance.¹⁹⁷ The court noted that the testimony of the petitioner's daughter established that the transfers were for valid reasons and were founded on fair consideration.¹⁹⁸ Additionally, the expert testimony of the petitioner's physician indicated that the petitioner had no reason to believe that she was in imminent need of medical assistance or nursing home care at the time of the transfers.¹⁹⁹

In *North Shore University Hospital v. D'Elia*,²⁰⁰ an applicant for medical assistance transferred real property to a corporation in which the applicant and her husband were the sole principals. The court held that a prohibited transfer had not occurred because the applicant continued to receive the same benefits and use of the property as she had before the title transfer.²⁰¹

A third person's transfer of assets on behalf of a medical assistance applicant is unlikely to disqualify the applicant from receiving benefits if the third person acted independently in transferring the assets. In *Zybach v. Nebraska Department of Social Services*,²⁰² the son of an

the proceeds of the sale. Hence, the court held that the conversion of the homestead into cash removed the exemption and made the proceeds income available to the petitioner for medical eligibility purposes.

194. 63 A.D.2d 849, 405 N.Y.S.2d 854 (1978).

195. *Id.* at 850, 405 N.Y.S.2d at 856.

196. 76 A.D.2d 885, 428 N.Y.S.2d 714 (1980).

197. *Id.* at 885, 428 N.Y.S.2d at 715.

198. *Id.*

199. *Id.* While injuries and other physical maladies that require hospitalization and occur a significant time before an asset transfer may increase the likelihood of an individual's need for medical care, prior injuries or hospitalization must be related to present physical conditions in order to disqualify a medical assistance applicant from benefits due to a prohibited asset transfer. *See Prezioso v. Amrhein*, 154 A.D.2d 468, 545 N.Y.S.2d 939 (1989). Similarly, a medical assistance applicant need not be in perfect health at the time an asset transfer is made in order to overcome the presumption that the transfer was made for the purpose of qualifying for benefits. A serious disability may be required. *Albert v. Perales*, 156 A.D.2d 619, 620, 549 N.Y.S.2d 426, 427 (1989).

200. 79 A.D.2d 605, 433 N.Y.S.2d 495 (1980).

201. *Id.* at 606, 433 N.Y.S.2d at 496.

202. 226 Neb. 396, 411 N.W.2d 627 (1987).

applicant for medical assistance, acting as his mother's attorney-in-fact, sold his mother's farmland and distributed the proceeds among himself, his wife, and his sister. The state agency denied medical assistance benefits on the basis that the transfer violated a state statute that declared an applicant to be ineligible if the *applicant* is deprived of assets either by giving away or disposing of assets for less than fair market value for the purpose of qualifying for assistance. The district court reversed the agency's determination, and the agency appealed.

On appeal, the Nebraska Supreme Court opined that the statutory disqualifying act was the act of depriving oneself of resources "for the purpose of qualifying for assistance," and that "purpose" means an intention requiring intelligence in seeking a desired result.²⁰³ The court noted that when the applicant allegedly acted with the "purpose of qualifying for assistance," she was ninety-four years old, incompetent, and had resided in a nursing home for twelve years.²⁰⁴

Thus, the court reasoned that the applicant never had sufficient mental capacity to transfer assets with the intent and purpose of qualifying for assistance.²⁰⁵ Additionally, the court concluded that because the son did not have the implied or apparent authority to act as a principal, the applicant did not act through her son.²⁰⁶

The presumption that an applicant for medical assistance transferred assets for the purpose of qualifying for medical assistance can also be overcome if the applicant establishes that the transfers were made to avoid probate. For example, in *Meier v. State*,²⁰⁷ the petitioner deeded a one-half interest in her home to her son and daughter for one dollar. A second daughter was to receive one-third of the value of the petitioner's home. The petitioner also executed a power of attorney, authorizing her son and daughter to serve as her attorneys-in-fact. Less than four months after the conveyance, the petitioner collapsed, was hospitalized, and was thereafter transferred to a nursing home. The petitioner applied for medical assistance soon after entering the nursing home.

Although the petitioner was diagnosed as having a mild case of Parkinson's and Alzheimer's diseases approximately nine months before she collapsed, neither the petitioner nor her family were informed of the diagnoses until after she collapsed. Testimony at trial established that the petitioner transferred her home in order to be free of the responsibilities of ownership and because she wanted someone to live with her.²⁰⁸ Trial testimony also established that the petitioner's family

203. *Id.* at 403, 411 N.W.2d at 631.

204. *Id.*

205. *Id.* at 403, 411 N.W.2d at 632.

206. *Id.*

207. 227 Neb. 376, 417 N.W.2d 771 (1988).

208. In fact, one week before the petitioner's collapse, new furniture was purchased

had a history of taking care of its kin without resort to nursing homes or public assistance. Based on these findings and the fact that the petitioner's lawyer wrote that the power of attorney was executed to avoid a conservatorship, and the fact that the deed was executed to avoid probate, the court held that the petitioner had overcome the presumption that she had transferred assets in order to become eligible for medical assistance benefits.²⁰⁹

In *Rinefierd v. Blum*,²¹⁰ however, the court determined that sufficient evidence was not presented to overcome the presumption that the petitioner had transferred assets for the purpose of qualifying for medical assistance.²¹¹ In *Rinefierd*, nine months after entering a nursing home, the petitioner sold his home and distributed the proceeds to his five sons. One year later, the petitioner applied for medical assistance. The court, in upholding the state agency's denial of benefits, noted that the petitioner had an established medical need and had virtually no hope of leaving the nursing home when he sold his home.²¹²

Several courts have dealt with the issue of whether a surviving spouse's waiver of the right to take against the deceased spouse's will constitutes a prohibited transfer of assets for less than fair market value, thereby disqualifying the surviving spouse from receiving medical assistance benefits. For example, in *Bradley v. Hill*,²¹³ a surviving spouse waived her marital rights to take against her deceased husband's will. The court held that a prohibited asset transfer had occurred.²¹⁴ The court reasoned that the surviving spouse has a personal and nontransferable right to take against her husband's will, but that the surviving spouse does not enjoy this benefit unless proper application has been made with the probate court and the probate court enters appropriate orders of allowance.²¹⁵

Likewise, in *Stamer v. Estate of Wright*,²¹⁶ the court held that a surviving spouse's right to take under a deceased spouse's will does not ripen into actual ownership and possession without an order of the probate court.²¹⁷ The court also noted that although exempt property becomes the absolute property of a widow upon the death of the spouse,

for her and improvements were made to her home in preparation for her daughter to move into the home.

