ELDER LAW DEVELOPMENTS

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BY

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ELDER LAW DEVELOPMENTS

I. Congress Passes ABLE Act.

A. Creates tax-favored accounts for disabled children and adults whose disability occurred before age 26.

B. Allows tax-favored accounts to be set up in an amount equal to the annual gift tax exclusion (currently $14,000 per donee per year).

1. Beneficiaries are restricted to one account, but anyone can contribute to that account. If an ABLE account is established for a designated beneficiary, then no account established later for that beneficiary is treated as an ABLE account. IRC § 529A(c)(4).

2. Modeled after Section 529 savings accounts.

3. ABLE programs must be implemented by States.

4. Assets in an ABLE account, and distributions from the account for qualified disability expenses, are disregarded when determining the qualified beneficiary's eligibility for most federally means-tested benefits.

a. Acronym stands for "Achieving a Better Life Experience," which contemplates using funds for the costs of treating the disability, or for education, housing and health care.

b. For SSI (Supplemental Security Income) purposes, only the first $100,000 in each ABLE account is disregarded.

c. States must set up programs for families to invest in the new "529A accounts," which will allow certain investment options.

d. ABLE Act took effect at the beginning of 2015.

5. Section 102 of the ABLE Act allows each state to establish and operate an ABLE program.

a. An ABLE account may be set up for any eligible State resident, who will generally be the only person who can take distributions from the account.

b. Contributions may be made by any person and are not tax deductible.

c. Income earned by the accounts is not taxed.

d. Any designated beneficiary may, directly or indirectly, direct the investment of any contributions to the program (or any earnings thereon) no more than twice in any calendar year. IRC § 529A(b)(4).

e. The account may not be used as security for a loan.

f. Distributions, including portions attributable to investment earnings generated by the account, to an eligible individual for qualified expenses, will not be taxable.

g. Distributions used for non-qualified expenses will be subject to income tax on the portion of such distributions attributable to earnings from the account, plus a ten percent (10%) penalty on such portion.

h. Upon the death of an eligible individual, any amounts remaining in the account (after Medicaid reimbursement) must be distributed to the deceased beneficiary's estate or to a designated beneficiary, and will be subject to income tax on the investment earnings, but not subject to the penalty.

6. Each individual may have only one ABLE account.

a. Total contributions by all individuals to any one ABLE account may not exceed the $14,000 gift tax annual exclusion amount (which is indexed and adjusted annually for inflation).

(1) Contributions may be in cash only and not in kind.

(2) Unlike 529 college savings plans, ***total*** contributions in a single year from any and all sources and all contributors combined are limited to the annual gift tax exclusion amount (currently $14,000 per year).

(3) Similar to 529 college savings plans, the maximum contribution limit is reduced to $0 (i.e., no more contributions can be made) once the account balance exceeds the *state-based maximum funding amount* (the account balance inside the 529 A plan can continue to grow beyond that point).

(4) Excess contributions above the applicable annual limit are subject to a six percent excess contributions penalty if not corrected in a timely manner.

b. Aggregate contributions are subject to the State's limit for education-related Section 529 accounts.

c. ABLE accounts can be rolled over only into another ABLE account to the same individual or into an ABLE account for a sibling who is also an eligible individual.

d. When an ABLE account is established, the qualified ABLE program must notify the IRS.

7. Eligible individuals must be severely disabled before turning age 26 based on severe functional limitations or the receipt of benefits under SSI or disability insurance (DI) programs.

   a. However, an individual is not required to be receiving SSI or DI to open or maintain an ABLE account, nor does the ownership of an account confirm eligibility for those programs.

      (1) An individual may be an “eligible individual” for a tax year if a disability certification for the individual has been filed with the IRS for the tax year.

      (2) A “disability certification” is a certification made by the eligible individual or the eligible individual’s parent or guardian to the IRS’s satisfaction. IRC § 529A(e)(2)(A).

      (3) It must certify that the individual (i) has a medically determinable physical or mental impairment that results in marked and severe functional limitations that can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months, or (ii) is blind, within the meaning of Section 1642(a)(2) of the Social Security Act (42 USC 1382c(a)(2).

      (4) The disability or blindness must have occurred before the date on which the individual reached age 26. IRC § 529A(e)(2)(A)(i)(ii).

b. Under current law, individuals with only very limited financial resources are eligible for traditional means-tested benefit programs, such as food stamps, housing assistance, Medicaid, and SSI.

(1) The SSI program limits eligibility to individuals with no more than $2,000 in cash, retirement savings, and other countable resources.

(2) Medicaid also imposes similar resource limitations with some differences. However, states are generally required to recover benefit costs from an individual or his or her estate after death.

(3) Certain parties have authority to establish a “special needs” trust for a disabled individual, using the disabled individual’s assets, which would be exempt from the SSI and Medicaid resource tests, but the Medicaid rules require that any remaining amounts be used for Medicaid reimbursement (i.e., “pay back”) after the Medicaid recipient’s death. The investment earnings of those trusts are taxable under the current law.

