Irrevocability of Special Needs Trusts: The Tangled Web That is Woven When English Feudal Law is Imported into Modern Determinations of Medicaid Eligibility
By Mary F. Radford, JD and Clarissa Bryan

Aid and Attendance Pension Benefits for Veterans and Surviving Spouses: Effective Methods to Defray Medical Expenses for Elders
By Adam J. Larson, Esq.

Reverse Mortgage Introduction
By E. Spencer Bates, Esq.

Keeping Grandma Off the Street: Can HECM Reverse Mortgages Keep More Seniors from Becoming Homeless?
By Robert T. Cannon, JD, MBA

Reverse Mortgages and the Current Financial Crisis
By Paul V. Black, Esq.

Case Note
District Court Fails to Recognize the Need for a Post-Ahlborn Hearing to Determine What Past Medical Expenses a Medicaid Beneficiary Recovered from a Tortfeasor
By Ron Landsman, Esq., CAP
ARTICLES

Irrevocability of Special Needs Trusts: The Tangled Web That is Woven
When English Feudal Law is Imported into Modern Determinations of Medicaid Eligibility

By Mary F. Radford, JD and Clarissa Bryan ................................................................. 1

Aid and Attendance Pension Benefits for Veterans and Surviving Spouses:
Effective Methods to Defray Medical Expenses for Elders

By Adam J. Larson, Esq. .................................................................................................. 37

Reverse Mortgage Introduction

By E. Spencer Bates, Esq. ............................................................................................... 65

Keeping Grandma Off the Street: Can HECM Reverse Mortgages
Keep More Seniors from Becoming Homeless?

By Robert T. Cannon, JD, MBA .................................................................................. 67

Reverse Mortgages and the Current Financial Crisis

By Paul V. Black, Esq. .................................................................................................... 87

Case Note
District Court Fails to Recognize the Need for a Post-Ahlborn Hearing
To Determine What Past Medical Expenses a Medicaid Beneficiary Recovered
From a Tortfeasor

By Ron Landsman, Esq., CAP ..................................................................................... 113
The NAELA Journal Editorial Board invites the submission of manuscripts year-round with the following guidelines:

1. For initial approval of publication you may submit a one- to two-page outline of the intended manuscript, along with a list of sources. Alternatively, you may submit your final paper for consideration.

2. NAELA Journal policy is to give priority of consideration to original work not previously published. If the proposed work has been previously published, or something very similar, please provide a copy, and explain why the NAELA Journal Editorial Board should consider re-publishing your work.

3. Please conform text to The Elements of Style, by William Strunk and E.B. White and citations to ALWD Citation Manual.

4. A table of contents will be generated from the main and subheadings in your article, so it is not required to submit a table of contents, but the heading levels should be clearly identified.

5. Please include a cover letter containing the title of your article, your professional affiliation or school, address, telephone, e-mail address, and a short biography with reference to recently published material.

6. Most articles are between 4,000 and 10,000 words including the footnotes.

7. NAELA Journal Editorial Board members review all submissions for appropriateness and they provide direction to potential authors. Author(s) will be notified by the NAELA Journal Editorial Board if the outline/article submitted is acceptable or not, or if changes should be made for further consideration of the article for publication. Submission does not guarantee publication. NAELA Journal reserves the right to reject any article submitted for publication whether solicited or not.

8. NAELA Journal articles accepted for publication will be assigned to a NAELA Journal editor who will work with the author or authors making any necessary changes to prepare the article for publication. Articles will be edited for clarity and will be edited to fit the publication’s editorial style and length requirements. In addition, all first-person references and references to the author’s organization, products, or clients may be deleted at the editor’s sole discretion.

9. Authors should provide a brief biographical statement for publication with the article.

10. Each author will be required to sign a standard author agreement that acknowledges the material submitted is authentic, and grants NAELA the proper permissions to publish such article. The agreement, however, does not change copyright, which is maintained by the author or authors.

11. Articles should be submitted electronically in a standard word processing document (not a pdf file) to Nancy Sween, NAELA Director of Communications and Publications, nsween@naela.org.
IRREVOCABILITY OF SPECIAL NEEDS TRUSTS:
THE TANGLED WEB THAT IS WOVEN WHEN ENGLISH FEUDAL LAW IS
IMPORTED INTO MODERN DETERMINATIONS OF MEDICAID ELIGIBILITY

By Mary F. Radford, JD and Clarissa Bryan

I. INTRODUCTION ...........................................................................................................2

II. BACKGROUND OF SNTs — THE SOCIAL SECURITY ACT, REGULATIONS,
AND THE POMS ........................................................................................................4
A. The History and Evolution of the Social Security Act, Supplemental
Security Income, and the Medicaid Program ............................................................4
B. The Tethering of SSI and Medicaid ........................................................................8
C. The Regulations and the POMS ..............................................................................9

III. TRUST LAW — COMMON LAW, CASE LAW, STATUTES, UTC, RESTATMENTS,
TREATISES......................................................................................................................11
A. Sources of Trust Law ...............................................................................................11
   1. The Restatements ..................................................................................................11
   2. Uniform Laws: The Uniform Probate Code and the Uniform Trust
      Code .......................................................................................................................11
   3. The Treatises ..........................................................................................................12
B. Description of the English Doctrines .....................................................................13
C. Status of the Doctrines under Modern American Law ...........................................15
   1. Doctrine of Merger ...............................................................................................15
   2. Rule in Shelley’s Case ..........................................................................................15
   3. Doctrine of Worthier Title ....................................................................................16

IV. SSA INTERPRETATIONS: THE POMS, TRUST REVOCABILITY, AND THE
   “SOLE BENEFICIARY” RULE ..................................................................................17
A. Grantor Trusts and Sole Beneficiaries ....................................................................17
B. Sole Beneficiaries and Revocability .......................................................................18
C. Residual or Successor Beneficiaries .......................................................................21
D. The Regional Office Reports ..................................................................................22
   1. Category 1: Trusts that are Expressly Irrevocable or are
      Presumed Irrevocable and No Residual Beneficiaries are Named .......... 23

Mary F. Radford, JD, Marjorie Fine Knowles Professor of Law, Georgia State University College of Law. President and Academic Fellow, American College of Trust & Estate Counsel. Member, American Law Institute. Reporter, Probate Code Revision Committee, Guardianship Code Revision Committee, Trust Code Revision Committee of the Fiduciary Law Section of the State Bar of Georgia.
At age five, Jaime Smith suffered an anoxic brain injury that caused extensive damage to the left side of her brain. Her parents sued the company that had caused her injury and entered into a settlement agreement with the company. The parents then set up a trust into which the settlement proceeds were paid. Knowing that Jaime would need extensive medical care for the rest of her life, her parents took great pains to set up the trust as a special needs trust (SNT) so that the trust funds would not cause Jaime to be ineligible for Medicaid. Cognizant of the rules set out by Congress and the Social Security Administration (SSA) that allow such trusts, the parents and their lawyer ensured that at Jaime’s death any remaining trust assets would be used to pay back to the state the amount of any Medicaid assistance received by her during her life. Should there be assets left over after this payback was made, those assets were, according to the terms of the trust, to be paid to Jaime’s heirs. The trust expressly provided that it was irrevocable and that Jaime had no right to terminate the trust and use the trust assets for her own benefit. The trust also stated that it was designed to be in compliance with the laws allowing such trusts. The SSA examined this trust and determined that, despite its clear and unambiguous terms, the trust was not irrevocable but rather revocable under the laws of the state in which it was established. Thus, the trust assets would be counted as resources of Jaime and she could not qualify for Medicaid assistance. This article examines the SSA’s basis for this astounding conclusion and calls for a reform of SSA procedures to prevent similar results in the future.

Since 1993, Congress has allowed potential Medicaid claimants such as Jaime to set up an SNT for the purpose of supplementing, rather than supplanting, the assistance offered by the Medicaid program. The term “special needs trust” does not have a precise definition in the federal statutes. The term will be used in this article to refer to a trust established with the assets of a potential Medicaid claimant that is designed to ensure that
the trust assets will not cause the claimant to be considered ineligible for Medicaid. The trusts described in this article are “self-settled” SNTs in that the trusts are set up with assets that belong to the claimant. As discussed in Part II, the assets in this type of trust are specifically authorized by Congress to be excluded as “countable resources” for purposes of determining Medicaid eligibility, provided that the trust is designed to use any remaining trust assets to pay back to the state Medicaid program any money that was expended for the claimant upon his or her death. In the event that there is still money left over after the Medicaid payback, these SNTs are often drafted to provide that any remaining funds will be paid to the claimant’s heirs or the claimant’s estate. As innocuous and sensible as this direction sounds, it is now being used in some instances by the SSA to deem the trust to be a revocable one, the assets of which would theoretically be available to the claimant, thus rendering the claimant ineligible for Medicaid. To reach this conclusion, the SSA employs an arcane set of English rules and doctrines that have been the bane of the existence of virtually every first-year law student and have been quickly forgotten upon the students’ graduation from law school and entry into practice. The doctrines invoked by the SSA are the Doctrine of Worthier Title (DWT), the doctrine of merger, and, to a lesser extent, the Rule in Shelley’s Case.

Discussions of the DWT, the doctrine of merger, and the Rule in Shelley’s Case have been components of Property Law courses in American and English law schools for as long as such courses have been taught. However, these lessons are forgotten almost as quickly as they are taught because U.S. lawyers typically consider these doctrines to be archaic and outmoded. State case law and statutory law relegate these doctrines to, at best, rules of construction rather than rules of law. In short, they are rarely invoked in

---

4 42 U.S.C. 1394p(d)(4)(a) states that the following type of trust will not be considered a countable resource for Supplement Security Income (SSI) purposes:

A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

As is discussed infra in Part II, eligibility for SSI is crucial for determining whether an individual is eligible for Medicaid.

5 Even though the assets belong to the disabled individual, by law, the trust must be established by that individual’s parent or grandparent, legal guardian, or a court. 42 U.S.C. 1394p(d)(4)(a). Third parties are also allowed to set up SNTs with their own assets, but these trusts do not invoke the problems described in this article and thus will not be discussed here.

6 The direction to pay to the claimant’s heirs is a common-sense solution to the problems associated with the fact that the Medicaid claimant is often so disabled that he or she lacks the capacity to make a valid will or otherwise name specific persons to whom the trust property should be paid when the claimant dies. Thus, the trust directs any remaining assets to those who would take under the state’s intestacy laws. These are most likely to be the claimant’s closest surviving relatives. Also, as noted by Andrew Hook and Thomas Begley in their seminal article on this issue, these trusts are often established by courts in the context of a personal injury lawsuit, and the “courts frequently insist that the trust agreement name the disabled person’s heirs as the remainder beneficiary.” Andrew H. Hook & Thomas D. Begley, Jr., When is an Irrevocable Special Needs Trust Considered to be Irrevocable?, 31 Est Plan 205, 206, http://oasthook.com/legal_information/When_is_an_Irrevocable_SNT_Revocable.pdf.

7 A rule of law is one that must be applied even if there is evidence that the drafter of a document (e.g.,
American law. In recent years, however, the SSA has resurrected these doctrines and is using them to disqualify trusts that would otherwise be construed as SNTs. The SSA’s understanding of these doctrines, as exhibited in its Policy Operations Manual System (POMS)\(^8\) and its Regional Chief Counsel decisions, is flawed (which is no surprise, given the doctrines’ complexity) and its application of these doctrines is erratic.

The purpose of this article is to describe these doctrines and to illustrate the various ways in which the SSA has used these doctrines to the detriment of Medicaid claimants. The SSA has attempted to figure out the status of the doctrines in the various states and this article highlights situations in which the doctrines have arguably been applied incorrectly. The article concludes with a call to eliminate the time-consuming, inefficient, and inaccurate policy of trying to discern whether and to what extent these arcane doctrines apply in each state. Instead, this article insists that the current approach be abandoned in favor of a clear, simple, and easily applied common-sense rule.

Part II of this article describes briefly the legislative and regulatory background of SNTs and the implementation of the law through the POMS. Part III explores the complex and confusing labyrinth of statutes, cases, rules, Restatements, and other secondary authorities that are used by the SSA to disqualify trusts on the ground that they are revocable, albeit unwittingly so on the part of both the settlors and the drafters of the trusts. Part IV examines the relevant POMS rules and directions on the revocability of trusts. This Part will show that the POMS, while it purports to expand upon general state law, uses terms that are rarely found in state law and employs concepts that are not accurate reflections of the common law of trusts. This Part discusses at length one particular situation in which the SSA arguably misinterpreted the state law (the law of Georgia), causing claimants to be refused Medicaid eligibility and eventually forcing the legislature to enact a statute that made it clear that the SSA’s interpretation of Georgia law was not on point. In conclusion, the article will call for a new approach by the SSA which would include a simply stated set of rules that reflect a common-sense approach to SNTs and sidestep the arduous task of attempting to apply obscure, outdated, and unnecessarily complex interpretations of common law.

II. BACKGROUND OF SNTS — THE SOCIAL SECURITY ACT, REGULATIONS, AND THE POMS

A. The History and Evolution of the Social Security Act, Supplemental Security Income, and the Medicaid Program

SNTs, such as the trust established for Jaime Smith in the Introduction to this article, are designed expressly to ensure that disabled beneficiaries like Jaime maintain their eligibility to receive Medicaid benefits. As will be discussed in detail in this Part II, eligibility for Medicaid is closely linked to eligibility for Supplemental Security Income. Thus, this part contains a description of the background of both of these programs, as well as a

---

\(^8\) The Program Operations Manual System (POMS) is described in Part II, *infra.*
description of the 1993 legislation that authorizes SNTs.