209. *Meier*, 227 Neb. at 384-85, 417 N.W.2d at 778.

210. 66 A.D.2d 351, 412 N.Y.S.2d 526 (1979).

211. *Id.* at 353, 412 N.Y.S.2d at 528.

212. *Id.*

213. 457 S.W.2d 212 (Mo. App. 1970).

214. *Id.* at 216.

215. *Id.* at 214.

216. 701 S.W.2d 789 (Mo. App. 1985).

217. *Id.* at 790.

title to exempt property does not vest absent an order of the probate court.²¹⁸

4. *Asset Valuation.*—At the heart of the asset test is the issue of asset valuation. Asset valuation is important not only to those individuals who transfer assets for less than fair market value during the thirty-month period, but also to persons who are trying to determine whether the value of their assets exceeds the applicable asset limit. For purposes of the asset test, the MCCA states that the proper measure of an asset's value is its fair market value.²¹⁹ Courts have defined fair market value as the price a willing buyer will pay to a willing seller, rather than the appraised value of the asset or a figure derived from a table based on the asset's appraised value.²²⁰ However, appraisals are typically used to value farmland.²²¹ Thus, a court's reluctance to use asset appraisal values as a measure of an asset's market value for Medicaid eligibility purposes may create problems for farm couples facing the potential institutionalization of one of the spouses and needing to determine, for estate planning purposes, how much value the state agency is likely to attribute to their nonexempt farmland.

In *Estate of Pearl v. Director, Missouri State Division of Welfare*,²²² the Missouri Court of Appeals held that the market value of a parcel of real estate "may be estimated according to the uses for which it is suitable, with due regard to existing or community wants."²²³ Hence, only the highest and best use to which a parcel of real estate is adaptable constitutes an element of present value.²²⁴ This opinion implies that land suited for agricultural use is to be valued according to its highest and best use as agricultural land.

218. *Id.* See also *In re Estate of Savage*, 650 S.W.2d 346, 351 (Mo. App. 1983) (holding that the statutory share that a surviving spouse may take upon renunciation of a will does not automatically vest upon the decedent's death).

219. 42 U.S.C. § 1396p(b)(c)(1) (1988). Interestingly, one court has ruled that the market value of gas lease royalties is the market value of the gas as marketed under a 20-year gas sale contract and not the current market value. See *Henry v. Ballard & Cordell Corp.*, 418 So. 2d 1334, 1338 (La. 1982).

220. *E.g.*, *Brumit v. State Dep't of Pub. Health & Welfare*, 521 S.W.2d 445 (Mo. 1975); *Davis v. State Dep't of Pub. Health & Welfare*, 483 S.W.2d 775 (Mo. 1972).

221. Appraisals are used for agricultural land because no continuous market exists that provides information about the value of a given parcel of farmland. Similarly, due to the lack of homogeneity among farmland parcels, relying on the price information from other farmland sales to make value estimates for a given farmland parcel is difficult. See W. MURRAY, D. HARRIS, G. MILLER, & W. THOMPSON, *FARM APPRAISAL* 3-21 (1983) [hereinafter *FARM APPRAISAL*].

222. 538 S.W.2d 922 (Mo. App. 1976).

223. *Id.* at 926.

224. *Id.*

Another Missouri case, *Hill v. State Department of Public Health and Welfare*,²²⁵ focused on the issue of what constitutes "fair and valuable consideration" under the Missouri statutory definition. The court held that a verbal promise to pay in the future, accompanied by sufficient part performance on the seller's behalf, satisfied the Missouri statute.²²⁶ Thus, according to the court, an unsecured oral promise to pay can be consideration approximately equal to the value of the property so long as the promisor is not insolvent and the promise to pay is enforceable.²²⁷ Planners facing a similar statutory definition of "fair and valuable consideration" may find *Hill* useful in rebuffing claims that a client who has sold farmland, but who has not yet received payment, sold the land for less than fair market value.

Perhaps an appropriate and consistent method for valuing farmland for Medicaid eligibility purposes is the market data approach. The market data approach involves a comparison of the subject property with other properties sold in the farmland market in order to estimate what the subject property would bring upon sale.²²⁸ Although the shortage of sales of comparable farmland poses a serious difficulty with the market data approach, the approach can be useful in arriving at a fair market value estimate of agricultural land when combined with other information concerning the income and cost structure of the particular parcel.²²⁹

Two recent cases, also in Missouri, concern the issue of valuing personal property subject to restraints on alienation. In *Williams v. Missouri Department of Social Services*,²³⁰ the petitioner claimed that a \$31,500 nonassignable promissory note payment, and payable at \$175 per month without interest over 180 months, lacked value because the note's nonassignability feature deprived it of *any* market value.²³¹ The court disagreed, and ruled that when a security cannot be assigned due to a legal impediment, yet still has an economic value to its owner, the finder of fact may consider "other" factors to determine value.²³²

225. 503 S.W.2d 6 (Mo. 1973).

226. *Id.* at 11 (construing Mo. REV. STAT. § 208.010.2(1)(a) (1969)).

227. *Id.* at 12.

228. The process of estimating sale value involves four steps: (1) defining the type of sale to be used; (2) selecting and analyzing nearby sales; (3) determining the comparability of the farmland sold to the subject property; and (4) adjusting value for differences in characteristics between the sale properties and subject property. FARM APPRAISAL, *supra* note 221, at 26.