(4) If a third party, such as a parent, grandparent, or other family member, establishes a so-called “third-party special needs trust,” as long as the trust is administered properly, neither the trust nor the use of the funds will necessarily impact the SSI or Medicaid recipient’s benefits and there will be no “pay back” required following the Medicaid recipient’s death.

8. Comparing 529 ABLE accounts to third party SNTs.

a. A 529 ABLE account is very similar to the so-called “(d)(4)(A)” special needs trust established as a “self-settled” trust using the disabled beneficiary’s own resources.

b. On the other hand, SNTs created and funded by a third party, e.g., the disabled beneficiary’s parents or others, are generally *not* subject to a Medicaid payback provision.

c. Consequently, a 529 ABLE account funded by a third party would be less advantageous than a third party SNT because of the Medicaid payback requirement.

(1) In addition, a third party SNT is not limited in annual contributions or total value.

(2) Third party SNT is not subject to unfavorable tax treatment if used for other purposes.

(3) Third party SNT does not have an age limitation tied to the age of the beneficiary at the onset of disability.

(4) One advantage of the 529 ABLE account is that it enjoys tax free growth (as long as used for qualified expenses), while a third party SNT would be subject to income taxation at compressed trust tax rates.

(5) Trusts are taxed at the maximum 39.6 percent rate beginning at $12,300 of income in 2015.

(6) This is ameliorated by the higher personal exemptions available for a qualified disability trust.

(7) An ABLE account will also avoid the drafting costs of establishing a properly written SNT as well as ongoing tax return preparation costs, etc.

C. No states have yet created any Qualified ABLE Programs, and it will take some time to do so.

1. It will take some time for regulations and guidance to be issued.

2. States must decide whether to take action and separately create the new account type.

3. Some states may decide that it is not worth the administrative costs to offer their own plans given the economic circumstances of that state.

4. As noted, the ABLE Act exempts the first $100,000 in an ABLE account balance from being counted toward the SSI program's $2,000 individual resource limit.

a. Please note that account distributions for "food and shelter expenses" could impact the SSI benefit because of the treatment of such expenditures as "in-kind" income, subject to the SSI limitation.

b. If the balance of an individual's ABLE account exceeds $102,000, the individual would be suspended from eligibility for SSI benefits but would remain eligible for Medicaid.

c. States may recoup Medicaid expense upon the death of the individual from the ABLE account.

5. The term "qualified disability expenses" means any expenses related to the individual's blindness or disability that are made for the benefit of an eligible individual who is the designated beneficiary. IRC § 529A(e)(5).

a. These would include education; housing; transportation; employment training and support; assistive technology and personal support services; health; prevention and wellness; financial management and administrative services; legal fees; expenses for oversight and monitoring; funeral and burial expenses; and other expenses that are approved under IRS regulations and consistent with the purposes of IRC § 529A. IRC § 529A(e)(5).

b. Exhibit "A" includes the portion of H.R. 5771 pertaining to qualified ABLE programs.

c. No later than six months after December 19, 2014, the IRS is directed to develop regulations or other guidance providing the information that must be presented to open an ABLE account.

(1) The IRS issued proposed rules on June 22, 2015, which can be found at http://www.gpo.gov/fdsys/pkg/FR-2015-06-22/pdf/2015-15280.pdf.

(2) Comments can be made until September 21, 2015.

II. Special Needs Fairness Act of 2015.

A. S.49 was passed on June 24, 2015 by the Senate Committee on Finance and was reported favorably without amendment.

B. It is a simple amendment to § 1917(b)(4)(A) of the Social Security Act [42 USC 1396t(v)(4)(A)] to allow an individual, as well as a parent, grandparent, legal guardian or a court having jurisdiction, to establish a self-settled special needs trust.

C. Currently, a so-called “(d)(4)(A) trust” or “under age 65 trust” can only be established using the assets of the individual eligible for SSI and Medicaid by a parent, grandparent, legal guardian or the court.

D. So-called “(d)(4)(B) trusts”, also called “Miller trusts” and “qualified income trusts”, can be established by an individual by himself or herself, as can a pooled trust sub-account under § 1917(d)(4)(C) (a so-called “pooled trust” or “non-profit corporation special needs trust”).

III. Indiana Enlarges Long Term Care Partnership Program Protection.

A. HEA 1341 was signed into law on May 4, 2015, which extends immediately the protection provided by long term care partnership program policies to include the assets of a spouse and not just the assets under the name of the insured.

1. This corrects a problem under current State policy and as contained in IHCPPM 2615.25.15.

2. Previously the disregard only applied to resources owned by the insured individual and not to the resources owned by the spouse.

B. Currently, IC 12-15-39.6-10 provides an asset disregard on a dollar-for-dollar basis equal to the benefits provided by a long term care insurance policy which does not pay benefits equal to the State-set dollar amount, or disregards the total value of all assets of an individual who is the beneficiary of a qualified long term care insurance policy that provides maximum benefits at the time of purchase equal to at least the amount of the State-set dollar amount then in effect.