The Social Security Act was drafted during the presidency of Franklin D. Roosevelt in 1935 as part of his New Deal. The Medicaid and Medicare programs were instituted during the presidency of Lyndon B. Johnson in 1965 as part of his Great Society initiative in response to growing national concern over rising medical costs and the lack of affordable health care insurance. The programs were added as an amendment under Title XIX of the Social Security Act. In his 1965 State of the Union Address, Johnson stated: “[W]e must open opportunity to all our people … . [F]ar too many are still trapped in poverty and idleness and fear. Let a just nation throw open to them the city of promise: to the elderly, by providing hospital care under [S]ocial [S]ecurity and by raising benefit payments to those struggling to maintain the dignity of their later years … .” In 1972, the Social Security Act was amended to add provisions that included the creation of the Supplemental Security Income program (SSI). From its inception, the SSI program was designed to provide financial support for the aged, blind, and disabled, including both adults and children. In effect, SSI created a unified income floor for individuals in all states.

With the flux of the economic and political tides over the past several decades, the Social Security Act, the Medicaid program, and the SSI program have undergone various revisions. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93), there was significant concern among legislators, long-term care providers, and state Medicaid agencies that wealthy individuals were abusing the Medicaid system by using trusts as a dual mechanism for Medicaid eligibility and asset protection. The worry, as expressed by critics at the time, was that elderly individuals would “hide” assets

13 The program appears in Title XIV of the Act at 42 U.S.C. 1381. The SSI program offers a fairly minimal monthly income to eligible claimants. However, as described infra, eligibility for SSI is a key component in determining whether a claimant qualifies for the extensive medical care assistance offered by the Medicaid program.
15 Overman, supra n. 10.
16 Ira Stewart Weisner, OBRA ’93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context, 19 Nova L. Rev. 679, 681 (Winter 1995). This abuse was accomplished when an individual placed all of his or her assets in an irrevocable trust to benefit his or her children, for example, and then claimed to be completely impoverished and thus eligible for Medicaid assistance.
and obtain the Medicaid benefit to finance medical costs. This perceived (and perhaps to some extent real) manipulation of the system was thought to be the means of preserving a rich inheritance for these elderly individuals’ children.

The timeline and confluence of the discussion of Medicaid “abuses” is especially instructive when viewed in the years leading up to the passage of OBRA ’93. In 1991, the Health Insurance Association of America funded a study to determine the frequency of suspected Medicaid eligibility abuses. This study was conducted as a series of interviews with Medicaid officials regarding their perception of Medicaid “estate planning,” which was defined as “the manipulation of Medicaid eligibility rules by non-poor elderly persons, their heirs, and their attorneys to obtain Medicaid coverage for nursing home care while protecting significant amounts of wealth.” The conclusion of the interviews by the author was that Medicaid officials were concerned that Medicaid estate planning was becoming a serious policy problem.

In 1992, the State Medicaid Directors’ Association (SMDA) held a conference to discuss strategies to close eligibility loopholes and increase asset recovery. According to SMDA’s Operations Committee chairman regarding the issue of Medicaid estate planning, “States feel that their eligibility workers are outnumbered and outgunned by estate planning attorneys who are looking for loopholes.” This attitude is further evidenced in the comments of key legislators at that time. In 1993, prior to the passage of the new OBRA’93, Rep. Henry Waxman (who chaired the Health and Environment subcommittee of the United States House of Representatives’ Committee on Energy and Commerce) wrote a letter to The Boston Globe that stated: “I am offended by wealthy individuals with the aid of lawyers … taking advantage of the Medicaid program for the poor to finance the transmission of wealth to their heirs … I believe we need to stop this abuse.”

When the bill was passed, the portion of OBRA ’93 that pertained to Medicaid included certain provisions to close these perceived loopholes and prevent abuses in the qualification process. New amendments to OBRA ’93 Section 1396p(d)(1) through (3) addressed the abuse of Medicaid qualification by setting forth federal standards regarding the treatment of trusts. Included in these standards were provisions that addressed both re-

17 Id. at 690.
18 Id. (citing Brian O. Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage, SysteMetrics (1991)).
19 Id. (“Burwell defined the term “Medicaid estate planning” to mean “the manipulation of Medicaid eligibility rules by non-poor elderly persons, their heirs, and their attorneys to obtain Medicaid coverage for nursing home care while protecting significant amounts of wealth.” His assessment included that the objective of this planning was to “avoid using private wealth to pay for nursing home care, and letting taxpayers pay for it instead through the Medicaid program.” It is important to note, as Weisner does in his article, that Burwell was a prominent voice for the long-term care facility industry at that time).
20 Id. at 691 (Weisner’s article also provided that while Burwell admitted that more rigorous research was needed to validate the findings, the content of this preliminary research created a significant impact on the perception of Medicaid “abuses”).
21 Id. at 692.
22 Id.
24 These provisions are codified in 42 U.S.C. § 1396p.
vocable and irrevocable trusts. The amendments contained language that resembled but did not always reflect accurately state law as it relates to the establishment of trusts. For example, the definition of the term “trust” in the statute is as follows: “The term ‘trust’ includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.” The inclusion of an annuity or other “device similar to a trust” in the definition of “trust” is created solely by the federal statute and does not appear in any state or common law definition of a “trust.”

While the underlying principle of OBRA ’93 as it pertained to Medicaid seemed to be a tightening of the eligibility belt, the statute did not ignore the fundamental spirit surrounding the creation of the Medicaid program. This spirit was embodied in a distinct qualifying exception carved out for certain disabled individuals. The addition under OBRA ’93 of Section 1396p(d)(4) created the niche for SNTs, and was designed to leave intact the much-needed programs of SSI and Medicaid for support of the poor and the disabled. This section excludes trusts described in Sections 1396p(d)(4)(A) through (C) as a countable resource in SSI and Medicaid qualification determinations. By specifically excluding these types of trusts from the more restrictive guidelines for other irrevocable trusts, Congress recognized that these types of trusts are not those that lead to abuse of the Medicaid eligibility system. The main purpose of the SNT provisions was to spell out an express set of rules that would allow this specific type of trust to be used in a way that would not disqualify the disabled individual from Medicaid eligibility.

25 Id. The statutory provisions include provisions that: 1) state that property that is held in a revocable trust is deemed to be a resource of the individual who established the trust, 42 U.S.C. § 1396p(d)(3)(A); and 2) render ineligible for Medicaid for a specified purpose an individual who transfers his or her assets to an irrevocable trust in order to appear “impoverished” enough to qualify for Medicaid, 42 U.S.C. § 1396p(d)(3)(B).
26 Id.
28 See Part III infra for a discussion of examples of the federal regulations obscuring and overriding other commonly accepted principles of trust law.
29 Comments from the legislative history point to a “closing of the loophole for the wealthy to qualify for Medicaid” and state a goal of reducing Medicaid costs by $7.8 billion (§ 5113, H3067). See also Weisner, supra n. 17, at 682, citing Hearings on H.R. 2264 Before the Subcomm. on Health and the Environment, 103d Cong., 1st Sess. 6 (1993) (“this proposal would close numerous loopholes in the Medicaid law, which allow persons with substantial assets to qualify for Medicaid and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay”).
30 See comments of Bernard Sanders regarding OBRA ’93 from H3016 (“Under the Republican proposal, there would have been no tax increases on the wealthy, which means that there would have been massive cutbacks in programs desperately needed by middle-income people, veterans, the poor, children, and the elderly ... Under the Republican proposal, Medicare and Medicaid would have been savaged, causing enormous pain and suffering for the elderly and the poor ... In other words, after 12 years of Reagonomics in which the rich got richer at everybody’s expense, the Republican proposal would have balanced the budget on the backs of those people least able to afford it. That would not be acceptable to me or, I believe, the vast majority of Vermonters”).
31 To meet the federal definition of “disabled,” an individual must satisfy the requirements set forth in 42 U.S.C. §1382c.
32 42 U.S.C. 1396p(d)(4). See supra n. 3 for the text of this statute.
Following the passage of OBRA ’93, Congress enacted the Foster Care Independence Act (FCIA) in 1999.34 The FCIA reinforced the rules for SSI eligibility and transfers of assets to trusts.35 However, the FCIA’s provisions mirrored OBRA ’93’s amendments concerning Medicaid by also exempting SNTs established under 42 U.S.C. 1396p(d)(4) (a) from the transfer of asset penalty rules.36 The exclusion of SNTs from the restrictive transfer of assets rules demonstrates that, once again, Congress was not concerned that the individuals who established this type of trust were attempting to abuse or game the Medicaid system.

B. The Tethering of SSI and Medicaid

As noted above, one’s eligibility for Medicaid is tied in many instances to eligibility for SSI. States have some autonomy in regard to how they choose to administer the Medicaid program in conjunction with the sister program of SSI.37 Because the Medicaid program is a mixed federal and state program with funding derived from both entities, states are not required to participate in the program.38 However, if a state does choose to participate in the program (as all to date have), it must comply with federal law.39 When the SSI program was created in 1972, states were given the option of adopting the same set of eligibility requirements for SSI and Medicaid, or retaining the criteria for Medicaid qualification that existed prior to the SSI program’s enactment.40

This option has created three separate categories of SSI/Medicaid states. In all three categories, however, the determination of eligibility for Medicaid is linked closely with eligibility for SSI. The three categories of states are those that adhere to the same eligibility criteria as set forth for SSI and provide automatic eligibility for Medicaid once SSI is granted; those that require that the determinations be made separately, but that use the same SSI eligibility criteria for Medicaid; and those that contain Medicaid eligibility criteria that are more restrictive than that of SSI in one or more eligibility areas.41 States in which SSI recipients automatically qualify for Medicaid are called “1634 states.”42 Under this framework, once an applicant is deemed to qualify for SSI, the individual is automatically enrolled in the State Medicaid program, and the state and the federal government split the applicable administrative fees.43 This is facilitated by computer systems that link the SSA offices to the state Medicaid offices so that information can be shared regarding

35 Id. See also Hook & Begley, supra n. 6, at 205.
36 Bridget O’Brien Swartz & Angela E. Canellos, The Wrongful Disregard of SSI Comparability By Some State Medicaid Agencies as it Relates to SNTs, 5 NAELA 2, 1 (2009).
37 Overman, supra n. 10.
38 Id.
39 Id.
40 Id.
41 Swartz & Canellos, supra n. 36, at 6.
42 These states entered into agreements with the federal government under § 1634 of the Social Security Act, which states that “the Commissioner will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State’s plan approved under title XIX” (codified as 42 U.S.C. § 1383c).
43 Swartz & Canellos, supra n. 36, at 6.
SSI eligibility and subsequent Medicaid qualifying determinations. The majority of the states are “1634 states.”

States that are considered “SSI Criteria States” are similar to the 1634(a) states in that the regulations used to determine eligibility for both SSI and Medicaid are the same. The primary difference between these two types of states is that in the SSI Criteria States, a separate application must be made to each program. Thus, instead of the administrative cost-sharing as described above, the state chooses to administer the Medicaid application on its own, individually. Currently, eight states have chosen to administer their Medicaid programs in this fashion. States in which Medicaid qualification is more restrictive than SSI qualification are termed “§ 209(b) States.” In these states, the Medicaid eligibility process contains at least one more restrictive criterion than the SSI process. In “209(b) states,” the two applications are completely separate, and the applicant for Medicaid must be deemed more “needy” than the applicant for SSI. However, the inverse of 1634(a) states and SSI Criteria States is true under this classification — if an individual is eligible for Medicaid the individual will almost always be eligible for SSI. There are 11 states that currently are classified as “209(b)” states.

C. The Regulations and the POMS

The SSI program is administered by both local and district offices of the SSA. Administratively, the Social Security Act contains a provision for the SSI program, which is regulated by the Code of Federal Regulations, and which is enforced by the transcription of these regulations into the general and regional instructions compiled in the Program Operations Manual System (POMS). Functionally, the POMS is a handbook for SSA employees who are involved in the determination of SSI (and in some cases, Medicaid)

---

44 Overman, supra n. 10, at 3.
45 Id. at 7.
46 Swartz & Canellos, supra n. 36, at 6.
47 Id. at 7 (These states are: Alaska, Idaho, Kansas, Nebraska, Nevada, the Commonwealth of the Northern Mariana Islands, Oregon, and Utah. See also Social Security Online, POMS SI 01715.010 Medicaid and the SSI Program (Feb. 15, 2008), https://secure.ssa.gov/poms.nsf/lnx/0501715010 (accessed Nov. 12, 2011)).
48 The term “§ 209(b) State” refers to Section 209(b) of Pub. L. No. 92-602 (codified as 42 U.S.C.A. § 1396a(f)).
49 Swartz & Canellos, supra n. 36, at 7.
51 Overman, supra n. 10, at 3 These offices are governed by regulations found in Title 20, Part 416 of the Code of Federal Regulations, and these regulations form the basis for the regional Centers for Medicare and Medicaid Services’ (CMS) POMS. See also the Centers for Medicare and Medicaid Services website, www.cms.gov (accessed May 6, 2011). CMS is the federal agency that, among other things, administers the Medicaid Program. The agency is comprised of 10 regional offices in the U.S.
SSI eligibility determinations are made using the POMS and hearings for reconsideration are handled by Administrative Law Judges (ALJ’s), whose decisions are binding on state Medicaid eligibility to a large degree.54

As illustrated by pertinent case law, the POMS and all resulting qualification determinations receive deference from the courts. Courts have noted that “the POMS remain definitive and mark the consummation of the SSA’s decision-making process.”55 In Washington State v. Keffeler, the U.S. Supreme Court stated that the Court “owe[d] deference” to the Social Security Act and the subsequent regulations.56 The level of deference given to the POMS was articulated in Davis v. Secretary of Health and Human Services, in which the Court stated that “[a]lthough the POMS is a policy and procedure manual that employees of the Department of Health & Human Services use in evaluating Social Security claims and does not have the force and effect of law, it is nevertheless persuasive.”57 The basis for this level of deference, as described in Skidmore v. Swift & Co., was that the decisions of administrators of federal statutes (in this case the agency established under the Fair Labor Standards Act) “constitute a body of experience and informed judgment.”58