229. Another interesting possibility for valuing farmland is the use of tax assessments. See *Harris v. Lukhard*, 547 F. Supp. 1015 (W.D. Va. 1982), *aff'd*, 733 F.2d 1075 (4th Cir. 1984) (approving the state's use of assessments to establish the value of a parcel of real estate for Medicaid eligibility purposes).

230. 718 S.W.2d 193 (Mo. App. 1986).

231. *Id.* at 194.

232. *Id.* at 195.

In *Wiser v. Division of Family Services*,²³³ a Missouri medical assistance applicant and her ex-husband sold a parcel of Florida real estate for \$17,000. The buyers paid \$5,000 and financed the balance with a promissory note secured by a deed of trust that specified that the buyers were to pay monthly installments of \$157. In 1986, the secured note was awarded to the claimant in a dissolution proceeding. A Missouri banker stated in a letter that the note had little or no value in Missouri, but that it might be of value in Florida, even though the note still had \$8,700 due and a discounted value of \$6,405.60.

The court rejected the banker's opinion, and determined that the note was a resource available to the petitioner because it was marketable in Florida.²³⁴ The court also opined that a review of the record showed that the note was worth more than the statutory minimum of \$999.99.²³⁵ Thus, the court upheld the trial court's denial of medical assistance benefits.²³⁶

5. *Validity of State Transfer-of-Asset Statutes.*—Estate planners and counselors for persons denied Medicaid benefits may want to consider challenging the validity of the particular state statute or regulation authorizing the denial. Many states' "transfer-of-assets" statutes have been invalidated either under the supremacy clause as contrary to controlling federal law, or under the due process clause as creating an irrebuttable presumption that a transfer of assets was made for the purpose of attaining Medicaid eligibility.

In general, a state transfer-of-assets statute will overcome a supremacy clause challenge if it is not more restrictive than the federal transfer-of-assets rule in determining asset availability.²³⁷ Likewise, in order to overcome a due process challenge, a state transfer-of-assets statute must focus on preventing asset transfers for the purpose of qualifying for assistance, and must expressly set out the requirements for overcoming the presumption that an otherwise permissible transfer was made for the purpose of attaining eligibility.²³⁸ Particular states may also be required to establish administrative hearing procedures for handling applicant appeals.²³⁹

233. 754 S.W.2d 35 (Mo. App. 1988).

234. *Id.* at 36.

235. *Id.*

236. *Id.*

237. *E.g.*, *Beltran v. Myers*, 677 F.2d 1317 (9th Cir. 1982); *Robinson v. Pratt*, 497 F. Supp. 116 (D. Mass. 1980).

238. *E.g.*, *Lavine v. Milne*, 424 U.S. 577 (1976); *Dawson v. Myers*, 622 F.2d 1304 (9th Cir. 1980).

239. *See Fabula v. Solomon*, 463 F. Supp. 830, 838 (D. Md. 1978), *rev'd sub nom.* *Fabula v. Buck*, 598 F.2d 869 (4th Cir. 1979) (state must adhere to federal requirements).

In *Deel v. Jackson*,²⁴⁰ the court upheld a Virginia transfer-of-assets rule as a reasonable means of identifying improper transfers when the rule was aimed at transfers made for the purpose of receiving benefits to which the applicant was not entitled and required applicants to provide evidence that other resources were available to meet their needs at the time of the transfer.²⁴¹ In *Deel*, the plaintiff transferred fifty-nine acres of land for less than fair market value two days before applying for AFDC benefits. The state agency denied the plaintiff's application. The plaintiff argued that the Virginia "transfer-of-assets rule violated the 'availability principle' derived from the Social Security Act, which requires that only assets currently available to an applicant may be considered in determining eligibility."²⁴²

The court reasoned that although the availability principle prevents states from denying benefits on the basis of income or resources imputed to an applicant that are not available for the applicant's use, the transfer-of-assets rule deals with applicants who owned property but who chose to give it away in order to qualify for undeserved benefits.²⁴³ Thus, the court ruled that the availability principle is not a clear-cut rule of literal availability and that its scope does not extend to the Virginia transfer-of-assets rule.²⁴⁴

In a case directly involving Virginia's Medicaid program, the district court in *Mowbray v. Kozlowski*²⁴⁵ held that Virginia's Medicaid eligibility guidelines violated the Social Security Act to the extent that they used income or resource methodologies that were more restrictive than those under the SSI program.²⁴⁶ Virginia, a section 209(b) state, established Medicaid eligibility guidelines that were more restrictive than those under SSI.²⁴⁷ For example, under SSI, property that includes or is contiguous to the actual home site is excluded from the resource computation.²⁴⁸ Under the Virginia resource methodology, however, only an applicant's home and the lot on which it stands (or one acre in rural areas) plus no more than \$5,000 worth of additional property are excluded.²⁴⁹ The plaintiffs were all low-income rural residents who owned property contiguous to their homes. The value of the contiguous property rendered

240. 862 F.2d 1079 (4th Cir. 1988), *cert. denied*, 109 S. Ct. 2434 (1989).

241. *Id.* at 1082.

242. *Id.*

243. *Id.* at 1084.

244. *Id.* at 1085.

245. 914 F.2d 593 (4th Cir. 1990).

246. *Id.* at 595.

247. *Id.*

248. 42 U.S.C. § 1382b(a)(1) (1988).