1. A policy which provides a benefit equal to at least the State-set dollar amount must include a provision under which the daily benefit increases by at least five percent (5%) per year, compounded annually.

2. The policy must meet all other requirements under Indiana law applicable to a qualified long term care insurance policy.

C. The Medicaid Program under IC 12-15-3 is now required to make an asset disregard adjustment for not only an individual who purchases a qualified long term care insurance policy, but also the assets owned by the individual's spouse which will be included in the individual's eligibility determination.

1. The asset disregard is available after the benefits of the long term care policy have been applied to the cost of long term care.

2. HEA 1341 does not change the other requirements applicable to a qualified long term care insurance policy.

3. Attached as Exhibit "B" is a copy of the chart listing the applicable State-set dollar amounts published online by the Indiana Long Term Care Partnership Program.

4. If a Partnership Program policy was purchased in 2001 and provided a State-set dollar amount of benefit equal to at least $162,068, then once the total benefits were paid out under that policy (which would be paid out at the rate in effect after applying the annual dollar benefit cost of living increase), the individual would then be eligible for Medicaid and all of the individual's and his or her spouse's assets will be protected.

IV. Healthy Indiana Plan 2.0.

A. The original Healthy Indiana Plan (HIP) was a demonstration waiver program designed for persons without other health insurance coverage.

1. Program began January 1, 2008.

2. Beginning February 1, 2015, HIP 2.0 was initiated when the U.S. Department of Health and Human Services accepted the new program.

B. HIP 2.0 is the Medicaid expansion vehicle for Indiana.

1. Authorized by IC 12-15-44.2 (referred to as the "Indiana Check Up Plan").

2. FSSA refers to it as HIP 2.0.

3. Regulations are found at 405 IAC 9-4.

a. The emergency rule for HIP 2.0 was published at www.in.gov/legislative/iac/20150204-IR-405150038ERA.xml.pdf.

b. The new proposed rule for HIP was published on March 23, 2015 at 405 IAC 10.

c. See www.in.gov/fssa/hip/index.htm for more information.

C. HIP requirements.

1. Must be between 19 and 65 years of age.

2. Must be an Indiana resident.

3. Must have income of not more than 138% of the Federal Poverty Level (FPL) for the individual's family size.

4. Must not be eligible for Medicare or other Medicaid categories, and not have health insurance coverage through the individual's employer.

5. There is no asset (resource) test for HIP.

6. Recipients contribute to POWER (Personal Wellness and Responsibility) Accounts modeled after Health Savings Accounts (HSAs).

7. The program encourages recipients to have "skin in the game."

8. Recipients contribute based on their income.

9. Persons with POWER Accounts have HIP Plus benefits.

10. Persons with income below 100% FPL who do not make POWER Account contributions receive the Basic HIP Plan (fewer services, co-payments for some services, etc.).

11. Persons with income above 100% FPL must make POWER Account contributions to receive HIP coverage.

D. The HIP State plan is available for low income parents and caretakers, 19 and 20 year old low income persons, and persons with serious and complex medical conditions deemed to be “medically frail.”

1. They receive full Medicaid services in addition to regular HIP services.

a. HIP State Plan-Plus is received by those persons making POWER Account contributions.

b. HIP State Plan-Basic is received by persons with income under 100% FPL who do not make POWER Account contributions.

2. HIP services are more limited than under Medicaid and services are managed by managed care entities.

E. Governor Mike Pence’s push to implement HIP 2.0 distinguishes him from some governors such as Nikki Haley of South Carolina and Bobby Jindal of Louisiana who not only opposed Obamacare, but refused to expand Medicaid.

1. HIP 2.0 is expected to expand coverage to between 350,000 and 600,000 Hoosiers.

2. Approximately 150,000 people enrolled as of June 1, 2015.

3. Gov. Pence promoted HIP 2.0 as one of the “...solutions that are state-based.”

a. It is promoted as a program for able-bodied people.

b. It is stated that it will replace Medicaid with market-based, consumer-driven health coverage.

c. The requirement for “every participant to make a contribution” is promoted.

F. When Gov. Pence announced the HIP 2.0 proposal, he vowed “no new state spending or tax increases will be required...”.

1. It is being financed through an existing cigarette tax and a revenue stream from the POWER Accounts.

2. The Indiana Hospital Association asserted that summarily rejecting Medicaid expansion would create a funding crisis for certain “Disproportionate Share Hospitals” which serve a large number of Medicaid patients.

G. For states that opted to expand Medicaid under the Affordable Care Act, enrollment surges have created a significant concern about state budgets.

1. For more than a dozen states which opted to expand Medicaid under the ACA, enrollment surges have been significantly beyond projections, raising concerns that the added cost will strain state budgets when the federal aid is scaled back in a few years.