Relevant to this article, the POMS contains a series of instructions to the SSA’s regional claims representatives to help them assess whether the assets in a trust are or are not a countable resource for SSI purposes, which is determinative of whether an individual will qualify for Medicaid.59 If a regional claims representative is uncertain about the application of these instructions to a specific case, the case is referred to the Regional Chief Counsel’s office, which will then render an opinion in the form of a “Precedent.”60

53 See Part II (B), supra, regarding the interplay of SSI and Medicaid eligibility in the various states.
54 Id.
56 537 U.S. 371, 382 (S. Ct., 2003), cited in Hook & Begley, supra n. 6, at 205.
60 Social Security Online, POMS GN 01010.805 Precedents of Fact, https://secure.ssa.gov/apps10/poms.nsf/lnx/0201010805 (accessed April 26, 2011). This work also provides an organized synopsis of the Precedents relevant to Special Needs Trusts. For an excellent discussion of the process by which individual cases are reviewed by the SSA Regional Chief Counsel offices and the opinions incorporated into “precedents,” see also David Lillesand, SSI Update: The “Top Ten Lessons” from a Review of SSA Regional Chief Counsel Precedents on Trusts Published between 2006-2008, now somewhat incorporated in the new 2009 POMS on Trusts, http://www.floridaspecialneedslaw.com/uploads/file/ASNP%202009%20SSI%20Update%20-%20RCC%20Ops.pdf, (accessed May 6, 2011). This work also provides an organized synopsis of the Precedents relevant to Special Needs Trusts.
III. Trust Law — Common Law, Case Law, Statutes, UTC, Restatements, Treatises

A. Sources of Trust Law

The original 13 colonies in large part adopted the common law of England as it pertains to property and trusts. This common law included rules and doctrines, such as the Rule in Shelley’s Case and the DWT, which had been established in the context of a feudal country where real property was the major source of wealth and was held in the hands of a few overlords. These rules and doctrines became part of early American trust law despite their incongruity with the political structure of the new union of states. To make matters more difficult, until recently, few states had codified their trust law. This delay meant that lawyers and judges had to look to case law, if it existed, to determine the status and applicability of the abstruse English rules. Trust law in the various states is an amalgamation of state constitutional law, state statutory law, common law, uniform laws, and scholarly opinions. The long-standing use of trusts in the United States has resulted in an evolution of trust law that provides many rich sources of background and authority for judges and trust law practitioners who deal with such matters.

1. The Restatements

The American Law Institute (ALI), an elected body of 4,000 of the most highly qualified practitioners, judges, and law professors in the United States, began publishing the Restatements of the Law in 1923. The Restatements, which cover a wide range of topics, were initially intended to be an orderly presentation and clarification of the common law in each area as it had been developed over time. In more recent versions, some of the Restatements have tended to become more likely to state a recommended version of the law, rather than merely restate the law as it exists. The Restatements contain a variety of “black letter” provisions accompanied by extensive commentary, reporter’s notes, illustrations, examples, and citations. While obviously not binding in any jurisdiction, the Restatements are often cited as persuasive authority, particularly when no statutory or case law exists in the relevant jurisdiction. The ALI has produced three Restatements of the Law of Trusts. The first Restatement of Trusts was approved by the ALI in 1935, the second in 1957, and the third in staggered portions throughout the last two decades. The SSA often relies upon the second two Restatements for interpretations of state trust law.

2. Uniform Laws: The Uniform Probate Code and the Uniform Trust Code

The National Conference of Commissioners on Uniform State Laws (NCCUSL, now known as the Uniform Law Commissioners or ULC), an organization that is even

---


62 Uniform Trust Code, *supra* n. 3. The Prefatory Note to the Uniform Trust Code, which was promulgated in 2004, noted that “the trust law in many States is thin.”

older than the ALI, was founded in 1892 for the purpose of promoting “uniformity of the laws” among the states in the United States.\textsuperscript{64} Once a uniform act is approved by the ULC, it is sent out to the states with the urging that it be adopted exactly as written. Until a state has adopted all or a portion of a uniform act, the Act has no binding effect in that state.

The Uniform Probate Code (UPC), which deals primarily with decedents’ estates but also contains provisions pertaining to trusts, was first approved by NCCUSL in 1969. Subsequent amendments of the UPC were promulgated 10 times between 1977 and 1993, with the most substantial modifications appearing in the 1990 version. In 2008, additional amendments were issued. The UPC trust provisions were adopted in many states and remain effective in some of those states, despite the promulgation of the Uniform Trust Code (the UTC). The UTC, which was first promulgated in 2000, was “the first national codification of the law of trusts.”\textsuperscript{65} As the use of trusts became more prevalent throughout the United States, it became apparent to the Commissioners that the trust law in most states was “thin” and “fragmentary.”\textsuperscript{66} The UTC was designed to “provide [s]tates with precise, comprehensive, and easily accessible guidance on trust law questions.”\textsuperscript{67} The drafters also noted that the UTC contains “a number of innovative provisions.”\textsuperscript{68} As it began to be enacted and enforced in states, the drafters found that some fine-tuning was necessary. The 2000 UTC has been amended five times. The UTC has been adopted, in whole or in part, by almost one-half of the states. Although the SSA does not cite the UTC frequently, it makes reference to code sections in state trust codes that are duplicative of those in the UTC.\textsuperscript{69}

3. The Treatises

A widely practiced tradition in early English and American law was the publication by an eminent scholar of a treatise on a specific area of the law. The purpose of the treatise was to compile, organize, and explain to judges, practitioners, and students of the law the myriad cases that comprised the common law on that subject. In more recent times, with the proliferation of Restatements, statutes, and uniform law, the use of these treatises has waned. However, the multi-volume treatises of two giants in the field of American Trust Law remain a valuable resource for judges and practitioners alike. These two scholars are Austin W. Scott\textsuperscript{70} and George Gleason Bogert.\textsuperscript{71} The SSA has consulted these treatises

\textsuperscript{64} For information on the background and work of NCCUSL (now ULC), see www.nccusl.org.

\textsuperscript{65} Uniform Trust Code, supra n. 3. UTC Prefatory Note.

\textsuperscript{66} Id.

\textsuperscript{67} Id.

\textsuperscript{68} Id.

\textsuperscript{69} See e.g., Social Security Online, POMS SI BOSO1120.200 Grantor Trust, part B(3) (discussion of New Hampshire law), https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200BOS.

\textsuperscript{70} Harvard University Professor Austin Wakeman Scott was the Reporter for the First Restatement of Trust Law. In 1939, he published a four-volume work which was structured around the “black letter” provisions of the Restatement and included extensive notes and explication from the Reporter’s view of the background and decision-making that produced the black letter provisions. This work is often referred to simply as Scott on Trusts. The 5th edition, which was published in 2006, is edited by Professor Mark L. Ascher. This edition consists of eight volumes of substantive information and a ninth volume in which appear the index and case cites.

\textsuperscript{71} In 1935, University of Chicago Professor George Gleason Bogert published his multi-volume treatise
when seeking to understand the complex state laws described in this article.\textsuperscript{72}

B. Description of the English Doctrines

As was seen with Jaime’s trust at the beginning of this article, the trusts that are challenged by the SSA sometimes are structured as follows:

The assets of a disabled individual are transferred into an irrevocable trust to be used for the benefit of that individual during her life to supplement assistance provided to her through governmental programs. At her death the trust assets are used to pay back to the state any amounts expended for her by way of Medicaid assistance. If there are then any assets remaining after the payback, these assets are distributed to her “heirs” (or “heirs at law” or “estate”).

The SSA’s approach to trusts that contain this type of language is to determine whether the settlor\textsuperscript{73} of the trust is also the “sole beneficiary” of the trust. The settlor is the sole beneficiary if there are no other beneficiaries (referred to by the SSA as “residual beneficiaries”) who will receive the trust property when the settlor dies. If the settlor is the sole beneficiary, then the SSA concludes that in most states the trust is revocable. If the trust is revocable, the settlor can revoke the trust and use the trust funds to meet her food and shelter needs and the trust fund will be deemed a “resource” of the claimant, thus making the claimant ineligible for government assistance.\textsuperscript{74} As noted above, the SSA has used a combination of old English rules and doctrines to construe such trusts to be revocable rather than irrevocable under the theory that the claimant is the sole beneficiary of the trust.

The first of these doctrines is known as the doctrine of merger.\textsuperscript{75} In its broadest sense, the doctrine provides that if all of the interests in property are held by one individual and there are no intervening holders of interests in the property, the interests merge and that individual is the sole legal and equitable owner of the property. Thus, if the grantor holds a life estate in property and the property reverts to him at his death, the grantor is the sole owner of the property because he holds all the interests in the property. Similarly,
if property is granted to a third party for life and upon her death to the third party’s heirs, the third party is the sole owner of the property. The merger doctrine is applied somewhat differently if a trust is involved. In that situation, a merger occurs if the sole trustee of the trust is also the sole beneficiary of the trust. (As noted below, this version of the doctrine remains in effect throughout the United States and has been embraced by the UTC.) Thus, if the settlor of a trust is also the sole trustee and the sole beneficiary, the interests all merge in that individual. This latter application of the doctrine is usually not applicable in the case of SNTs, as these trusts always have a third-party independent trustee.

The doctrine of merger, as described above, is directly dependent upon two subsidiary doctrines, the DWT and the Rule in Shelley’s Case, which dictate whether one individual is the sole owner of property. The DWT and Rule in Shelley’s Case are best understood in their historical context. In the English feudal system, the rights of a feudal overlord in property were different if the property was transferred “by descent” as opposed to “by purchase.” Property was transferred by descent when a property owner died intestate and his heirs inherited the property. Property was transferred by purchase if it was transferred via an instrument to persons named in that instrument. If the property transferred by descent, the overlord was entitled to an inheritance tax. Also, if the heir who received the property was a minor, the overlord acquired additional rights to control the marriage of that minor. These benefits did not accrue to the overlord if the property was acquired by purchase. Thus, within a framework of law that favored the feudal lords, a transfer by descent was deemed the preferred option.

The grants in which the overlords benefitted if these mandatory rules were imposed were of two types:

1. A transfer to a third party for life, with the remainder payable to the third party’s heirs. The grant appears on its face to have created two interests: a life interest in the named life tenant and a remainder interest in his heirs. However, the Rule in Shelley’s Case applied in this case, merging both interests into the life tenant, causing the third-party life tenant to be the sole owner of the property. When the life tenant died, the property passed by intestacy to his heirs and his heirs owed an inheritance tax to the overlord.

2. A transfer by a grantor to someone for life and then, when that individual died, the property would be paid to the grantor’s heirs. The DWT applied in this case. The DWT labeled the interest in the grantor’s heirs as a simple reversion in the grantor (saying that he had reserved all rights to himself) rather than deeming it to be a separate transfer in remainder to the grantor’s heirs. When the intervening life tenant died and then the grantor died, the property transferred by intestacy to the grantor’s heirs. The heirs thus owed an inheritance tax to the overlord.

77 Restatement (Third) Trusts § 16.3(a).
78 Thomas, supra n. 76 at 306.
79 Id. at 307.
As noted above, the SNTs in question combine these two grants. The Medicaid claimant is the settlor (or, in the terminology used by the SSA, the “grantor” of the trust) whose property is used to set up a trust\textsuperscript{80} with the benefits to be paid to herself for her life, with the remainder to her heirs. A combined application of the doctrine of merger, the DWT and the Rule in Shelley’s Case would cause the remainder interest to merge into the claimant, thus causing her to be the sole beneficiary of the trust. There is some irony in the fact that a doctrine that was developed in the feudal overlord system to maximize the payments of inheritance taxes to overlords would be used centuries later by the United States Government to disqualify Medicaid claimants from receiving government benefits to which they would otherwise be entitled.

C. Status of the Doctrines under Modern American Law

1. Doctrine of Merger

One version of the doctrine of merger, particularly as it applies to trusts, is still viable under modern American law. Section 402(a)(5) of the UTC lists as one of the requirements of a valid trust that the sole trustee and sole beneficiary not be the same person. The comment to this section addresses the doctrine of merger and provides that a trust is not created if the settlor is the sole trustee and sole beneficiary of all beneficial interests.\textsuperscript{81} The reason for this is that a trust cannot exist if there is no separate person to whom the trustee owes a fiduciary duty.\textsuperscript{82} Thus, the doctrine of merger is properly applicable only if all beneficial interests, both legal and equitable interests (as well as life and remainder interests), are vested in the same person, whether in the settlor or someone else. However, this doctrine applies only if the same person is both the trustee and the sole beneficiary, which is never the case with an SNT.

2. Rule in Shelley’s Case

The Rule in Shelley’s Case was abolished in England in 1925.\textsuperscript{83} In the United States, the rule either has never been adopted or has been abolished by statute in virtually every state.\textsuperscript{84} Thus, as pointed out in the Restatement (Second) of Trusts,\textsuperscript{85} if a grantor transfers

\textsuperscript{80} Although the assets belong to the disabled individual, by law, the trust must be established by that individual’s parent or grandparent, legal guardian, or a court. 42 U.S.C. 1394p(d)(4)(a).