249. *Mowbray*, 914 F.2d at 595 (citing VA. CODE ANN. § 32.1-325(A)(3)).

each of the plaintiffs ineligible for Medicaid benefits under Virginia's guidelines, but would not have resulted in ineligibility under the SSI guidelines.²⁵⁰

The district court invalidated the Virginia rule on the grounds that section 303(e) of the MCCA amended section 209(b) to prevent states from utilizing standards more restrictive than the SSI standards and that were not in effect as of January 1, 1972.²⁵¹ States still have the right, however, to utilize more restrictive standards as long as they were in place before January 1, 1972.²⁵²

On appeal, the Fourth Circuit reversed the district court, and held that section 303(e) did not partially repeal section 209(b).²⁵³ Thus, Virginia's more restrictive Medicaid eligibility criteria did not violate section 303(e).²⁵⁴ The court based its holding on its belief that Congress had not spoken clearly enough to infer repeal of a prior statute allowing states to utilize more restrictive eligibility criteria.²⁵⁵ Additionally, the court gave great deference to the Secretary's interpretation of section 303(e)'s statement that state methodologies "'may be less restrictive' than SSI methodologies"²⁵⁶ and was designed to permit states to use more liberal methodologies.²⁵⁷ The court also stated that the phrase "'shall be no more restrictive'" was simply a condition on that liberality.²⁵⁸

II. ESTATE PLANNING TECHNIQUES AND CONSIDERATIONS

A. Trusts

1. *General Provisions.*—For persons who are not categorically eligible for Medicaid, the Medicaid eligibility criteria include a consideration of the applicant's assets and income. Thus, Medicaid eligibility for these persons is premised upon their inability to meet the cost of supporting themselves with funds from other sources. Special considerations arise when a Medicaid applicant is also the named beneficiary of a trust. The primary problem for courts considering this issue is deciding how to

250. *Id.* at 594.

251. Section 303(e) of the MCCA states: "The methodology to be employed in determining income and resource eligibility for individuals under subsection . . . (f) [the 209(b) option] . . . may be less restrictive, and may be no more restrictive than that under SSI." 42 U.S.C. § 1396(r)(2)(A)(i) (1988).

252. *Mowbray v. Kozlowski*, 914 F.2d 593, 596 (4th Cir. 1990).

253. *Id.* at 594.

254. *Id.*

255. *Id.*

256. *Id.* at 600.

257. *Id.* at 601.

258. *Id.*

balance a settlor's intent to prevent the invasion and ultimate depletion of trust funds against the interests of taxpayers bearing Medicaid's financial burden when the applicant could be self-supporting if the trust corpus is invaded.

As mentioned above, only nonexempt assets are counted toward an applicant's asset limit.²⁵⁹ In general, funds placed in a trust to which a Medicaid applicant is a named beneficiary are not exempt if the trust is revocable or is designed to pay the applicant's medical needs or general expenses.²⁶⁰ Similarly, any part of the trust's income or principal that an applicant has a right to obtain is counted toward the applicant's asset limit.²⁶¹

Before 1986, estate planners were able to use a discretionary trust to isolate the trust corpus from the beneficiary and to maintain the beneficiary's Medicaid eligibility.²⁶² In 1986, however, Congress amended the Medicaid statute to prevent the use of discretionary trusts to shelter assets for Medicaid eligibility purposes.²⁶³ The 1986 amendment provides that the amounts included in a "Medicaid qualifying trust" shall be considered available to the maximum extent possible, assuming that the trustee exercises the greatest possible discretion in the beneficiary's favor.²⁶⁴ The amendment defines a "Medicaid qualifying trust" as

a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.²⁶⁵

259. See *supra* notes 167-93 and accompanying text.

260. See *infra* notes 266-88 and accompanying text. The grantor's ability to revoke the trust could invite creditors to attack the trust for reimbursement.

261. The MCCA's attribution rules for trust income provide that any income to be paid to a Medicaid recipient will be considered to be income available to the recipient for Medicaid eligibility purposes. Similarly, if the trust provides for income to be paid to both an institutionalized Medicaid recipient and the recipient's at-home spouse, any income made payable to both spouses will be considered available to each spouse in proportion to the spouse's interest. 42 U.S.C. § 1396r-5(b)(2) (1988). These attribution rules for trust property, however, may be varied by specific trust language.

262. Under a truly discretionary trust, the trustee may withhold the entire trust income and principal from the beneficiary, and the beneficiary, as well as the beneficiary's creditors and assignees, cannot compel the trustee to pay over any part of the trust funds. *Lineback v. Stout*, 79 N.C. App. 292, 296, 339 S.E.2d 103, 106 (1986). Courts have almost uniformly held that a truly discretionary trust is not "available" to the applicant for Medicaid eligibility purposes. See *infra* notes 267-88 and accompanying text.

263. See 42 U.S.C. § 1396a(k)(1) (1988).

264. *Id.*

265. *Id.* § 1396a(k)(2).

2. *Testamentary Trusts*.—Although the 1986 amendment was clearly intended to proscribe the use of discretionary trusts to shelter assets for Medicaid eligibility purposes, the amendment contains several loopholes that permit estate planners to set up discretionary trusts to shelter excess assets. For example, the amendment clearly excludes testamentary trusts.²⁶⁶ Thus, a discretionary trust may be created under a will for a surviving spouse, and the trust's funds will not be considered to be resources available to the beneficiary for Medicaid eligibility purposes.

In *In re Estate of Tashjian*,²⁶⁷ the decedent executed a will designating his wife as the beneficiary and instructing the trustee, within his discretion, to expend such amount of the trust principal as the trustee determined was necessary for the beneficiary's support and maintenance. Under the terms of the trust, the beneficiary was to be paid the trust income on a regular basis. Upon determining that the trust income would not cover the beneficiary's living expenses, the trustee petitioned the trial court for a determination of whether the trust principal should be invaded for the beneficiary's benefit.

The trial court ruled that the testator had directed the trustee to pay only the trust income and that the trustee could not invade the trust corpus for the beneficiary's benefit. On appeal, the Pennsylvania Superior Court affirmed, opining that although ambiguous trust provisions should be viewed as authorizing the invasion of trust principal even when the beneficiary has access to other income sources, courts must effectuate the testator's intent.²⁶⁸ The court focused on the specific trust language granting the trustee sole discretion over the disbursement of the trust funds, and determined that the testator gave the trustee considerable discretion to withhold the trust's funds from a beneficiary with independent resources.²⁶⁹ Similarly, the court noted that the circumstances surrounding the trust's execution indicated that the testator intended the trust corpus to serve as a reserve for his wife in the event that her income from other sources proved inadequate to meet her needs.²⁷⁰

266. Under the 1986 amendment, a "Medicaid qualifying trust" is defined in part as "a trust, or similar legal device, established (*other than by will*)" *Id.* (emphasis added).