2. It should be noted that 30 states and the District of Columbia have expanded Medicaid, or plan to do so, to include all adults with income at or below 138 percent of the federal poverty level (currently $16,243 for an individual).

a. The federal government agreed to pay all costs for the new enrollees through 2017.

b. However, the federal government will begin lowering its share in 2017.

c. States will pay ten percent of the costs by 2020.

3. California has enrolled nearly 2.3 million people so far, almost three times more than had been anticipated.

4. Enrollment in neighboring Washington more than doubled, and Oregon's new enrollments have exceeded estimates by 73 percent.

5. In Michigan, estimated costs have shot up by 50 percent.

6. Ohio's projected costs more than doubled.

7. This could mean that the price of expanding the health care program for poor and lower income Americans could mean less money is available for other state services, including education.

a. News reports suggest that in Kentucky, enrollments during the 2014 fiscal year more than doubled the number projected, with almost 311,000 new eligible residents signing up.

b. Kentucky revised the Medicaid cost estimate from $33 million to $74 million for the 2017 fiscal year, and by 2021, those costs are projected to climb to $363 million.

c. Supporters of the expansion, including Kentucky Governor Steve Beshear, project that their states will save money in the long run because Medicaid will allow some state-run services to be eliminated and will stimulate the economy through new revenues and job creation.

V. CFPB And SEC Issue Bulletin On Diminished Capacity.

A. The Consumer Financial Protection Bureau and the Office of Investor Education and Advocacy of the Securities and Exchange Commission issued a June 2015 consumer advocacy and investor bulletin which addresses planning for diminished capacity and illness.

1. The purpose was to help investors and consumers understand the potential impact of diminished capacity and their ability to make financial decisions and to encourage investors and consumers to plan for possible diminished financial capacity before it happens.

2. The bulletin defines “diminished financial capacity” as a term “...used to describe a decline in a person’s ability to manage money and financial assets to serve his or her own best interests, including the inability to understand the consequences of investment decisions.”

3. Additional information is available at www.consumerfinance.gov.

B. Two written guides are available:

1. Managing Someone Else’s Money - Help for trustees under a revocable living trust.

2. Managing Someone Else’s Money - Help for agents under a power of attorney.

C. These advisories include tips on getting one’s documents in order, watching out for financial exploitation, suggestions on ways to help older relatives and friends with their finances, etc.

1. The CFPB Office for Older Americans is the only federal office dedicated to the financial help of Americans age 62 and over.

2. It works along with other agencies to support sound financial decision making and to prevent financial exploitation of older adults.

3. The guides were developed by the American Bar Association and are not intended to provide legal advice or serve as a substitute for obtaining legal counsel.

VI. Proposed Changes To The VA Pension Rules.

A. The Veterans Administration (VA) published comprehensive proposed rules that would impose net worth, asset transfer and income exclusions for needs-based VA benefits.

1. Changes are comprehensive and address net worth, asset transfers, medical expenses and income and deductions.

a. Refer to Federal Register RIN 2900-AO73.

b. The net worth limit will equal the maximum community spouse resource allowance under Medicaid on the effective date of the final rule. This amount would increase by the same percentage as the cost-of-living increase for Social Security benefits.

B. Other limitations.

1. Annual income would be added to a claimant's net worth as well, which is a change from existing law.

a. If the net worth limit is $119,220, and the surviving spouse's annual income limit is $7,000 and her total assets equal $117,000, adding the spouse's annual income to her assets produces a net worth of $124,000 which exceeds the net worth limit.

b. A veteran's assets are defined to include the assets of the veteran as well as the assets of his or her spouse, while a surviving spouse's assets include only the assets of the surviving spouse.

2. Ways of decreasing net worth:

a. The assets may decrease.

b. Annual income may be decreased.

c. Both may decrease.

3. Assets decrease when a veteran, surviving spouse, child or someone acting in their behalf spends their assets on basic living expenses such as food, shelter, clothing, health care or education or vocational rehabilitation.

a. Allowable exclusions of income will be applied first to decrease annual income.

b. If there are additional expenses that are appropriate to deduct from income, those expenses may be used to reduce assets.

4. Exclusions from the definition of "assets."

a. Primary residence remains excluded, and if so, the proceeds will not count if used to purchase another residence within the same calendar year.

b. If claimant is not residing in the primary residence, it would still be included.

c. Mortgages on the primary residence will not reduce the value of other assets.

d. Personal effects both suitable to and consistent with a reasonable mode of life will be excluded from total asset value.

5. Asset transfers and penalty periods.

   a. These are set out at Proposed Rule 38 CFR §3.276.

   b. Only those “covered” assets that are transferred will be subject to a penalty.

      (1) A “covered” asset is defined as an asset that “was part of a claimant’s net worth, was transferred for less than fair market value, and if not transferred, would have cause or partially caused the claimant’s net worth to exceed the net worth limit...”.