\textsuperscript{81} Louisiana has the only state statute that expressly allows the settlor to be “the sole beneficiary of the trust.” L.S.A.-R.S. 9:1901. L.S.A.-R.S. 9:1804 also provides that the settlor may be “the sole beneficiary of income or principal or both, or one of several beneficiaries of income or principal or both.” See W. Va. 44-5-15(b), which is cited infra. And N.R.S. 163.007. See also M.C.A 72-33-210, SDCL 55-1-15 (which use the term “trustor” instead of “settlor”).

\textsuperscript{82} This concept is also articulated in Ind. Code Ann. 30-4-2-8 as follows: “(a) If the settlor transfers both the title and the entire equitable interest in property to the same person as both the sole trustee and the sole beneficiary, no trust will be deemed to have been created and the transferee shall treat the property as the transferee’s own.” Texas law provides that a trust is not validly created if the settlor “transfers both the legal and all equitable interests in property to the same person or retains both the legal title and all equitable interests in property in himself as both the sole trustee and the sole beneficiary.” V.T.C.A. Property Code 112.034(a).

\textsuperscript{83} 15 & 16 Geo. 5, ch. 20, § 131 (1925) (Eng.), cited in Thomas, supra n. 76.

\textsuperscript{84} Reppy, supra n. 76, at 88.

\textsuperscript{85} Restatement (Second) Trusts, § 127.
property to an individual for life, and then to that individual’s heirs, the individual is not the sole beneficiary of the trust.

3. Doctrine of Worthier Title

The Doctrine of Worthier Title (DWT) was abolished in England in 1833. The DWT has been abolished by statute in many states of the United States, both as a rule of law and as a rule of construction. The DWT is addressed in the UPC at Section 2710 and provides as follows:

The doctrine of worthier title is abolished as a rule of law and as a rule of construction. Language in a governing instrument describing the beneficiaries of a disposition as the transferor’s “heirs,” “heirs at law,” “next of kin,” “distributees,” “relatives,” or “family,” or language of similar import, does not create or presumptively create a reversionary interest in the transferor.

This provision of the UPC has been adopted in ten states and other states have enacted similar statutes that abolish the DWT.

Other states have addressed the DWT in case law and have refused to apply it as either a rule of law or a rule of construction. In 1919, in the landmark case of Doctor v. Hughes, Judge Benjamin Cardozo concluded that the only modern relevance of the DWT was as a rule of construction. The Restatement (Second) Trusts essentially embraced the doctrine as an existing rule of construction in most states. The Restatement (Third) of Trusts repudiated the DWT as a rule of law or construction, and went further by reversing the rule of construction so that the presumption is “that language expressing an apparent intention to create a remainder in someone’s heirs is so intended and is to be given that effect.”

Eminent scholars have roundly condemned the theory. There remain, however, many states in which the status of the DWT is unclear. This has provided the SSA with the opportunity to apply the DWT to render ineligible for Medicaid the settlors of many trusts that name the settlor’s heirs or estate as the ultimate distributees of the trust assets.

86 3 & 4 Will. 4, ch. 106, § 3 (1833) (Eng.), cited in Thomas, supra n. 76, at 307.
88 See e.g., Hatch v. Riggs National Bank, 361 F.2d 559 (D.C. Cir. 1966).
90 Restatement (Second) Trusts, § 137, Comment (b).
91 Restatement (Third) Trusts, § 49, Comment (a).
92 See e.g., Lewis M. Simes, Fifty Years of Future Interests, 50 Harvard Law Review 749, 756 (1937); Nt., 48 Yale Law Jnl. 874 (1939); Nt., 39 Columbia Law Rev. 628, 656 (1939); Comment, 34 Ill. Law Rev. 835, 850-51 (1940), and Harold E. Verrall, The Doctrine of Worthier Title: A Questionable Rule of Construction, 6 U.C.L.A. Law Rev. 371 (1959).
IV. SSA INTERPRETATIONS: THE POMS, TRUST REVOCABILITY AND THE “SOLE BENEFICIARY” RULE

The 2000 POMS requires SNTs to be irrevocable. The POMS contains a general discussion of the revocability of trusts but also recognizes that state laws differ about whether a trust is revocable. Six of the Regional General Counsel Offices have issued reports that purport to describe the laws of the states of their regions. These reports approach the question of revocability in a variety of ways and some contain numerous conclusions as to the effect of state law without citing any statutory or legislative authority.

A. Grantor Trusts and Sole Beneficiaries

The primary POMS section covering SNTs is POMS SI 01120.200. The POMS section begins by providing a glossary of terms for use in the analysis of trusts. As will be seen, some of these terms are not commonly used in trust law or are defined by the POMS in an unusual way.

The first relevant term in the POMS is the term “grantor.” The term is defined as follows: “A grantor (also called a settlor or trustor) is the individual who provides the trust principal (or corpus).” The term “grantor,” while acceptable, is not used as commonly in state trust law as the term “settlor,” which is the term used by the UTC. Thus, the term “settlor” will be used interchangeably with the word “grantor” in this article.

The second relevant term is the term “grantor trust,” which is defined in a way that does not reflect the common law or any state statutory law. The POMS section defines a “grantor trust” as a “trust in which the grantor is also the sole beneficiary of the trust.” The term “grantor trust” rarely appears in any state trust code and is nowhere defined the

---

93 Social Security Online, POMS SI 01120.202 Development and Documentation of Trusts Established on or after 1/1/00, (Oct. 31, 2011), https://secure.ssa.gov/poms.nsf/lnx/0501120202!OpenDocument&Click=. This requirement reflects the requirement in the POMS provision relating to whether a trust is an exempt resource for SSI purposes.

94 These offices are the Atlanta office (covering the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee), the Boston office (covering the states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont), the Chicago office (covering the states of Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin), the Dallas office (covering the states of Arkansas, Louisiana, New Mexico, Oklahoma, Texas), the Denver office (covering the states of Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming), the Kansas City office (Iowa, Kansas, Missouri, Nebraska), the New York office (covering the states of New Jersey, New York), the San Francisco office (covering the states of Arizona, California, Hawaii, Nevada) and the Seattle office (covering the states of Alaska, Idaho, Oregon, Washington).

95 Self-settled Medicaid trusts are in fact covered under POMS SI 01120.203. However, this provision refers back to POMS SI 01120.200 for the determination of whether a trust is a countable resource for SSI purposes.

96 Social Security Online, POMS SI 011120.200(B)(1), Glossary of Terms – Trusts, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501112000/b. (The POMS emphasizes in bold type certain defined terms. That emphasis will be eliminated when the POMS is quoted in this article in order to avoid confusion or distraction.) The POMS points out that sometimes the person who physically transfers the assets to the trust is not the “grantor,” e.g., when a minor receives a personal injury and the minor’s parent or conservator transfers that property into a SNT.

97 Social Security Online, POMS SI 011120.200(B)(8), Grantor Trust, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501112000/b. Note that this section begins “Subject to State law…”
way it is defined in the POMS. The term “grantor trust” is often used in the context of the income tax treatment of trusts under IRC Sections 671-679, and when the term appears in a state trust code it is usually being used to refer to that type of trust.

A significant term used in the POMS definition assigned to a “grantor trust” is the term “sole beneficiary.” This term, again, is not commonly seen in state trust codes, at least in the context to which it is assigned by the POMS. As noted above, Section 402 of the UTC uses the term “sole beneficiary,” but only as part of the requirement for creation of a valid trust that the “same person is not the sole trustee and sole beneficiary.” Very few state trust codes use the term in any other context.

B. Sole Beneficiaries and Revocability

The terms “grantor trust” and “sole beneficiary” are crucial to this portion of the POMS because these concepts are used to address the issue of whether a trust is revocable. As stated in the POMS, “If an individual… has legal authority to revoke or terminate the trust and then use the funds to meet his food or shelter needs, …the trust principal is a resource for SSI purposes.” Thus, if the settlor of the trust has the power to revoke the trust, it will not qualify as an SNT in that the trust assets will be a countable resource, thus rendering the settlor ineligible for SSI and Medicaid.

The POMS section points out that under state law there are various ways in which a trust may be revocable. The most obvious of these is if the trust is revocable by its terms. The settlor may merely label the trust as “revocable” or may expressly reserve the right to revoke or amend the trust. Under the laws of some states, a trust is deemed revocable if the trust instrument is silent as to revocability. UTC Section 602(a) provides that “[u]nless the terms of a trust expressly provide that the trust is irrevocable, the settlor

98 See e.g., Ala. Stat. Ann 40-18-25(j), F.S.A. § 201.02(b)(5). The Uniform Principal and Income Act, which is incorporated into many state codes, uses the term, but again to refer to the income tax treatment of the trust. See e.g., UPIA § 506.

99 UTC 402(a)(5). See discussion of the doctrine of merger supra at text accompanying nn. 75-77.

100 UTC 402(a)(5). See discussion of the doctrine of merger supra at text accompanying nn. 75-77.

101 The term “legal authority,” however, is somewhat clouded in meaning by a later example in the same POMS in which a mother of an individual, who is also that individual’s guardian, sets up a trust for the individual that is expressly revocable. See Social Security Online, POMS SI 011120.200 (L)(1), Examples of Trusts, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#l. The POMS states unequivocally that the trust is a resource because it is revocable, despite the fact that the imposition of a guardianship may well indicate that the individual lacks the legal capacity to engage in such a revocation. See e.g., Ga. Stat. 29-4-21(6).

102 Social Security Online, POMS SI 011120.200 (D)(1)(a) Trust Principal is a Resource, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#d (emphasis in original). Sometimes individuals such as trustees or trust protectors have the authority to terminate a trust. However, it would be rare that such an individual could then apply the trust assets to his or her own “food or shelter needs.” Consequently, the authority in a trustee or trust protector would most likely not result in the trust property being considered a resource of that individual.

103 The POMS states that “[i]n some cases, the authority to revoke a trust is held by the grantor.” Social Security Online, POMS SI 011120.200 (D)(1)(b), Authority to Revoke or Terminate Trust or Use Assets, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#d.

104 Id.
Irrevocability of Special Needs Trusts

Spring 2012

19

may revoke or amend the trust.” This provision reverses the long-held common law rule, which has been adopted by many states in their trust codes, that a settlor must expressly reserve the right to revoke or modify a trust. Otherwise, the trust is irrevocable.105

A major concern of the POMS is that under some state laws, even if the trust expressly provides that it is irrevocable or state trust law deems it to be irrevocable, certain circumstances may cause the trust to be, in fact, revocable. The circumstance in which this may happen is, according to the POMS, when the trust is a “grantor trust” — that is, when the grantor is also the “sole beneficiary.”106 The POMS notes that “[i]f the individual at issue ... is the grantor of the trust, the trust will generally be a resource to that individual if that individual can revoke the trust and reclaim the trust assets.”107 The POMS goes on to cite “the general principle of trust law that if a grantor is also the sole beneficiary of a trust, the trust is revocable regardless of language in the trust to the contrary.”108

After its reference to the “general principle of trust law,” the POMS section indicates that state laws on the revocability question vary and directs the reader to “[c]onsult with your Regional Office if necessary.”109 In fact, most state trust codes do not address this issue directly. In unusual legislation, West Virginia provides expressly in its trust code that “[n]o trust, which is otherwise irrevocable because the grantor or settlor of the trust has not expressly reserved the right to alter, amend, modify, or revoke the trust or because the creating instrument expressly provides or states that the trust is irrevocable, is or becomes revocable by the grantor or settlor because the grantor or settlor is the sole beneficiary of the trust.”110 But most state statutes leave unclear as to when the settlor is the “sole beneficiary” and when that status causes the trust to be revocable.

In Regional Chief Counsel Precedents (PS),111 the SSA seems to rely heavily on the Restatements of Trusts for guidance on trust law. The “sole beneficiary” principle is in fact set out in the Restatement (Second) of Trusts. Section 339 provides as follows:

105 See Restatement (Second) Trusts 330. The Comment to UTC 602 explains that the UTC reversed this presumption because an instrument that is silent as to revocability was “likely drafted by a non-professional, who intended the trust as a will substitute.” The Comment also points out that this provision will have “limited application” because professional drafters of trusts will not leave the trust silent but will spell out whether the trust is revocable or irrevocable.


110 W.Va. Code 44-5-15(b). This 2004 legislation was most likely enacted in response to an unreported federal district court case in Vermont, applying West Virginia law, which held that a trust was revocable under the DWT, even though the DWT had been abolished as a rule of law in West Virginia. The court applied DWT as a rule of construction. Thompson v. Barnhart, No. 2-02-CV-141 (DC Vt., 7/17/03), which is described in Hook & Begley, supra n. 6, at 206.

111 See Lillesand, SSI Update: The “Top Ten Lessons,” supra n. 60, for an excellent discussion of the process by which individual cases are reviewed by the SSA Regional Chief Counsel offices and the opinions incorporated into “Precedents.”
If the settlor is the sole beneficiary of a trust and is not under an incapacity, he can compel the termination of the trust, although the purposes of the trust have not been accomplished … . The rule stated in this Section is applicable although the settlor does not reserve a power of revocation, and even though it is provided in specific words by the terms of the trust that the trust shall be irrevocable.\textsuperscript{112}

Although the POMS relies on this general principle, the POMS fails to give full weight to a key provision of the Restatement section, which is the provision that the settlor is not “under an incapacity.” Many of the settlors of SNTs are incapacitated as a result of their disabilities.\textsuperscript{113} Thus, even if they were the “sole beneficiaries” of a trust, the Restatement would indicate that the trust for such a beneficiary would not be revocable.