267. 375 Pa. Super. 221, 544 A.2d 67 (1988).

268. *Id.* at 226, 544 A.2d at 70.

269. *Id.* at 228-29, 544 A.2d at 71. The court also cited *Lang v. Department of Public Welfare*, 515 Pa. 428, 528 A.2d 1335 (1987), for the proposition that the fact that a will establishes a trust for the beneficiary's support does not create an irrebuttable presumption that all of the beneficiary's living expenses must be funded from the trust.

270. *Tashjian*, 375 Pa. Super. at 229, 544 A.2d at 71-72. Likewise, in *Tidrow v. Director, Missouri State Division of Family Services*, 688 S.W.2d 9 (Mo. App. 1985), one

In contrast, in *Tutino by Portela v. Perales*,²⁷¹ the court held that the State Commissioner of Social Services may require a person who is both the settlor and the beneficiary of an inter vivos trust to execute an assignment of rights to seek an allowance from the trust principal as a prerequisite to granting medical assistance.²⁷² In *Tutino*, a husband and wife established an inter vivos trust and directed the trustee to "hold, invest, and reinvest the Trust Estate, collect the income therefrom and pay and apply all of the net income to the settlors" for their foreseeable costs of living.²⁷³ Approximately six months after the trust was created, the husband died and the wife was placed in a nursing home. The trustee applied for medical assistance on behalf of the wife, and the application was denied.

In confirming the commissioner's denial of benefits, the court noted that other cases involving *testamentary* trusts that were construed as precluding an allowance from the principal were not applicable.²⁷⁴ The court reasoned that the trust was a potentially available resource because the settlor was the same person "whose medical needs prompted the application for assistance."²⁷⁵

3. *Nonspousal Trusts*.—The 1986 amendment also applies only to discretionary trusts that run between an individual and that individual's spouse.²⁷⁶ Hence, the amendment does not prohibit discretionary trusts established by a child for a parent, a parent for a child, or for any persons not in a spousal relationship.

In *Snyder v. Department of Public Welfare*,²⁷⁷ a nursing home resident's medical assistance benefits were terminated because assets of a trust established by the resident's mother were allegedly available to the resident. The court, following the general rule that the settlor's intent determines whether trust assets are an available resource to the bene-

of the reasons the court did not find the trust corpus to be a resource available to the beneficiary was because the settlor intended the trust funds to supplement rather than supplant the benefits to which the beneficiary would otherwise be entitled. As evidence of the settlor's intent, the court noted that the trust was established to support the beneficiary for the beneficiary's life and the trust corpus was not intended to be depleted in a few years.

271. 153 A.D.2d 181, 550 N.Y.S.2d 21, *appeal denied*, 76 N.Y.2d 708, 559 N.E.2d 678, 559 N.Y.S.2d 984 (1990).

272. *Id.* at 186, 550 N.Y.S.2d at 24.

273. *Id.* at 182-83, 550 N.Y.S.2d at 22.

274. *Id.* at 187, 550 N.Y.S.2d at 24.

275. *Id.* at 187, 550 N.Y.S.2d at 25. One can argue, however, that the 1986 amendment would not prohibit an irrevocable inter vivos trust in which a person deposits a sum of money in the name of another as trustee for the benefit of a third party beneficiary.

276. 42 U.S.C. § 1396a(k)(2) (1988).

277. 124 Pa. Commw. 511, 556 A.2d 31 (1989).

ficiary, set forth four factors which, if present, indicate that a settlor did not intend for the trust assets to support a beneficiary.²⁷⁸

First, the court noted that the trust was established to benefit all of the settlor's children, not just the child who became institutionalized.²⁷⁹ Second, the court noted that the trust language stating that the trustee was directed to "use as much of the net income as may be necessary . . . for the support, maintenance, and care" of the beneficiaries gave the trustee great discretion in disbursing the trust funds.²⁸⁰ Moreover, the trust instrument clearly directed the trustee to use the trust's net income for the support of the institutionalized child, and did not give the trustee discretion to distribute or accumulate income that was not necessary for the institutionalized child's care.²⁸¹ Finally, the court attached special significance to the fact that the settlor accepted the state's help in paying for the institutionalized child's health care costs.²⁸²

In *Hoelzer v. Blum*,²⁸³ a testamentary trust established by a parent for a child contained a provision authorizing the trustee to distribute the trust's principal only if the beneficiary died or an "emergency" arose. The state agency denied the beneficiary's application for medical assistance on the authority of a state statute empowering courts to invade the corpus of a trust established for the maintenance, support, or education of an income beneficiary absent authority in the trust instrument.

On appeal, the court reversed the agency's denial of benefits.²⁸⁴ Not only did the statute not apply,²⁸⁵ the court opined, but the beneficiary's need for medical assistance was not an "emergency" mandating invasion of the trust corpus.²⁸⁶ The court noted that the beneficiary had been disabled since birth, had been cared for in the family home for forty-four years before her father's death, and the settlor had made a specific provision in the trust for the beneficiary to be placed in a home with

278. *Id.* at 515, 556 A.2d at 33-34.

279. *Id.* at 515, 556 A.2d at 34. In *Stoudt v. Department of Public Welfare*, 76 Pa. Commw. 576, 464 A.2d 665 (1983), the court held that the funds in a trust established by a parent for a child were resources available to the child because the child was the sole beneficiary of the trust.

280. *Snyder*, 124 Pa. Commw. at 516, 556 A.2d at 32-33. Similarly, in *Chenot v. Bordeleau*, 561 A.2d 891 (R.I. 1989), the court held that because the trustee was not required to provide any specific support to the child, funds in a trust established by a parent for a child were available to the child in determining the child's eligibility for medical assistance benefits.