      (2) Therefore, only the amount transferred in excess of the net worth provisions will be subject to a penalty.

   c. A transfer for less than fair market value includes the sale, gift or exchange of an asset for less than the fair market value, or the transfer to a trust or purchase of any financial instrument that reduces the net worth and the total would not be in the claimant’s financial interest but for the claimant’s attempt to qualify for VA pension”, including the purchase of an annuity.

6. The look-back period for all transfers is 36 months preceding the date the VA receives an original pension claim or a new pension claim after a period of non-entitlement.

   a. There is a presumption that an asset transfer made during the 36 month look-back period was for the purpose of decreasing net worth in order to qualify for pension.

b. There is an exception for a transfer by a veteran, the veteran's spouse, or the surviving spouse of a veteran to a trust established on behalf of a child if the VA has rated the child incapable of self support pursuant to 38 CFR §3.36 **AND** there is no circumstance where the trust assets can benefit the veteran, the veteran's spouse or the veteran's surviving spouse.

7. There is a ten year limit on the penalty imposed.

a. To calculate the penalty, the maximum annual pension rate or pension with an aid & attendance allowance will be used for veterans and surviving spouses who apply.

b. A single veteran would use the aid & attendance allowance amount with no dependants, a married veteran would use the aid & attendance allowance with one dependant, and a surviving spouse would use an aid & attendance allowance amount from the death pension table.

c. The monthly rate is figured by dividing the maximum annual amount by 12 and rounding down to the nearest whole dollar.

d. The penalty begins the first day of the month following the transfer.

e. If more than one transfer is made, the penalty begins the first day of the month following the last asset transfer.

VII. Temporary Guardian - Ethical Duty.

A. The Indiana Commission on Judicial Qualifications issued an advisory opinion on April 23, 2015 addressing circumstances when a temporary guardianship may be issued without notice to the required parties.

1. The Opinion concerns the Code of Judicial Conduct.

2. The views of the Commission are not necessarily those of a majority of the Indiana Supreme Court, which ultimately decides judicial disciplinary issues.

B. The Commission had received a number of ethical complaints alleging that judges have granted *ex parte* petitions for temporary guardianship when the "irreparable harm" alleged as a factual basis for the petition is neither exigent nor irreversible.

1. The Commission wanted to again impress upon Indiana judicial officers the importance of abiding by the attempted notice and proof requirements contained within Trial Rule 65(B).

2. The opinion also addresses attorney behavior.

a. If an attorney solicits a judge to grant an emergency petition for temporary guardianship without alleging sufficient facts and proof of the efforts to notify the other party (or the reason supporting why the notice should not be mandated) as required by Trial Rule 65(B)(1) and (2), the attorney may be in violation of the Rules of Professional Conduct.

b. The advisory opinion is attached as Exhibit "C".

c. The judge's knowledge of this potential violation may require a confidential report to the Attorney Disciplinary Commission under Rule 2.15 of the Code of Judicial Conduct.

VIII. *In The Matter of John M. Joyce*, 9 N.E.3d 142 (Ind. App. 2014).

A. United Financial Systems Corporation ("UFSC) was an insurance marketing agency that provided estate planning services advertised to avoid probate.

1. Joyce provided legal services to UFSC customers.

2. Prospective customers who responded to UFSC's solicitations dealt with non-lawyer sales representatives who were not directly supervised by Joyce.

B. Joyce typically spoke with clients but rarely made recommendations not suggested by UFSC.

1. Legal documents may also have been provided originally by UFSC.

2. After completion of the estate plan documents, Joyce sent the documents to UFSC, where a sales representative assisted the clients in executing them.

C. UFSC paid Joyce a small portion of the total fee collected from a client's purchase of an estate plan.

D. UFSC earlier was found to have engaged in the unauthorized practice of law and Joyce was a named defendant in that case. The Court had held in 2010 that UFSC engaged in the unauthorized practice of law for several years.

E. *See State ex rel. Indiana State Bar Assn'n v. United Financial Systems Corp*., 926 N.E.2d 8 (Ind. 2010).

F. Joyce had no prior disciplinary history.

1. Joyce was found to have violated the Indiana Professional Conduct Rules prohibiting the following misconduct:

a. 1.4(a)(2): Failure to reasonably consult with a client about the means by which the client's objectives are to be accomplished.

b. 1.8(f): Improperly accepting compensation for representing a client from one other than the client.

c. 5.4(a): Improperly sharing legal fees with a non-lawyer.

d. 5.4(c): Permitting a person who recommends, employs or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services.

e. 5.5(a): Assisting in the unauthorized practice of law.

f. 7.3(e): (2009) Improperly accepting referrals from a lawyer referral service.

2. The Court imposed a suspension for 180 days without automatic reinstatement.

IX. Florida Bars Non-Lawyers From Engaging In Medicaid Planning.

A. In *The Florida Bar re: Advisory Opinion - Medicaid Planning Activities By Non-Lawyers* (Fla., No. SC14-211, Jan. 15, 2015), the Florida Supreme Court ruled that non-lawyers who engage in various Medicaid planning activities are engaging in the unlicensed practice of law.