The Restatement (Second) of Trusts sets forth situations in which the settlor is considered the “sole beneficiary” of a trust.\textsuperscript{114} A somewhat unusual but obvious situation is the one in which the settlor is the only possible beneficiary of the trust. For example, the settlor transfers money to a trust for 10 years with income payable to her during that time and at the end of which time the remaining trust assets are to be paid to her.\textsuperscript{115} A more common example would be that of a settlor who puts her property in trust for some period of time during which she anticipates that she will be unable to manage the property — for example, while she is serving a tour of duty in the armed forces. This would have the advantage of having another party, the trustee, manage her property (e.g., paying her bills, monitoring her investments) during her absence. If she names no other beneficiary but dies during her tour of duty, the trust would fail at that point (for lack of a beneficiary) and the trust property would presumably become property of the settlor’s estate.\textsuperscript{116}

A well-drafted trust, however, will address how the trust property is to be distributed in the event of the death of the primary beneficiary or other termination of the trust.\textsuperscript{117} In this context, the POMS explores whether there is some person or class of persons named in the trust who will take the trust property upon the death of the life beneficiary. The POMS somewhat ineptly defines the concept of a “residual beneficiary.” Again, this

\textsuperscript{112} Restatement (Second) Trusts § 339.
\textsuperscript{113} An individual who has a disability is not necessarily “incapacitated” under law. For example, an individual who is paralyzed may still retain the capacity to make significant, responsible decisions about his or her own welfare and property. On the other hand, an individual who has suffered severe brain injuries may be both disabled and incapacitated in that sense that the individual no longer has the legal capacity to make such decisions.
\textsuperscript{114} Restatement (Second) Trusts 127, Comment (a).
\textsuperscript{115} Id., Illustration (1).
\textsuperscript{116} As stated in the Restatement (Second) Trusts, a “resulting trust” will be imposed upon the trust property for the benefit of the settlor’s estate. The POMS uses the example of a 17-year-old who receives $125,000 as the result of a car accident and whose father or mother, as his guardian, places the property in a trust to be used for his sole benefit. POMS SI 011120.200 (L)(3), Principal Held in a Grantor Trust is a Resource, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#l.
\textsuperscript{117} For example, it is not uncommon for an individual who is in the early stages of a disabling disease, such as Alzheimer’s disease, to place his or her property in trust for future management when he or she is unable to manage it himself or herself. The trust will usually state how the trust property is to be distributed upon the death of the settlor or his or her restoration to capacity.
is a term that rarely appears in state trust codes.\footnote{The term appears in the Idaho Code chapter on charitable trusts, I.C. 68-1204.} The POMS states that a “residual beneficiary (also referred to as a contingent beneficiary) is not a current beneficiary of a trust, but will receive the residual benefit of the trust contingent upon the occurrence of a specific event, e.g., the death of the primary beneficiary.”\footnote{Social Security Online, POMS SI 011120.200 (B)(12), Residual Beneficiary, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#b.} The definition confuses the common law concepts of “vested” as opposed to “contingent” beneficiaries. The beneficiary described at the end of the definition (the one who takes at the death of the “primary beneficiary”) could be either a vested beneficiary or a contingent beneficiary.\footnote{If the beneficiary were simply named as the recipient upon the life beneficiary’s death, the beneficiary’s interest would be vested. If the named beneficiary would take only if he or she survived the life beneficiary, the beneficiary’s interest would be contingent.} Presumably, what this definition is intended to convey is the concept that if there is a beneficiary other than the current beneficiary, the grantor is not the “sole beneficiary.” Some states provide in their trust codes that if there are “successor beneficiaries after the death of the settlor,” a trust is not merged or terminated simply because “there is one settlor who is the sole trustee and the sole beneficiary during the lifetime of the settlor.”\footnote{N.R.S. 163.007. See also M.C.A 72-33-210, SDCL 55-1-15 (which use the term “trustor” instead of “settlor”).}

\section*{C. Residual or Successor Beneficiaries}

The question that next arises is: who would be an appropriate “successor” or “residual” beneficiary in this context? Again, to state the obvious, if there are specific persons who are named in the trust, they would constitute “residual beneficiaries.”\footnote{Id. The example used in the POMS is a trust in which the SSI claimant’s siblings will be the trust beneficiaries when the claimant dies. Social Security Online, POMS SI 011120.200 (L)(2)(b)(Example 2), https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#l. The POMS states that in this case the siblings are “residual beneficiaries who become the beneficiaries upon the prior beneficiary’s death or occurrence of another event” and thus “the trust is not revocable under the rule for grantor trusts … because the claimant is not the sole beneficiary.”} But often a trust will not name living persons as the successor beneficiaries, but rather will use a class of persons, such as the individual’s “heirs” or “heirs at law” or “issue.” Other trusts may provide simply that any remaining assets in the trust will be paid to the settlor’s estate or to the personal representative of the settlor’s estate. Presumably this means that the assets will be distributed under the settlor’s will, if there is a valid will in place, or to the heirs of the settlor’s estate as determined under the laws of descent and distribution.

Although these doctrines are never mentioned in the POMS, the issue of the effect of “unnamed” residual beneficiaries evokes the doctrine of merger, the DWT, and the Rule in Shelley’s Case.\footnote{These doctrines are discussed in Part III (B), supra.} As discussed earlier, these doctrines provide that a grant to an individual for life, followed by a purported remainder interest in that individual’s heirs, is in reality a grant to that individual alone. Furthermore, if the grantor is the one who is named as the life beneficiary — that is, if the grantor transferred property to himself for life and then to his heirs — he in essence retained the entire interest in the property. Using the words of the POMS, there would be no recognizable “residual beneficiaries”
and thus the grantor would be the sole beneficiary and, following the “general principle of trust law,” the trust would be revocable. As also noted above, these doctrines have been abolished by legislation or case law in many states, and in many states have been reduced from a rule of law to a rule of construction. As a rule of construction, the doctrine would cause the grantor to be viewed as the sole beneficiary absent evidence of a contrary intent to create a remainder interest in the settlor’s heirs or estate. The POMS embraces the approach of the Restatement (Third) of Trusts as the “modern view” but still insists upon a state-by-state analysis. Thus, the Regional Counsel Offices were left with the somewhat daunting task of analyzing state case law and legislation to determine whether certain trusts are indeed “grantor trusts” and whether such trusts are revocable.

D. The Regional Office Reports

The Regional Office of General Counsel (RGC) reports of some of the SSA regions contain detailed explanations of whether and to what extent “unnamed” beneficiaries (such as “heirs” or the settlor’s “estate”) will or will not cause a trust to be revocable. The RGC reports unfortunately do not cite statutes or case law for the conclusions that are reached. The reports are not uniform either internally or when compared one to another, and they contain information in a variety of different formats. This article will provide a summary of the RGC reports’ conclusions and some speculation as to why those conclusions were reached.

The RGC reports consistently provide that a trust in which a specific person is named as the remainder beneficiary is not a revocable grantor trust. The reports of state law begin to vary when no remainder beneficiary is named or when a class of beneficiaries (the settlor’s children, issue, descendants, heirs, etc.) is the named remainder beneficiary. The conclusions in the RCG reports about trusts for which there is no identifiable person specifically named as the residual beneficiary generally fall into the following two categories:

1. Trusts that are expressly irrevocable or are presumed irrevocable but in which no residual beneficiaries are named; or
2. Trusts that are expressly irrevocable or are presumed irrevocable but a class of residual beneficiaries or the settlor’s “heirs” or “estate” is named.

In Category 2, further exploration reveals that different states accept different beneficiaries as appropriate residual beneficiaries.

126 See supra text accompanying n. 91.
127 “Under the modern view, residual beneficiaries are assumed to be created, absent evidence of a contrary intent, when a grantor names heirs, next of kin, or similar groups to receive the remaining assets in the trust upon the grantor’s death. In such case, the trust is considered to be irrevocable.” Social Security Online, POMS SI 011120.200 (D)(3), Revocability of Grantor Trusts, https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200#d.
128 In fact, these reports are not even uniformly named, bearing such titles as Grantor Trusts (SI BOS01120.200) Revocability of Grantor Trusts (SI KC01120.200), and Trust Property (SI DAL01120.200).
129 An exhaustive analysis of the state case and statutory law in the states covered by the RGCs’ reports is beyond the scope of this article.
1. Category 1: Trusts that are Expressly Irrevocable or are Presumed Irrevocable and No Residual Beneficiaries are Named

In some states, according to the Boston regional report, the mere labeling of the trust as “irrevocable” or the presumption of irrevocability that arises by law is adequate to make the trust irrevocable without further exploration. There is no need to name residual beneficiaries in these trusts. Some state statutes provide this rule expressly. In those states that do not contain such a clear statutory provision, presumably the RGC has unearthed case law or other statutory law that leads to such a conclusion, although such law is rarely cited in the reports. This conclusion deserves closer scrutiny, however. For example, the RGC report for the Boston region lists the following states as states in which such trusts would be irrevocable without naming residuary beneficiaries: Massachusetts, New Hampshire, and Maine. The comment on New Hampshire states in part that New Hampshire has “enacted the Uniform Trust Code. Under this statute, a New Hampshire grantor trust created October 1, 2004, or later is presumed to be irrevocable if it states that it is irrevocable, despite the lack of a residual beneficiary.”

The same conclusion (without the accompanying explanation) is reached for Maine, which has also adopted the UTC. This conclusion is curious in light of the fact that the revocation provision of the Uniform Trust Code, Section 602, which was adopted by New Hampshire and Maine, does not use the term “grantor trust” nor does it make any mention of the presence or absence of “residual beneficiaries.” It is interesting that the RGC reports of other states that have adopted the UTC do not draw this broad conclusion from the UTC revocation language. In fact, the Boston RGC report is one of only a few reports that list states in which no residual beneficiary at all need be named. The other regional reports concentrate instead on who are appropriate residual beneficiaries.

---

130 See Nev. Rev. Stat. 163.550, which provides as follows: “1. If the settlor of any trust specifically declares in the instrument creating the trust that such trust is irrevocable it shall be irrevocable for all purposes, even though the settlor is also the beneficiary of such trust. 2. Such trust shall, under no circumstances, be construed to be revocable for the reason that the settlor and beneficiary is the same person.” Nevada law is not addressed in any of the regional reports. As noted above, in New Jersey and Ohio, Medicaid trusts are addressed specifically and are irrevocable regardless of whether a residual beneficiary is named.


132 This provision states simply: “Unless the terms of a trust expressly provide that the trust is irrevocable, the settlor may revoke or amend the trust.”

133 For example, both North Carolina and South Carolina have adopted this UPC provision. See N.C. Stat. 36C-6-602 S.C. Stat. 62-7-602. Yet, in the Atlanta POMS, the two states are said to have different state laws relating to revocability. In South Carolina, according to the POMS, “the trust must specify a particular person or entity as the residual beneficiary.” Social Security Online, POMS SI ATL 01120.201(C), Residual Beneficiary, https://secure.ssa.gov/poms.nsf/lnx/0501120201ATL. Yet, for North Carolina, the words “heirs” or “estate” are also sufficient to name a residual beneficiary. In neither state does the UTC revocability provision abrogate, as it did in New Hampshire and Maine, the need for a residual beneficiary to be named at all.

2. Category 2: Trusts that are Expressly Irrevocable or are Presumed Irrevocable and Residual Beneficiaries are Included

As noted above, most of the regional reports conclude that a grantor is the “sole beneficiary” of a trust, thus making the trust revocable despite its terms, unless there are one or more appropriate “residual beneficiaries.” As also noted, the decision of whether a trust is irrevocable is an easy one if actual persons are named as the residual or successor beneficiaries. The vexing question is: What happens if the trust uses only vague terms, such as “issue” or “descendants” or “my estate” to define the ultimate distributees of the trust property? The regional reports zero in on this problem and in many cases are quite specific as to which classes, groups or entities do or do not rise to the level of appropriate residual beneficiaries.

a. Children of the Grantor

It seems relatively undisputed that when a trust names the settlor’s living child or children as the residuary beneficiary and the settlor does in fact have living children, the settlor is not the sole beneficiary. But what if the trust names the settlor’s children and the settlor has no children? The Atlanta regional report addresses this question as it applies in two states, Tennessee and Mississippi. The report says that a Tennessee trust has a residual beneficiary if the trust names any residual beneficiary — “even an unborn child.”

The description of Mississippi law, on the other hand, is as follows: “[A]s long as the trust names a residual beneficiary, other than an unborn child, it is not a sole beneficiary trust and, therefore, cannot be revoked by the grantor. When the residual beneficiary is an unborn child or children, and the grantor has no children, examine the file for evidence that the grantor is unable to have children.” This direction to determine whether the settlor can have children is apparently drawn from the case of Citizens National Bank of Meridian v. Longshore. One issue in this trust termination case was whether the court had all of the proper parties before it. The case involved a trust that was to pay the life beneficiary for her lifetime and then pay her issue when they reached age 21. The life beneficiary had a hysterectomy, so the court determined that there would be no issue of the life beneficiary. That being the case, the court determined that the trust should terminate and the trust property be distributed over to the life beneficiary. This case revolved around whether termination of the trust was appropriate, not whether the trust was revocable, but the conclusion the SSA has apparently extrapolated from the case is that, if the settlor has no children and is unable to have any children, there is no residual beneficiary of a trust that purports to give the remainder over to the children. Thus, such a trust would be deemed revocable.


As noted above, the DWT would cause a trust in which the settlor specified that the remainder interest was to be paid to his heirs, heirs at law, etc., to be revocable because the designation would do nothing more than reserve a reversion in the settlor, making him the sole beneficiary of the trust. As also noted, this doctrine has been abolished by

---

135 This concept is supported by the Restatement (Second) Trusts Sec. 127 comment b.
statute in many states, although there remains a question in even some of those states as to whether it remains as a rule of construction.