281. *Snyder*, 124 Pa. Commw. at 517, 556 A.2d at 34.

282. *Id.* at 516, 556 A.2d at 34.

283. 93 A.D.2d 605, 462 N.Y.S.2d 684 (1983).

284. *Id.* at 609, 462 N.Y.S.2d at 690.

285. *Id.* at 611, 462 N.Y.S.2d at 688.

286. *Id.* at 614, 462 N.Y.S.2d at 689-90.

the trust *income* to go to the home.²⁸⁷ From these facts, the court reasoned that the settlor clearly did not intend nursing home care to be an "emergency" requiring the trustee to invade the trust corpus.²⁸⁸

4. *Estate Planning Considerations.*—A discretionary trust can be an extremely useful and practical device for isolating otherwise nonexempt assets in order to maintain the beneficiary's eligibility for Medicaid. Discretionary trusts, however, must be structured in accordance with certain guidelines in order to ensure protection of the trust corpus from creditors and to ensure the elimination of nonexempt assets from the computation of a beneficiary's available assets. For example, the trust terms should specifically state that the trust's purpose is to provide assistance to the beneficiary in addition to any public assistance benefits including but not limited to Medicaid. Although courts will examine the circumstances surrounding the trust's creation in order to determine the settlor's intent, they may find that the settlor intended the trust to supplement other available benefits.²⁸⁹ Specific trust language can make the settlor's intent clear and eliminate the possibility of an adverse decision.

Similarly, as was the situation in the cases in which the court ruled that the trust corpus was unavailable to the beneficiary for Medicaid eligibility purposes, the trust provisions should clearly prohibit the beneficiary from demanding either the trust corpus or income. The trustee should be given full discretion over the distribution of the trust income and the corpus.

As previously mentioned, any trust income that the trustee pays to the beneficiary will be considered income available for Medicaid eligibility purposes.²⁹⁰ Thus, the trust provisions should limit the amount of trust income that the trustee disburses to the beneficiary to an amount less than the applicable income eligibility limit.

Finally, the trust provisions should avoid language that places limitations on the trustee's discretionary powers. Mandatory language *must* be avoided. The trustee must be granted complete and uncontrolled discretion to allocate the trust funds when the trustee deems allocations necessary. When a trustee has complete discretion, a beneficiary can only compel the trustee to distribute trust funds if the beneficiary can

287. *Id.* at 613, 462 N.Y.S.2d at 689-90.

288. *Id.* at 614, 462 N.Y.S.2d at 690.

289. *See, e.g.,* *Tidrow v. Director, Missouri State Div. of Family Servs.*, 688 S.W.2d 9, 12 (Mo. App. 1985) (father intended trust to supplement benefits); *In re Estate of Tashjian*, 375 Pa. Super 221, 229, 554 A.2d 67, 71 (1988) (testimony indicated that testator intended that the corpus serve as a reserve for widow).

290. *See supra* note 261 and accompanying text.

show that the trustee is abusing his or her discretion or acting arbitrarily or dishonestly.²⁹¹

B. Protecting the Estate from Reimbursement Claims

1. *Federal Statutory Provisions.*—Medicaid eligibility does not ensure that the recipient has successfully preserved any remaining assets for inheritance. The Medicaid statute contains provisions authorizing state agencies to recover for medical assistance benefits paid on behalf of an individual under the state Medicaid plan.²⁹² Estate planners for Medicaid applicants should take these provisions into consideration in order to preserve the largest possible amount of the estate for inheritance.

The Medicaid statute contains two provisions authorizing the recovery of Medicaid benefits paid to recipients. The first provision, commonly known as the third-party recovery provision, requires state agencies administering Medicaid programs to “take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services” available under Medicaid.²⁹³ When potential liability for payment is identified, the statute obligates the state to pursue the third party “where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery.”²⁹⁴ One court recently opined that the overriding purpose of the third-party liability provision was to benefit both the federal and state governments.²⁹⁵ Thus, the court held that a state may not seek third-party liability from the federal government.²⁹⁶

Another provision authorizing the recovery of Medicaid benefits states:

No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made except —

(A) in the case of an individual described in subsection (a)(1)(B) of this section, from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate.²⁹⁷

291. See, e.g., *Town of Randolph v. Roberts*, 346 Mass. 578, 195 N.E.2d 72 (1964).

292. See 42 U.S.C. §§ 1396(a)(25), 1396p (1988).

293. *Id.* § 1396a(a)(25)(A).

294. *Id.* § 1396a(a)(25)(B).

295. *New York State Dep't of Social Servs. v. Bowen*, 684 F. Supp. 775, 779 (E.D.N.Y. 1988).

296. *Id.*

297. 42 U.S.C. § 1396p(b)(1)(A), (B) (1988).

Recent case law has developed concerning the definition of "estate" and whether a state agency's recovery is limited to the Medicaid recipient's estate.

In *Citizens Action League v. Kizer*,²⁹⁸ plaintiffs succeeded to property that they had formerly held in joint tenancy with a Medicaid recipient. A California statute authorized the state agency to "claim against the estate of the decedent, *or against any recipient of the property of the decedent by distribution or survival*, an amount equal to the [Medi-Cal] payments received."²⁹⁹ However, the statute only discussed recoupment from a recipient's "estate." The Ninth Circuit reversed the lower court's finding that the state agency was entitled to reimbursement,³⁰⁰ and held that Congress's use of the word "estate" limited a state's recovery to property that descends to the recipient's heirs or to the beneficiaries of the recipient's will.³⁰¹ The court, in reaching its decision, noted that at common law, the term "estate" *excluded* interests in a decedent's property that were formerly held in joint tenancy.³⁰²

Perhaps even more important from an estate planning standpoint is that the court also noted that many of the plaintiffs "became joint tenants with the now deceased recipients under arrangements that Congress wanted to encourage."³⁰³ Namely, Congress wanted to encourage at-home care to be provided for a Medicaid recipient in exchange for the caregiver having "a place to live, both during the provision of care and after the recipient's death."³⁰⁴

In *In re Imburgia*,³⁰⁵ a state agency filed a reimbursement claim against the estate of a Medicaid recipient's surviving spouse. The estate's executors refused to reimburse the state agency, and argued that because the Medicaid statute only provides for reimbursement from a *recipient's* estate, recovery against a surviving spouse's estate is prohibited.