1. A copy of the advisory opinion is attached as Exhibit "D".

2. Contrast this Florida advisory opinion to *In The Matter of John M. Joyce* referenced above.

B. The court's ruling embraces a proposed advisory opinion of the Florida Bar.

1. The Elder Law Section had asked the Bar to consider whether it constitutes the unlicensed practice of law for a non-lawyer to engage in three Medicaid planning activities leading up to the Medicaid application; the drafting of personal service contracts; the preparation and execution of

Qualified Income Trusts; or the rendering legal advice regarding the implementation of Florida law to obtain Medicaid benefits.

2. After considering the resulting proposed opinion and the briefs of interested parties, the Supreme Court of Florida directed the Florida Bar's Standing Committee on the Unlicensed Practice of Law to revise its opinion to exempt the activities of non-lawyer staff of the Florida Department of Children and Families in relation to their duties to assist the public in the Medicaid application process.

3. The Court then approved the resulting revised opinion in total.

C. That advisory opinion concludes that non-lawyers engaging in any of the following activities constitutes the unlicensed practice of law:

1. Drafting a personal service contract.

2. Determining the need for, preparing, and executing a Qualified Income Trust, including gathering the information necessary to complete the trust.

3. Selling personal service or Qualified Income Trust forms or kits in the area of Medicaid planning;

4. Rendering legal advice regarding the implementation of Florida law to obtain Medicaid benefits, including advising an individual on the appropriate legal strategies available for spending down and restructuring assets and the need for a personal service contract or Qualified Income Trust.

5. A non-lawyer's preparation of the Medicaid application itself would not constitute the unlicensed practice of law.

D. The advisory opinion also takes aim at non-lawyer Medicaid planning companies that claim to have relationships with lawyers who draft the legal documents for the company's clients.

1. The opinion concludes that such a company would be engaged in the unlicensed practice of law unless the client establishes an independent attorney-client relationship with the attorney, payment from the client is directly to the attorney, and the initial determination that the particular legal document or Medicaid planning strategy is appropriate for the client given the client's particular factual circumstances is the determination of the attorney.

2. The opinion notes that due to a lack of regulation, "non-lawyer Medicaid planners include a disbarred Florida lawyer, an individual who lost his securities license for fraudulent practices, and a life insurance agent who was convicted of two felonies and lost his insurance license."

E. The advisory opinion states that "most of the testimony was from attorneys practicing in the area of elder law and Medicaid planning, and, by and large, reflected the opinion that a formal advisory opinion is needed to protect the public."

F. For the court's ruling and the advisory opinion it adopts, go to: http://tinyurl.com/elr-FloridaBar.

X. Enacted Legislation.

A. Delegation of Parental Authority - Health Care. Section 18 of SEA 355 signed by the Governor and effective July 1, 2015 adds "health care" to the powers that can be delegated by parents or guardians.

B. Healthcare Consent - Entity. Sections 5 to 14, 20, and 22 of SEA 355 signed by the Governor and effective July 1, 2015 allow entities to be a healthcare representative appointee under I.C. 16-36-1.

C. Power of Attorney - Accounting.

1. Section 21 of SEA 355 signed by the Governor and effective July 1, 2015 adds a new I.C. 30-5-6-4.1 which allows a past or present attorney-in-fact to provide an accounting and then seek judicial approval of the accounting cutting off later objections.

2. Notice of the hearing must be given to the persons listed in the statute with time to object.

3. The attorney-in-fact is protected from further liability except when: (1) notice is not given, (2) accounting is inadequate, or (3) fraud or misrepresentation occurs.

4. Section 22 of SEA 355 provides a new I.C. 30-5-6-4.2.

   a. If the procedure outlined above is not used, it limits actions against the attorney-in-fact from matters in the accounting to two years after the receipt of the accounting.

   b. This limitation does not apply to claims based upon (1) fraud, (2) misrepresentation, or (3) inadequate disclosure.

D. Trust - Incorporation by Reference.

1. Section 19 of SEA 255 effective July 1, 2015 adds a new section to the Trust Code, I.C. 30-4-2.1-11.1, making it clear that a trust may incorporate by reference a document already in existence at the time of the execution of the trust.

2. The language is similar to that provided for incorporation by reference in wills under the Probate Code.

XI. Recent ALJ Decision Changes FSSA Position Regarding Transfers To A Surviving Spouse's TSNT.

A. A Hearing Decision issued March 30, 2015 in one of my cases determined that the surviving spouse's failure to elect her spousal share, and the resulting receipt of assets pursuant to the decedent's last will and testament by a testamentary special needs trust (TSNT) for the benefit of the surviving spouse, gave rise to a penalizable transfer.

B. I have handled dozens of cases involving TSNTs for the benefit of a surviving spouse, and this is the first time that the FSSA asserted that position in any of my cases, and the first time that an ALJ issued an opinion on that issue in any of the cases in which I have been involved.