In some states, it is unclear whether the DWT still exists as a rule of law or a rule of construction. In those states, the SSA calls not only upon case law in the state but upon the Restatements (Second and Third) of Trusts and trust treatise writers such as Professor Austin Scott137 to determine whether to apply the doctrine. The process itself cannot help but be quite time consuming and its accuracy cannot be guaranteed.138

---

137 See supra n. 70, for a discussion of the work of Professor Scott.

138 For example, it is worth quoting in detail a 2006 Illinois PS in which the SSA determined that the trust in question was a revocable trust despite arguably conflicting dictates from its chosen sources of law:

Based on our research, we conclude that Monica is also the sole beneficiary of the trust. Monica is the only named beneficiary of the trust during her lifetime, and on termination of the trust, or her death, the remainder of the trust assets, after reimbursement to state agencies for benefits received and other specified administrative costs, are to be distributed as provided in Monica’s will, or if there is no will, to her estate. Trust, Article Three. Scott on Trusts clarifies that Monica is the sole beneficiary of the trust. Under Scott, a settlor is a sole beneficiary when she conveys property in trust to pay the income to her for life, and on her death to convey the property to her estate, or as she should by will or deed appoint. William F. Fratcher & Austin Wakeman Scott, *Scott on Trusts*, § 127.1 (4th ed., Little Brown & Co. 1987).

It follows that, under the Restatement (Second) of Trusts, the inference is that, although there is a provision under the power of appointment as to the disposition of the trust property on Monica’s death, Monica intended to be the sole beneficiary of the trust and no residual interest was created. See Restatement (Second) of Trusts § 127, comment b; *Bescor, Inc., v. Chicago Title & Trust Co.*, 446 N.E.2d 1209, 1211 (Ill. App. 1983), the test for determining who is the beneficiary of an express trust is the intent of the parties imposing the trust, and this intention will be ascertained from the express language of the trust. Section 127 also provides that Monica is the sole beneficiary where she transfers the property in the trust to pay the income to herself for life and on her death to pay the principal to her estate. See also Restatement (Second) of Trusts § 127, comment b. Under Restatement (Second) of Trusts § 127, Monica is the sole beneficiary of the trust. The trust is, therefore, revocable and should be considered a resource. Sections of the Restatement (Third) of Trusts present apparently conflicting interpretations of the trust’s language and whether Monica would be the sole beneficiary. Under § 44 of the Restatement (Third), it is not necessary that the intended beneficiary or beneficiaries be known at the time of the creation of the trust, but a beneficiary must be capable of becoming existent and ascertainable in the future by exercise of a power of appointment. Restatement (Third) of Trusts § 44, comment a. Under this explanation, the power of appointment by will arguably creates a residual interest and Monica is not the sole beneficiary. However, § 46 of the Restatement (Third) of Trusts states that where “…the owner of property transfers it upon intended trust for the members of an indefinite class of persons, no trust is created.” Restatement (Third) of Trusts § 46(1). A class of persons is indefinite if the identity of all individuals comprising its membership cannot be ascertained. Restatement (Third) of Trusts § 44, general comment. We note that, with the paragraph discussing the termination of the trust upon Monica’s death with the remainder of the trust assets to be distributed as provided in Monica’s will, the trust gives Monica the right to distribute the property to persons to be selected from an indefinite class of beneficiaries. Under this explanation of the Restatement (Third) of Trusts, this power of appointment by will does not create a residual interest, and Monica is, therefore, the sole beneficiary. Because the Restatement (Third) does not resolve this apparent conflict, and does not purport to reverse the position taken in the Restatement (Second), we believe that application of § 127 of the Restatement (Second) and Scott is appropriate. Accordingly, the disposition of the trust property on Monica’s death under the power of appointment does not create a residual interest, and the trust
Even in some of those states in which the RGC generally approves the use of these terms, the agent is reminded that he or she should look for any evidence that “suggests that such designation was not intended to create a beneficial interest in any individual other than the grantor himself or herself.” It is hard to fathom the type of evidence that is contemplated by this direction and still more difficult to envision the type of sophisticated analysis that would be required by an agent who is left with this discretion. The two probable results are that: 1) the average agent will not even know to look for additional evidence and thus approve all trusts that contain this language or 2) the overly scrupulous agent will refer almost every trust that has this language to the Office of General Counsel.

Claimants who have the easiest time withstanding the application of the DWT are those in states that have statutes that make it clear that the DWT is not applicable as a rule of law or as a rule of construction, or that otherwise make clear that a grant to an individual’s heirs, etc., is intended to create a remainder interest and thus to contemplate appropriate residual beneficiaries. Recent additions to this list of states include Florida, Georgia, Massachusetts, and Virginia. It is no accident that these states have enacted such specific laws. In each state, the members of the Elder Law and Fiduciary Sections of the State Bars realized the need for a specific law to wrest from the SSA the discretion to decide whether or not the DWT applied.

Massachusetts was one of the first states to encounter the possible ill effects of the misinterpretation of its state law by the SSA. Beginning in 1994, the regional offices of HHS and the SSA issued circulars that dictated that in all the states in the Boston region, a trust must contain specific named residual beneficiaries in order to be considered irrevocable. “Heirs” and the “estate” of the settlor were not considered to be appropriate beneficiaries. At that time, Massachusetts had in place two statutes, one applying to testamentary transfers and one applying to inter vivos transfers, which said exactly the opposite of each other. The wording of these statutes may have been confusing to the federal lawyers who interpreted them, because the statutes spoke of grants to heirs and next of kin as conveying “by purchase and not by descent.” It was not until 2003 that the Boston RGC issued a corrected report that indicated that Massachusetts does not follow the DWT. There is no record of how many trusts were rejected during that time due to this misinterpretation of the law. Finally, in 2008, the Massachusetts legislature removed

is revocable and should be considered a resource.


140 See e.g., AZ 2008 PC which concluded that “[s]ince Arizona does not recognize the Doctrine of Writhe Title, there would be no reversionary interest to the grantor. Ariz. Rev. Stat. Ann. § 14-2710.”

141 The origin and content of these circulars is described in Linda L. Landry & Neal A. Wilson, Estate Planning for the Aging or Incapacitated Client in Massachusetts: Protecting Legal Rights, Preserving Resources, and Providing Health Care Options, Volume I, Part II: Income Programs, Chapter 6, Supplemental Security Income (available on Westlaw).

142 M.G.L.A. 134 § 33A.

143 M.G.L.A. 134 § 33B.

144 As explained in Part III, the DWT and the Rule in Shelley’s Case dictate that conveyance by descent is the preferable interpretation.
all doubt by adopting the UPC statute that clearly and unequivocally abolishes the DWT as a rule of law and a rule of construction and that expressly blesses the use of words such as “heirs,” “heirs at law,” “next of kin,” “distributes,” “relatives,” or “family” to establish residual beneficiaries.

In Florida, Elder Law attorneys were continually challenged with the application of the DWT to their trusts in accordance with the statement in the regional report that Florida essentially followed the DWT.\textsuperscript{145} In 2007, the Florida legislature enacted a statute similar to the one enacted by Massachusetts. At the behest of the Elder Bar Section of the State Bar of Florida, the SSA issued a revised report stating that, in Florida, “wording such as “to my heirs,” “to my heirs at law,” “to my next of kin,” “to my distributees,” “to my relatives,” or “to my family” (or language of similar intent) is sufficient to name a residual beneficiary.”

In Virginia, case law had applied the DWT as a rule of construction if not as a rule of law.\textsuperscript{146} In 2007, the Virginia legislature enacted a statute that says simply, “The doctrine of worthier title is abolished in this Commonwealth as a rule of law and as a rule of construction.”\textsuperscript{147}

The situation in Georgia is perhaps the most indicative of the danger to Medicaid claimants when federal government workers who are not schooled in trust law are allowed to interpret this highly complex area of the law. Prior to 2010, the POMS for the Atlanta region listed Georgia as one of those states in which a particular person must be identified as the remainder beneficiary of a trust. The words “estate” or “heirs” were not adequate to create an interest in anyone other than the life beneficiary. This provision was applied in 2008 in POMS PS 01825.012. In that case, a Georgia trust was created that, by its terms, was “to be in full compliance with … the provisions and requirements contained in 42 U.S.C. Section 1396p or related Statutes ….” After the required Medicaid payback to the State of Georgia, any remaining trust amounts were to be paid to the claimant’s “estate.” The trust contained no power on the part of the settlor to amend or revoke the trust, thus making the trust irrevocable under Georgia statutory law. The PS recognized this provision of the Georgia Code, but then expanded its reach beyond the clear mandate of the statute, by stating: “Despite these general provisions within the Georgia Code, however, long-standing case law has held a settler, who is the sole beneficiary of a trust, has the right to terminate the trust despite language in the trust instrument that states the trust is irrevocable.” The PS then cited two Georgia cases which in fact stood for that proposition, Moore v. First Nat’l Bank & Trust Co. of Macon, 130 S.E. 2d 718, 721-22 (Ga. 1963), and Woodruff v. Trust Co. of Ga., 210 S.E. 2d 321, 324 (Ga. 1974). In Moore, the trust provided that income to the settlor for life “and for such other persons after her

\textsuperscript{145} See Smiarowski v. Commissioner of SSA, 2002 WL 32163769 (11th Cir. 2002), in which the Court of Appeals for the Eleventh Circuit affirmed a SSA determination that a trust was revocable due to the application of the DWT. This case is described in detail in Hook & Begley, supra n. 6, at 206. Florida attorney David Lillesand was not successful in arguing this case for Tiffany Smiarowski, but was a driving force behind the adoption of the new Florida clarifying statute. See also Administration of Trusts in Florida, Chapter 17, David J. Lillesand & Marjorie J. Wolasky, Special Needs Trusts, § 17.25 (6 th ed., Florida Bar 2009).

\textsuperscript{146} Braswell v. Braswell, 195 Va. 971, 81 S.E.2d 560 (1954), and Bottimore v. First and Merchants National Bank of Richmond, et al., 170 Va. 221, 196 S.E. 593 (1938).

death as she may by deed or will designate.” The court, citing the Restatement (Second)
of Trusts, held that the trust was revocable even though its terms it was irrevocable. In *Woodruff*, the trust was originally made revocable, but was soon amended to make it revocable only with the consent of the trustee. Ms. Woodruff, the settlor, was the sole life beneficiary with amounts remaining at her death to be payable “to my personal representative.” The trust also authorized encroachments in such amounts as she requested. The court allowed her to revoke the trust. What the PS failed to appreciate was that the statute cited in both cases was the statute as it existed prior to its amendment in 1973. This amendment added new subsections (b) and (c) to then Ga. Code Ann. Section 108-111.1 (enacted in 1950, later codified as O.C.G.A. Section 53-12-3), which provided as follows:

(b) No such trust which is expressly or impliedly made irrevocable may be revoked or terminated in whole or in part while the trust is executory.

(c) No such trust shall be considered to be executed or revocable because the testator or settlor or some other person has a life estate therein and has or retains a general power of appointment over assets in the trust or because a remainder interest therein goes to or vests in the estate of the testator or goes to or vests in the settlor or other person or in the estate of the settlor or other person.

In *Woodruff*, which dealt with a trust that was established prior to the 1973 amendment, the court examined the retroactivity of that amendment. In its discussion, the court noted that the “apparent purpose of this 1973 amendment was to nullify the ruling of this court in *Moore*.” However, because the Woodruff trust was created prior to the amendment, the court found that Ms. Woodruff had a vested right to terminate, which could not be impaired by the enactment of the amendment. In this respect, the *Woodruff* discussion made it clear that *Moore* was no longer the law in Georgia. Unfortunately, this revised Code section was not carried forward when the Georgia Trust Code was recodified in 1991. However, the statute on its face overturned the holding in Moore and the fact that it was not carried forward in the 1991 Code would most likely have not negated that result. Furthermore, this amended Code section was not the only provision of the Georgia Code that dealt with this issue. Georgia Code Section 44-6-23 (formerly Ga. Code Ann. 85-504), which was not cited by the courts in the *Moore* and *Woodruff* cases, provides as follows:

Limitations over to “heirs,” “heirs of the body,” “lineal heirs,” “lawful heirs,” “issue,” or words of similar meaning shall be held to mean “children” whether the parents are alive or dead. Under such words the children and the descendants of deceased children by representation in being at the time of the vesting of the estate shall take.

This Code section had been found by the Supreme Court of Georgia to be the “re-
verse of the Rule in Shelley’s Case.” 148 Both Professor Verner Chaffin,149 a leading expert in Georgia fiduciary law, and Professor Lewis Simes,150 a national expert in property law, opined that the effect of this statute was to abrogate the DWT in Georgia. In Thompson v. Batts,151 a North Carolina statute with virtually the same language was found to make a gift to an individual’s heirs a remainder rather than a reversion to the grantor.

As the above discussion illustrates, the rule of law that was so confidently cited in both the Atlanta Regional POMS and the PS was far from solid. Georgia law, like that of so many states, contained a complex web of cases and statutes that had an impact on the application of outmoded doctrines such as the DWT and the Rule in Shelley’s Case. It is highly improbable that the lawyers who drafted the trust at issue in the POMS had any notion that these abstruse rules still had any bearing in Georgia. Even more absurd is the notion that the claimant in the cited PS would have purposely used the trust terminology in order to “game” the system and create a trust that appeared irrevocable but in fact was not.

In response to this unrelenting and incorrect application of the DWT by the SSA, the 2010 Georgia Trust Code included a provision that was designed specifically to codify what the SSA could not glean from the Georgia laws and cases.152 Georgia Code Section 53-12-44 now provides as follows:

No trust shall be considered to be revocable merely because the life beneficiary has a reversion in or a power of appointment over assets of the trust or because the life beneficiary’s heirs or estate have a remainder interest therein.

In October 2010, the Atlanta Regional POMS was amended, citing this statute, to take Georgia out of the group of states in which the use of the terms “heirs” or “estate” caused a trust to be irrevocable.