The court disagreed, and held that the Medicaid statute authorizes state agencies to claim reimbursement from the estates of responsible

298. 887 F.2d 1003 (9th Cir. 1989), *cert. denied sub nom.* Department of Health Servs. of Cal. v. Citizens Action League, 110 S. Ct. 1524 (1990).

299. *Id.* at 1005 (quoting CAL. WELF. & INST. CODE § 14009.5 (West Supp. 1989) (emphasis in original)).

300. *Id.* at 1008.

301. *Id.* at 1006.

302. *Id.* The term "estate" probably also excludes property held in tenancy by the entirety. In *In re Savage's Estate*, 650 S.W.2d 346 (Mo. App. 1983), the court held that property held in tenancy by the entirety is not subject to a lien or attachment for the debt of one tenant, and the voluntary conveyance of property to the other tenant is not fraudulent to creditors of the grantor.

303. *Citizens Action League v. Kizer*, 887 F.2d 1003, 1008 (4th Cir. 1989).

304. *Id.*

305. 127 Misc. 2d 756, 487 N.Y.S.2d 263 (1984), *aff'd*, 103 A.D.2d 658, 515 N.Y.S.2d 590 (1987).

relatives of Medicaid beneficiaries.³⁰⁶ The court, in reaching its decision, noted that the policy that precludes a Medicaid recipient's spouse from becoming impoverished during the spouse's lifetime does not apply after the spouse's death.³⁰⁷ Additionally, the court noted that the spouse's estate contained income beyond the eligibility limits.³⁰⁸

2. *State Laws*.—States may also claim reimbursement for Medicaid payments based on authority outside the Medicaid statute's scope. For example, in Maine, illegally obtained Medicaid benefits may be recovered from a decedent's estate.³⁰⁹ Similarly, a participating state may assert that a transfer of assets that did not interfere with an applicant's Medicaid eligibility should be set aside as a fraudulent conveyance under applicable provisions of the state's debtor-creditor laws.

In *Crabb v. Estate of Mager*,³¹⁰ the court held that a county department of social services may use the applicable provisions of the state's debtor-creditor law to set aside an allegedly fraudulent conveyance of a homestead in order to bring the homestead back into a former medical assistance recipient's estate.³¹¹ Although ownership of homestead property does not affect Medicaid eligibility, the presence of homestead property in the estate of a former benefit recipient may be used to reimburse the state agency.³¹²

In *Crabb*, an institutionalized medical assistance recipient transferred her home to her son without compensation, thereby removing the home from the recipient's estate. A few months before the transfer, the recipient's son executed an instrument acknowledging that upon the recipient's death, the department could file a claim for reimbursement. The court opined that the sole reason for the recipient's transfer of her home was to prevent the department from receiving reimbursement from the recipient's estate³¹³ and, citing prior case law, ruled that a fraudulent conveyance of an interest in real estate may be set aside under the state's debtor-creditor laws.³¹⁴

3. *Trusts*.—When a Medicaid recipient who is also a trust beneficiary dies, a state Medicaid agency may claim reimbursement from the trust for Medicaid payments made on the beneficiary's behalf. Whether an agency succeeds in obtaining reimbursement from a trust depends

306. *Id.* at 758, 487 N.Y.S.2d at 265.

307. *Id.* at 760, 487 N.Y.S.2d at 266.

308. *Id.* at 759, 487 N.Y.S.2d at 266.

309. ME. REV. STAT. ANN. tit. 22, § 14(2-G) (1990).

310. 66 A.D.2d 20, 412 N.Y.S.2d 508 (1979).

311. *Id.* at 25, 412 N.Y.S.2d at 511.

312. *Id.* at 25, 412 N.Y.S.2d at 510.

313. *Id.* at 25, 412 N.Y.S.2d at 509.

314. *Id.* at 25, 412 N.Y.S.2d at 511.

largely upon the type of trust from which reimbursement is sought, the circumstances surrounding the creation of the trust, and the settlor's intent. An additional concern is whether a participating state has enacted a statute obligating a settlor to reimburse a state Medicaid agency for benefits paid on behalf of the trust beneficiary.

In *Department of Mental Health and Developmental Disabilities v. Phillips*,³¹⁵ a mother established an inter vivos trust for the benefit of her institutionalized child. The trust contained a spendthrift clause designed to "protect the trust income and corpus from claims of creditors or legal process."³¹⁶ The trust also named the beneficiary's two brothers as remaindermen. Due to the spendthrift provision, the trustee did not disburse any of the trust funds to compensate the defendant for medical services provided to the beneficiary. Consequently, the defendant petitioned the court for reimbursement from the trust.

The court, in holding that the defendant was not entitled to reimbursement, noted that although the trust provisions were unclear as to whether the settlor intended to establish a fund to provide the beneficiary with services to supplement state care, the circumstances surrounding the trust's creation clearly established that the settlor's intent was to provide services that the defendant was unwilling or unable to provide.³¹⁷ The court also noted that the settlor was not under a statutory obligation to reimburse the defendant for medical services provided to the beneficiary.³¹⁸

Another important aspect of *Phillips* is that the court clearly stated that in Illinois, trusts containing spendthrift or discretionary provisions are not automatically protected from reimbursement claims.³¹⁹ The court opined that the trustee's absolute discretion is "not an arbitrary one which would permit the trustee to provide no support whatsoever for the beneficiary, thereby throwing the beneficiary on the charity of others or the state."³²⁰ Thus, the court reasoned that a spendthrift trust may be considered to be a part of the beneficiary's estate.³²¹ As a result, the settlor's intent and the factors surrounding the trust's creation become even more significant in determining whether a particular trust is subject to reimbursement.³²²

315. 114 Ill. 2d 85, 500 N.E.2d 29 (1986).