1. In the instant case, the Medicaid recipient was the surviving husband. The deceased wife (who died in August of 2014, and the will and first and second codicils were thereafter admitted to probate) owned the residence in which the Medicaid recipient husband lived. He was eligible for a Medicaid under a Medicaid waiver.

a. It should be noted that transfer penalties are invoked only when a Medicaid applicant or recipient becomes eligible under a Medicaid waiver or for institutional coverage.

b. Traditional Medicaid recipients, not covered under a waiver or for institutional services, are not subject to a Medicaid penalty, although the five year look-back period would apply for transfers by them which would affect their Medicaid eligibility later under either a waiver or for institutional services.

2. As noted above, after the predeceasing wife died, her self-proved last will and testament and first and second codicils were admitted to probate.

a. There was no need to commence an estate administration.

b. The residential property simply passed into the TSNT by virtue of probating the decedent's last will and testament and codicils thereto.

c. There were no other probate assets, and no non-probate assets were used to fund the TSNT (such as life insurance, property passing by means of a POD or TOD transfer, etc).

d. The only asset held by the TSNT was the residential real estate which was encumbered by a mortgage.

C. The FSSA was notified of the existence of the TSNT.

1. Following a request for additional information (a pending verifications request), information was provided regarding the assessed value of the property and the balance due under a real estate mortgage affecting the subject property.

2. The FSSA issued a notice on January 15, 2015, invoking a Medicaid penalty beginning February 1, 2015 (i.e., the month after the notice) based on an alleged transfer in the amount of $29,967.27.

3. Note that as referenced above, the predeceasing wife died in August of 2014.

4. The alleged amount of the penalizable transfer represented the statutory survivor's allowance ($25,000) plus the net assessed value of the property minus the mortgage and the $25,000 statutory survivor's allowance.

D. One of the arguments made in the appeal was that the plain language of the Indiana Administrative Code exempts the imposition of a transfer penalty when the trust involved is a "testamentary" SNT, i.e., when the SNT arises under the decedent's last will and testament.

1. 405 IAC § 2-3-1.1 provides as follows:

> (d) A transfer of assets includes any cash, liquid asset, or property that is transferred, sold, given away, or otherwise disposed of as follows:
>
> > (1) Transfer includes any total or partial divestiture of control or access, including, but not limited to, any of the following:
> >
> > . . .
> >
> > (F) Waiving the right to receive a distribution from a decedent's estate, or **failing to take action to receive** a distribution that the individual is entitled to receive by law subject to subsection (j).
>
> (j) This subsection applies to a transfer of assets that results from failure to take action to receive assets to which one is entitled to receive by law. **No penalty will be imposed if any of the following circumstances applies**:
>
> > . . .

(4) In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, **no penalty will be imposed if the deceased spouse has made other equivalent arrangements to provide for a spouse's needs**. "Other equivalent arrangements" includes, but is not limited to, a trust established for the benefit of the surviving spouse. [Emphasis added.]

2. It was pointed out that the trust was for the sole benefit of the surviving spouse during his lifetime, and was funded with assets more than equivalent to the amount the surviving spouse would have received from the deceased spouse's estate had he chose to take action to receive a distribution of her estate. It was also argued that there were many reasons why a special needs trust is a more beneficial arrangement for a surviving spouse, thus enhancing its value relative to the benefit received from making the spousal election.

E. Other arguments were raised as well.

1. The history of 405 IAC § 2-3-1.1 indicates that the purpose of the language was to provide for a supplemental needs trust.

2. The provision of 405 IAC § 2-2-1.1 (j) which imposes a transfer penalty for "failing to take action to receive a distribution that the individual is entitled to receive" is in conflict with Section 1917 of the Social Security Act as codified at 42 USC § 1396p.

3. The notice given by the FSSA imposing a transfer penalty was insufficient.

4. If a penalty is in fact to be imposed, the penalty commencement date set forth in the notice was incorrect.

5. A copy of the brief filed in support of the appeal is attached as Exhibit “E” (the exhibits filed with the appeal are not included).

F. The Notice of Hearing Decision is attached as Exhibit “F”.

1. The ALJ found that the surviving spouse would have had a right to receive the $25,000 survivor’s allowance pursuant to I.C. 29-1-4-1(a), and one-half of the value of the real estate, minus the existing mortgage, pursuant to I.C. 29-2-1(b)(1).

a. The ALJ determined that the amount deemed to have been transferred was $27,483.64, not $29,967.27, taking into account only one-half of the value of the real estate after subtracting the mortgage and the $25,000 survivor’s allowance.

b. The State had determined the uncompensated value to be $29,967.27 based on the full value of the real estate, rather than one-half, after subtracting the mortgage and the $25,000 survivor’s allowance.

c. If the surviving spouse had been a second or subsequent surviving spouse, the right of inheritance by virtue of the “elective share” would have been different.

d. Pursuant to I.C. 29-1-2-1(c), a second or other subsequent spouse who did not have children by the decedent, if the decedent left surviving a child or children or the descendants of the child or children by a previous spouse, the surviving second or subsequent

childless spouse would take only an amount equal to 25 percent of the remainder of the fair market value of the real property of the deceased spouse minus the value of the liens and encumbrances on the real property of the deceased spouse.

e. A second or subsequent childless spouse would be entitled to the same portion of the net personal estate.

f. Note that pursuant to I.C. 29-1-3-1(a), in determining the net estate of a deceased spouse for the purpose of computing the amount due to the surviving spouse electing to take against the will, the court shall consider only such property as would have passed under the laws of descent and distribution.