The Georgia example is perhaps the most illustrative, but certainly not the only one that conveys the myriad issues that can be overlooked when any government official or lawyer — even those most skilled in trust law — tries to comprehend and clarify policies that have become muddied and inconsistent with the law. The fact that a trust was not deemed eligible for Medicaid purposes due to the misapplication of long-forgotten doctrines would be laughable were it not for the tragic context in which this decision was made. The claimant in the Georgia PS was a 10-year-old child who had experienced extensive brain damage after an anoxic brain injury five years earlier. Her parents had established the trust for her from the settlement proceeds of the lawsuit filed in connection with the injury. The unnamed but ubiquitous doctrines from English feudal law made her ineligible for SSI and

150 Lewis M. Simes, Law of Future Interests: a treatise dealing with the creation, characteristics, vesting and termination of future interests in land and other things, including the construction of instruments involving such interests, 65, n. 7 (West Pub. Co. 1936).
151 168 N.C. 333, 84 S.E. 347 (1915).
152 The author of this article was the Reporter for the Georgia Trust Code Revision Committee and thus can attest first-hand as to why this provision was included in the 2010 Georgia Trust Code.
thus caused her trust to be counted as a resource for Medicaid purposes.\textsuperscript{153}

c. **Estate, and Last Will and Testament**

Despite the fact that in many of the states a gift over to the settlor’s heirs is deemed to create sufficient residual beneficiaries, a gift over to the settlor’s “estate” or “to be distributed under the terms of the settlor’s Last Will and Testament” is not. A quick summary of some of the regional reports indicates the confusion that reigns on this issue.

1. The Kansas City report provides: “If the trust states only that the grantor’s own estate will receive any remaining trust assets on the grantor’s death, and names no other beneficiaries to the trust, the trust should be considered revocable.” No mention is made of the result if the trust directs that payment be made in accordance with the settlor’s last will and testament.\textsuperscript{154}

2. In Indiana and Illinois, the regional report provides that a trust made payable to the settlor’s estate is considered revocable. However, if the trust states that the trust assets are to be distributed according to the settlor’s Last Will and Testament, the reviewer should send the trust to the regional office for referral to the Office of General Counsel.\textsuperscript{155}

3. For Michigan and Minnesota, the same regional report that discusses the Indiana and Illinois rules states that if the trust states that the trust assets are to be distributed according to the settlor’s Last Will and Testament, the reviewer should send the trust to the regional office for referral to the Office of General Counsel. However, this section of the report makes no mention of the result if the trust assets are to be paid to the settlor’s estate.\textsuperscript{156}

4. In the Atlanta report, a distribution to the settlor’s estate is appropriate under the laws of North Carolina and Georgia. No mention is made for any of the states in this region of the effect of a direction that the trust assets be distributed under the settlor’s Last Will and Testament.\textsuperscript{157}

d. **The State**

A final possible “residual beneficiary” to be considered is the state. As has been discussed, the Medicaid rules allow a trust to be exempt as a resource for Medicaid purposes if the trust provides that any assets remaining upon the death of the Medicaid recipient will be used to reimburse the state for Medicaid amounts expended on that recipient’s behalf. The trust must explicitly include such a payback provision. Does the inclusion of this provision result in the state being a “residual beneficiary” so as to prevent the trust from being deemed a revocable grantor trust? Although conceding that this is a matter of state law, the general POMS provides that “[a]ccording to the law in most [s]tates, the [s]tate

\textsuperscript{153} This case is similar to the one described \textit{supra} in the text accompanying n. 1.

\textsuperscript{154} Social Security Online, POMS SI KC01120.200, \textit{Revocability of Grantor Trusts} (July 13, 2009), \url{https://secure.ssa.gov/poms.nsf/lnx/0501120200KC}.

\textsuperscript{155} Social Security Online, SI CHI 01220.200 (D)(1) \textit{Illinois}, (2) \textit{Indiana}, \url{https://secure.ssa.gov/poms.nsf/lnx/0501120200chi}.

\textsuperscript{156} SI CHI 01220.200 (D)(3) \textit{Michigan}, (4) \textit{Minnesota}, \url{https://secure.ssa.gov/poms.nsf/lnx/0501120200chi}.

\textsuperscript{157} Social Security Online, SI ATL01120.201, \textit{Trust Property} (Oct. 19, 2010), \url{https://secure.ssa.gov/poms.nsf/lnx/0501120201ATL}. 
is not considered a residual or contingent beneficiary, but is a creditor and the reimbursement is payment of a debt, unless the trust instrument reflects a clear intent that the [s]tate be considered a beneficiary, rather than a mere creditor.”

In Carden v. Astrue, 159 a federal district court addressed this question in the context of a West Virginia SNT that provided for the appropriate payback to the state and then that any remaining amounts in the trust would be paid to the life beneficiary’s estate, to be distributed in accordance with his Last Will and Testament. The court held that the trust was revocable. The court dismissed the claimant’s argument that the state was a named residual beneficiary under the trust. The court cited extensively the Restatement (Third) of Trusts, Section 48, for its discussion distinguishing trust beneficiaries from trust creditors and found that the state was merely a creditor. 160

That presumption, however, does not carry in all states. In the RGC report for New York and New Jersey, the report stated that the inclusion of a named beneficiary in a New York trust such as “the State of New York (for Medicaid reimbursement payments made on behalf of the beneficiary)” would result in the settlor not being deemed to be the sole beneficiary. 161 The Dallas report provides that the same rule applies in Arkansas, New Mexico, Oklahoma, and Texas. 162 The Chicago report indicates that in all the states in its region, with the exception of Ohio, 163 the state is generally not a residual beneficiary “unless there is a clear intent that the state is an intended beneficiary of the trust rather than a mere creditor.” This seems to be a somewhat obscure reference to an unpublished opinion from the federal district court in the Northern District of Illinois in which the trust named the state as the “sole successor beneficiary” and the court found the trust to be irrevocable. 164

V. Conclusion

As the foregoing discussions indicate, state laws relating to the effect of the feudal English doctrines are in a state of confusion and disarray. There is no need for the SSA to wade into this fray, as it could easily establish a clear and simple set of rules of uniform application that would maximize the number of trusts that would be accepted as SNTs,

159 2008 WL 867942 (not published in Fed. Supp.).
160 In PS 01825012 Georgia PS 08-109 (2008), the Regional General Counsel found that the state of Georgia had no case law designating the state as a residual beneficiary and thus that Carden would be applied for the principle that the state was not a creditor. By this application, the GC seemed to indicate that the presumption would be that the state is not a creditor. No explanation was given as to why case law from the state of West Virginia should be determinative of the law in Georgia.
162 Social Security Online, SI DAL01120.200(C), Residual Beneficiary by State, https://secure.ssa.gov/poms.nsf/lnx/0501120200DAL.
163 Ohio has a statute that provides that any trust that states that it is irrevocable and that meets the criteria of the SNT statute is automatically irrevocable regardless of whether residual beneficiaries are named. Ohio Rev. Code Ann. Sec. 5804.11(A). See also Quinchett v. Massanari, 185 F.Supp.2d 845 (S.D.Ohio 2001).
cut down significantly on the bureaucratic, judicial and legislative time spent on resolving these issues, and bring fairness and clarity into an arena whose hallmarks have been chaos and disparate treatment.

A. Reasons for Simplification

There are several reasons why this simplification should be endorsed:

1. The application of the DWT, the Rule in Shelley’s Case, and the doctrine of merger as rules of construction to discern a settlor’s intent is completely inappropriate in these cases. Most SNT documents are replete with information as to what is the settlor’s intent, thus abrogating the need to turn to a rule of construction. Many, if not most, state that the document is intended to be irrevocable. Many, if not most, state that the purpose of the document is to provide a means for supplementing, not supplanting, any governmental assistance available to the settlor. Many, if not most, even cite the applicable federal statutes and state that the trust is intended to comply with those statutes. It defies logic that a settlor’s trust that contains all of these indices of intent would even need to be construed. The intent is clear on the face of the document. There is no need to delve further.

2. The current process for defining revocable trusts is a wasteful expenditure of federal money, legislative effort, court time, and the assets of claimants. Those states for which GRC reports have been issued are sometimes saddled with misinterpretations of a very complex area of trust law. Much time, energy, and staff time is spent on the compilation of these reports and, in some cases, the attempted refutation of their findings by attorneys in the various states. Time also has been devoted to legislative reform in those states in which the SSA has construed cloudy state law in its favor. Other states that do not have reports are left with little or no guidance as to what the SSA’s interpretation of their state’s law will be. Most tragically, disabled claimants who are in precarious financial situations are forced to expend their precious funds in legal challenges to these SSA findings.

3. The SNT statutes were designed to help people qualify for Medicaid, not to serve as a bar to them doing so. Prior to the enactment of OBRA’93, the status of a trust that was established by a disabled beneficiary’s assets was unclear. While portions of OBRA’93 were aimed at curtailing abusive situations in which persons of means sought to make themselves eligible for Medicaid by transferring their property to trusts, the SNT legislation had the opposite purpose. This legislation was not enacted to counteract abuse but rather to map out for disabled individuals a way in which they could transfer their own assets to trusts that would supplement (rather than supplant) any available government assistance. The harsh treatment by the SSA of refusing to qualify these trusts due to an application of arcane and confusing law is contrary to the intent and spirit of the SSA statutes.

4. The SNT statutes do not require the SSA to look to state trust law in order to define which trusts are revocable. Although federal laws have typically taken that approach when matters such as family law or property law are at issue, the SSA in the POMS does not hesitate to present its own version of state law terms and definitions.

5. The attempted application of state law, even if accurate, results in arbitrary distinctions
among the states. In some states a remainder interest in “heirs” is sufficient; in others it is not. In some states a remainder interest in the settlor’s “estate” or a distribution in accordance with the settlor’s Last Will and Testament is sufficient; in others it is not. In some states a remainder interest in the settlor’s “estate” is sufficient while a remainder interest to be paid in accordance with the settlor’s Last Will and Testament is not. In some states, the state’s Medicaid authority is a creditor while in other states it is an appropriate “residual beneficiary.” The list of discrepancies is a long one, and for many states there are not even GRC reports to reveal what is the SSA’s perception of that state’s laws.

6. The current process for defining a revocable trust is an imprecise one at best. As discussed above, the GRC reports vary across the board as to how they define revocable trusts. The reports have been arguably inaccurate at times, as was discussed above in Part IV. In other situations, the General Counsel has found no clear law in the state and thus resorted to the laws of other states or even the Restatements, the trust treatises, and general dictionaries of legal terms. A typical judge or lawyer (in fact, even experienced trusts and estates lawyers) does not understand these topics, as the variety of holdings in these cases show. There is no evidence that the lawyers who are performing the research for the SSA have any more advanced understanding. The law in many states is simply not clear and defies any attempt to elucidate.

7. Although Medicaid is a state and federal joint venture, it is doubtful that state governments would jealously guard their authority to use arcane English doctrines to define what makes a trust revocable. States can and have taken advantage of their authority to govern in the realm of Medicaid. However, it is doubtful that any state Medicaid authority would have the time, assets, and background, let alone the desire, to challenge an SSA-imposed definition of a revocable trust. In the event a state should exercise its authority and declare a purportedly irrevocable trust to be revocable, the POMS has already considered that eventuality. In Section H of POMS SI 01120.200, the SSA describes the payback provision in trusts as one that provides that upon termination of the trust or the death of the beneficiary, the State Medicaid agency will be reimbursed for medical assistance paid on behalf of the individual. It would be very simple for the SSA to add the payback requirement for an SNT that terminates prior to the death of the beneficiary.

8. The SSA’s basic stance of allowing a trust to qualify if it contains specifically named “residual beneficiaries” is easily avoided by those lawyers who are “in the know.” For example, Elder Law attorneys Andrew Hook and David Lillesand suggest that lawyers drafting SNT trusts add a vested $10 interest in some named individual and then direct the remaining assets to the heirs of the settlor. Professor Rodney Johnson has suggested vesting a one-day income interest in a named charity followed by

---

165 See e.g., the various ways in which states choose to implement the interaction between SSI and Medicaid, as discussed supra in Part I (B).
166 The SNT statute itself does not speak of “termination of the trust” but rather only of the payback being required upon the death of the beneficiary. 42 U.S.C. 1396p(d)(4)(A).
167 Hook & Begley, supra n. 6, at 208.
a remainder interest in the grantor’s heirs. Such solutions highlight how the SSA’s stance glorifies form over substance. Unfortunately, many claimants for whom such trusts are drafted do not have lawyers who have the knowledge, expertise, and insight of Mr. Hook, Mr. Lillesand, and Professor Johnson. While clients in many areas of the law are most often better served by lawyers with the most experience, the penalization of a disabled individual because he or she was not lucky enough to have hired one of these lawyers seems remarkably unfair.

9. The prospects of claimants using subtle techniques such as naming their “heirs” rather than their “descendants” in order to game the Medicaid system and create a secretly revocable trust is virtually nil. First, many of the disabled claimants have lost the capacity to revoke a trust, so even if the trust is revocable, it will remain intact. Second, it strains the imagination to think that a claimant would spend the time and money necessary to create an SNT only to then turn around and revoke it and risk being suspended from the very government assistance program for which he or she worked so hard to become eligible. Third, many SNTs are created by the guardians of disabled settlers. In states that do not allow a guardian to make a will for the ward, the courts often insist that the remainder beneficiaries of the trust be the heirs of the settlor.

The notion that a court requires an SNT to be created in a certain manner, which the SSA then deems inappropriate for Medicaid purposes, borders on the absurd. As noted above, the SNT legislation was not enacted to counteract rampant abuse of the Medicaid system through the use of these trusts, but rather to provide disabled claimants with a safe harbor method of creating a trust that would not render them ineligible for Medicaid.