316. *Id.* at 88-89, 500 N.E.2d at 31.

317. *Id.* at 94, 500 N.E.2d at 33.

318. *Id.*

319. *Id.* at 90, 500 N.E.2d at 31.

320. *Id.* at 90, 500 N.E.2d at 32 (citing *Estate of Lackman v. Department of Mental Hygiene*, 156 Cal. App. 2d 674, 320 P.2d 186 (1958)).

321. *Id.* at 90, 500 N.E.2d at 31.

322. *Id.* at 91, 500 N.E.2d at 33.

Another Illinois case decided two years after *Phillips* also involved reimbursement from a discretionary trust. In *Button v. Elmhurst National Bank*,³²³ the Illinois Court of Appeals determined that the circumstances surrounding the trust's execution did not indicate that the settlor intended the trust to provide benefits that the state agency did not provide.³²⁴ Thus, the court held that the defendant was permitted to obtain reimbursement from the trust.³²⁵

The court also noted that at the time of the trust's execution, the settlor was under a legal obligation to reimburse the defendant for medical services.³²⁶ The court also cited *Phillips* favorably for the notion that discretionary trusts may be considered to be part of a beneficiary's estate, and noted a long-standing policy permitting state agencies to seek reimbursement for their costs from recipients who can afford to pay.³²⁷ In *Button*, the court also observed that substantial assets would remain in the trust after reimbursement.³²⁸

Alternatively, in *Miller v. Department of Mental Health*,³²⁹ the court ruled that the defendant could not receive reimbursement of funds if on remand the probate court found that the trust was discretionary.³³⁰ The court held that because the beneficiary of a discretionary trust does not have an ascertainable interest in the assets of the trust, the assets cannot be subject to reimbursement.³³¹

In summary, estate planners can follow several general guidelines of trust construction to protect the trust income and corpus against reimbursement. For instance, the trust terms should clearly specify that the trust income may be used only to *supplement* public assistance benefits that the beneficiary may receive. The trust terms should also specify that the trust income may be used as a supplement to other sources until the beneficiary's death, whereupon the remainder interest passes to the remaindermen. Courts are more likely to protect the trust corpus if it will pass to a person holding a remainder interest. Similarly, creditors are likely to be less successful in receiving reimbursement from the trust corpus or other undistributed income if the remainder interest is already vested in persons or entities other than the beneficiary's estate.

323. 169 Ill. App. 3d 28, 522 N.E.2d 1368, *appeal denied*, 112 Ill. 2d 570, 530 N.E.2d 240 (1988).

324. *Id.* at 42, 522 N.E.2d at 1377.

325. *Id.* at 40, 522 N.E.2d at 1376.

326. *Id.* at 43, 522 N.E.2d at 1378.

327. *Id.* at 39, 522 N.E.2d at 1375.

328. *Id.* at 44, 522 N.E.2d at 1379.

329. 432 Mich. 426, 442 N.W.2d 617 (1989).

330. *Id.* at 437, 442 N.W.2d at 617.

331. *Id.* at 427, 442 N.W.2d at 617.

4. *Miscellaneous*.—The reimbursement issue also has surfaced in other contexts. For example, in *In re Porter*,³³² the Arkansas Supreme Court upheld a probate court's ruling that the principal of a certificate of deposit in a Medicaid beneficiary's estate was inaccessible to the guardian for reimbursement for Medicaid benefits.³³³ The Arkansas Supreme Court ruled that exclusive jurisdiction rested with the probate court.³³⁴

Similarly, in *Beltrami County v. Goodman*,³³⁵ the court ruled that funds received from a wrongful death action are available to reimburse a state agency for payment of medical assistance.³³⁶ The court, in reaching its decision, reasoned that the legislature intended to place the burden on the tortfeasor rather than the taxpayer.³³⁷

III. CONCLUSION

Americans are living longer, and an increasing number of the elderly are likely to need extended medical care in their old age. This increased need for costly long-term health care complicates estate planning. Consequently, estate maximization includes structuring the estate so that Medicaid eligibility may be established and maintained.

The federal Medicaid statute is extremely complex and contains many traps for the uninitiated planner. Estate planners must recognize and address several problem areas when formulating plans for elderly clients who are contemplating a potential need for long-term health care. First, planning must be structured to meet the Medicaid eligibility tests for an individual client in the applicable jurisdiction. Of primary concern is the transfer-of-assets and transfer-of-income regulations. Second, estate planning must be organized so that a Medicaid beneficiary's estate is protected to the greatest extent possible from creditors' claims after the recipient's death. To achieve this result, estate planners should encourage at-home care givers to hold property in joint tenancy with Medicaid benefit recipients.

Although discretionary trusts can be an effective estate planning tool for handling long-term health care needs, planners must recognize the requirements for maintaining Medicaid eligibility for their clients who are also trust beneficiaries. Similarly, estate planners should learn to

332. 765 S.W.2d 944 (1989).

333. *Id.* at 945-46.

334. *Id.* at 948.

335. 427 N.W.2d 662 (Minn. 1988).

336. *Id.* at 664.

337. *Id.* See also *In re K.S.*, 427 N.W.2d 653 (Minn. 1988).

construct trusts in a manner that effectively protects the trust corpus against reimbursement claims from medical service providers.

In general, practitioners should counsel their younger clients, especially those who have an increased potential for long-term health care, to develop a lifetime strategy of financial management. Long-term health care in old age can be financially devastating. Yet, disciplined stewardship of financial resources practiced over the course of a lifetime, coupled with an effective estate plan, can significantly lessen the financial burden of long-term health care.