2. The ALJ found that the trust under the last will and testament was not an "equivalent arrangement" and an improper transfer of property occurred when the surviving spouse failed to elect the spousal share.

3. However, the ALJ determined that the penalty was calculated incorrectly, and further, the penalty began the first day of the month when the property passed into the trust upon the decedent's death (i.e., the date of the decedent's death).

a. Since the decedent died in August, the penalty began in August of 2014.

b. Consequently, the penalty had expired by the time the FSSA notice was issued and the Medicaid recipient's Medicaid eligibility was not adversely impacted.

G. I have had numerous other cases involving testamentary special needs trusts when the FSSA did not assert the position taken in the case described above.

1. Utilizing a testamentary special needs trust for the benefit of a Medicaid recipient spouse, in anticipation of the possibility that the community spouse may predecease the Medicaid recipient spouse, is still perhaps the best and most flexible planning arrangement available.

2. In cases involving planning for the community spouse after Medicaid eligibility has been determined for the Medicaid recipient spouse, it might be better for the community spouse to transfer a significant portion of the assets to an irrevocable income-only trust ("IIOT").

   a. Transfer planning by the community spouse is generally advisable after the Medicaid recipient spouse becomes eligible for Medicaid, both to protect assets for the benefit of the community spouse if he or she later requires long term care, and also to protect the assets if the community spouse actually predeceases the Medicaid recipient spouse, as happened in the instant case.

   b. As previously noted, I have had many cases involving TSNTs established by the community spouse for the benefit of the Medicaid recipient spouse, and this is the first time the FSSA asserted that the failure to assert the surviving spouse's right of election gave rise to a penalizable transfer when the assets passed to the TSNT.

3. Since it is doubtful that the spouse's right of election would apply to an irrevocable trust, it would seem less likely that the FSSA would prevail if it

took a position that the failure to assert the elective share at the time of the death of the predeceasing community spouse gave rise to an impermissible penalizable transfer.

a. A pay-on-death (POD) or transfer-on-death (TOD) transfer, being a non-probate transfer, might also work, as might a non-probate transfer to a TSNT under the terms of the community spouse's revocable living trust.

b. However, since Indiana has adopted an augmented state concept for the purpose of estate recovery, and since clearly claims can be asserted against non-probate transfers other than an irrevocable trust, a POD/TOD or revocable trust arrangement might not be effective for the purpose of avoiding the transfer penalty issue in the case of a failure to assert the elective share by the surviving Medicaid recipient spouse.

c. However, clearly claims cannot be asserted and estate recovery does not apply to an irrevocable trust, which will normally be the most advantageous planning arrangement for asset protection purposes by a surviving community spouse.

4. When the planning involves an ill spouse who has not yet been institutionalized and a well spouse to whom the assets are being transferred in anticipation of the possible need to apply for Medicaid in the future, it would still seem to be appropriate for the well spouse to execute a last will and testament containing testamentary special needs trust provisions for the benefit of the ill spouse.

a. In many instances it is not appropriate for the well spouse to transfer assets to a trust, whether revocable or irrevocable, because of the likely need to apply for Medicaid for the ill spouse within a much shorter period than the five year look-back period.

b. If the well spouse in fact predeceases the ill spouse, and all of the assets are funneled into the TSNT, then even if the FSSA did take the position that an impermissible transfer had occurred, the maximum value of that transfer would be $25,000 representing the survivor's allowance and one-half of the value of the net personal estate (assuming that the spouses have children), and only twenty-five percent of the value of the real estate would be subject to the spousal elective share if the surviving spouse is a second or subsequent childless spouse and the Medicaid recipient had children by a previous spouse. Since only approximately one-half of the assets would be deemed to have been transferred, a shorter penalty would result than if the ill spouse had received all of the assets following the death of the well spouse and then had entered into a transfer plan, thus being subject to the five year look-back and possibly resulting in a penalty based on the full value of all of the transferred assets.

c. However, it is virtually always my recommendation that after the Medicaid recipient spouse becomes eligible for Medicaid, the community spouse should establish an irrevocable income-only trust (IIOT) in order to protect assets for the community spouse

should he or she require long term care, with a “pour-back” from the IIOT to the TSNT (to assure that assets are available as a supplemental care fund for the Medicaid recipient spouse) if the community spouse actually predeceases the Medicaid recipient spouse.