B. The Solution

The solution to this issue is a simple one and it is one that has been codified in a few states and recognized by at least one state supreme court. The SSA should issue a ruling that provides that if a trust that is specifically designed to be an SNT states that it is irrevocable, the trust is irrevocable, regardless of who is named as a “residual beneficiary” or even if no residual beneficiaries are named at all. The State of New Jersey and State of Ohio have addressed this problem directly by enacting statutes that provide expressly that a trust created as an SNT is irrevocable. Nevada does not refer specifically to SNTs in its code but it provides more generally that if the settlor declares in the trust that it “is irrevocable, it shall be irrevocable for all purposes, even though the settlor is the sole beneficiary of such trust.”

The Supreme Court of New Hampshire articulated well the reasons for the approach suggested by this article. In Lanoue v. Commissioner, Social Security Administration, the Supreme Court reversed a finding by the SSA that an SNT was revocable by its terms

168 Hook & Begley, supra n. 6, at 208, n. 26.
because it left to the disabled settlor’s heirs any assets remaining after the Medicaid payback to the state. The SSA had quoted the sections of the Restatement (Second) of Trusts that were described earlier in this article as their authority for declaring the trust to be revocable. (The DWT was not mentioned by the Court.) The Court instead focused on the intent of the settlor. The Court looked to the terms of the trust, which indicated that it was established to supplement rather than supplant any governmental assistance available to the settlor. The trust explicitly provided that it was irrevocable and that the settlor had no power to influence or direct the distributions from the trust. The Court concluded very simply, “The settlor’s intent is clear. To conclude that the trust is revocable would defeat the purpose of the trust and thwart 42 U.S.C. § 1396p. We will not adopt a construction that will defeat the clearly expressed intent of the settlor.” Many years earlier, when the Court of Appeals for the District of Columbia Circuit held that the DWT was not applicable in the District of Columbia, it used similar reasoning:

The rule we adopt, which treats the settlor’s heirs like any other remaindermen, although possibly defeating the intention of some settlors, is overall, we think, an intent-effectuating rule. It contributes to certainty of written expression and conceptual integrity in the law of trusts. It allows heirs to take as remaindermen when so named, and promises less litigation, greater predictability, and easier drafting. These considerations are no small element of justice.173

A simple acceptance by the SSA that a trust that is established as an SNT is irrevocable would save countless dollars, hours of intellectual labor by the administration, the courts, and the lawyers who represent claimants, and, most importantly, would promote the very purpose for which the SNT legislation was enacted.

AID AND ATTENDANCE PENSION BENEFITS
FOR VETERANS AND SURVIVING SPOUSES:
EFFECTIVE METHODS TO DEFRAY MEDICAL EXPENSES FOR ELDERS

By Adam J. Larson, Esq.

I. INTRODUCTION ................................................................. 37

II. BACKGROUND TO AID AND ATTENDANCE BENEFITS .................. 38

III. ELIGIBILITY REQUIREMENTS ............................................. 41
A. Overview of Eligibility for Pension Benefits with Aid and Attendance ........ 41
B. Active Service ................................................................. 41
C. Qualifying Wartime Periods (WWI, WWII, Korea, Vietnam, Gulf) ............. 43
D. Not “Dishonorably Discharged” ............................................ 44
E. Need for Aid and Attendance .................................................. 46
F. Permanent and Total Disability ................................................ 47
G. Limited Assets and Income ...................................................... 47
1. Net Worth ............................................................................. 47
2. Income .................................................................................. 49
3. Treatment of Trusts ............................................................... 50
4. Overview of Unreimbursed Medical Expenses ..................................... 51
5. Spousal and Dependent Eligibility ............................................. 52

IV. EFFECT OF OTHER PUBLIC BENEFITS ON PENSION CLAIMS ......... 53
A. Medicaid ............................................................................... 53
B. Social Security Income (SSI) .................................................... 54

V. APPLICATION PROCESS ....................................................... 54
A. Note on Powers of Attorney (POAs) ......................................... 54
B. Informal Claims ...................................................................... 55
C. Formal Claims ........................................................................ 56
1. Primary Form ......................................................................... 56
2. Supporting Forms ..................................................................... 57
3. Additional Documentation ....................................................... 59
D. Claimant’s Death and Accrued Benefits ........................................ 59

VI. IMPLICATIONS FOR ATTORNEYS ............................................ 61
A. Accreditation .......................................................................... 61
B. Prohibition of Attorney Fees .................................................... 61

VII. CONCLUSION ...................................................................... 63

I. INTRODUCTION

Astute Elder Law attorneys should always ask one key question when planning for long-term care needs: Are you (or is your loved one) a veteran? Given the new planning challenges facing seniors now that provisions of the Deficit Reduction Act of 2005 have been implemented, veterans benefits can play a crucial role in planning for long-term care.

Adam J. Larson, Esq., is the Executive Director of the Veterans’ Legal Aid Society and specializes in providing pro bono representation to VA pension claimants. He received his Juris Doctor and Certificate in Health Law from Loyola University Chicago School of Law. At Loyola, he served as Publications Editor for Annals of Health Law and published on the topic of Health Savings Accounts.
needs. Many veterans or surviving spouses of veterans (and their attorneys) are unaware that they could likely qualify for significant cash benefits (up to $30,480 annually)\(^1\) under the improved pension program. The basic eligibility requirements are relatively straightforward: 1) 90 days of active duty service, one day of which was during wartime, 2) limited assets and income, 3) the need for regular assistance from another person, 4) the veteran was “not dishonorably discharged,” and 5) the claimant is permanently and totally disabled (or over the age of 65).\(^2\)

This article provides guidance on how Elder Law attorneys can effectively apply for aid and attendance (A&A) benefits on behalf of their clients and addresses some problems inherent in the current VA system attorneys may face in planning for these benefits and navigating the application process. Part II gives a background and context to non-service-connected pensions and the A&A allowance. Part III discusses eligibility requirements regarding military service, disability, assets, and income limitations. Part IV provides an overview of the impact that VA pension benefits may have on other government benefit programs. Part V illustrates the VA application process and potential eligibility barriers. Part VI briefly describes the prohibition on legal fees and the VA attorney accreditation process.\(^3\)

## II. BACKGROUND TO AID AND ATTENDANCE BENEFITS

Pension payments for veterans of the U.S. Military have existed, in one form or another, since the 18th century.\(^4\) The availability of increased pension payments based on the need for aid and attendance, meaning “permanently and totally disabled as to render them utterly helpless, or so nearly so as to require the constant personal aid and attendance of another person,” has existed since the Reconstruction Era.\(^5\) Such pensions,

---


3 Discussion in this article is purposely limited to the applications and eligibility requirements for non-service-connected pension benefits with the aid and attendance allowance. Thus, the topics of VA compensation benefits and the VA benefits appeals process are beyond the scope of this article. Claims for compensation benefits are processed differently than those for pension benefits. Compensation benefits are payable where a veteran’s disability was incurred in the service, or afterward if he or she is able to subsequently prove that his or her disability results from military service. Pension benefits, on the other hand, are available for low-income veterans or for disabled veterans, regardless of whether their disabilities resulted from military service. For an overview of these topics, see Joseph Butler & Brian Clauss, Military Service & the Law (Ill. Inst. For Continuing Legal Educ. 2009).

4 Act of Sept. 29, 1789, ch. 24, 1 Stat. 95, providing pension benefits to “invalids who were wounded and disabled during the late war.”

5 See e.g., Act of June 6, 1866, ch. 106, 14 Stat. 56, providing increased pension payments to disabled soldiers in need of aid and attendance. Pensions, however, were not available to Confederate soldiers, widows, or children. See also Act of July 14, 1862, 12 Stat. 566, 567-68, pensions available only to those “while in service of the United States,” and the act specifically precluded pension eligibility from widows, children, and heirs who “in any way .... aided or abetted the existing rebellion in the United
however, required that the active duty, wartime veteran become disabled as a result of his or her military service.

The relatively modern concept of pensions for non-service-connected disabilities resulted from legislation enacted after World War I. Starting in 1920, Civil War veterans who served in active duty for 90 or more days were eligible for increased pension if their non-service-connected disability necessitated the need for aid and attendance of another person. The availability of pension benefits resulting from non-service connected disabilities was extended to widows and dependent children in 1930. The regulations in effect by 1938 provide the starting point for non-service-connected pensions as they exist today, and the last major changes to the pensions occurred in 1959 and 1978. The basic eligibility requirements in the 1930s — 90 days of active duty wartime service, not dishonorably discharged, non-service-connected disability, limited income — are still in place today. The major changes in 1959 effectuated a slight reduction in eligibility by creating more stringent income standards and incorporating a limitation on the veteran’s net worth. Further, the 1959 Act required pensioners to submit annual income verification reports and provided for adjustment of pension rates if the VA deemed that the pensioner was overpaid benefits.

While the 1959 Act restricted eligibility, the 1978 Act liberalized it — and quite sig-
nificantly. Part of the political push behind this liberalization could have arisen from the fact that a large percentage of the 16 million World War II veterans had attained (or were nearing) retirement age by the late 1970s. Under the 1978 Act, the most significant change was that unreimbursed medical expenses became explicitly excluded from a claimant’s income.\textsuperscript{14} Although Congress allowed the VA to deduct “unusual medical expenses” from income starting in 1972, such deductions were not required under the U.S. Code.\textsuperscript{15} Under the Code of Federal Regulations (C.F.R.), the VA could deduct “unusual medical expenses,” but the determination of whether the expenses were “unusual” was left to the VA adjudicator.\textsuperscript{16} Determining whether such expenses were deductible was fact-specific. “Unusual” encompassed “expenses incurred by reason of chronic invalidism or for surgery or prolonged illness,” but excluded expenses resulting from “brief periods of illness with moderate medical expenses…” In contrast, the term “unusual” was redefined as “excessive” in the 1978 Act, meaning that any unreimbursed medical expenses exceeding 5 percent of the claimant’s income were considered “unusual” and could be deducted.

Another significant change in the 1978 Act was that pension payment rates would increase in tandem with adjustments to Social Security payments.\textsuperscript{17} Given the high inflation rates at that time, and the new (for 1975) Social Security cost-of-living adjustments (COLAs), many pensioners experienced dramatic decreases in their monthly benefit amounts.\textsuperscript{18} The 1959 Act created new income guidelines — thus, any increase in Social Security income caused a veteran’s pension to be adjusted accordingly. Since the COLA was 8 percent for 1975, 6.4 percent for 1976, and 5.9 percent for 1977, many VA pensioners saw dramatic decreases in their monthly pension payments. Consequently, any gains in a pensioner’s Social Security income were effectively neutralized by dollar-for-dollar reductions in pension benefits.\textsuperscript{19}

In 1978, President Carter signed into law the Veterans’ and Survivors’ Improved Pension Act, which expanded the eligibility for active duty wartime veterans, their surviving spouses, and dependent children, to receive pension benefits for non-service-connected disabilities.\textsuperscript{20} Two of the significant advancements arising from this legislation include additional benefits for housebound veterans, as well as the ability of housebound veterans and veterans in need of aid and attendance to subtract unreimbursed medical

\begin{itemize}
\item \textsuperscript{14} Pension Improvement Act of 1978, supra n. 10, at § 102. Contrast the 1972 regulations with those enacted in 1979. The Code further stated that health insurance premiums were considered “unusual” for these purposes. 38 C.F.R. § 3.262(l) (1979). For the “improved” pensions created by the 1978 Act, the medical expense exclusion is defined at 38 C.F.R. 3.272 (2009).
\item \textsuperscript{16} 38 C.F.R. § 3.262(l) (1972).
\item \textsuperscript{17} Pension Improvement Act of 1978, supra n. 10. See also Improved Pension Program, 44 Fed. Reg. 12695 (Mar. 8, 1979), “One of the principal purposes … is to ensure that pension benefits will never be reduced solely as a result of cost-of-living increases in social security benefits.”
\item \textsuperscript{19} Since VA non-service-connected pension payments are determined (partly) by subtracting a claimant’s countable income from the maximum annual pension rate (MAPR), and Social Security retirement benefits are counted in the income calculation, increased Social Security payments without a corresponding increase in the MAPR caused a reduction in pension benefits prior to the passage of the Pension Improvement Act of 1978. See 44 Fed. Reg. 12695, supra n. 17.
\item \textsuperscript{20} See e.g., President’s Statement on Signing H.R. 10173 Into Law, 2 Pub. Papers 1965 (Nov. 6, 1978).
\end{itemize}
expenses from their incomes in order to qualify.\textsuperscript{21} Since VA pension benefits are means-tested, this enhancement expanded eligibility to veterans with moderate income but significantly high out-of-pocket care expenses in relation to their income. Given that non-service pensions were designed to provide veterans a standard of living above the poverty level (without resorting to welfare assistance),\textsuperscript{22} this exclusion was necessary to prevent impoverishment of A&A recipients with high medical expenses in relation to their income. This necessity arises from the fact that, generally, older and disabled individuals have greater (higher cost) care needs and lower incomes when compared to the general population. Because this program pays cash benefits, qualified recipients have the flexibility to pay for in-home care that Medicaid does not necessarily provide.\textsuperscript{23} Alternatively, the pension benefits may be used to defray the cost of assisted living or long-term skilled nursing care.

The Pension Improvement Act of 1978, with minor amendments, provides the basis for the current pension guidelines. The basic eligibility requirements for non-service-connected pensions are largely unchanged after 33 years.

III. \textbf{Eligibility Requirements}

\textit{A. Overview of Eligibility for Pension Benefits with Aid and Attendance}

As previously discussed, there are five basic eligibility criteria for the VA pension with enhanced A&A benefits: 1) 90 days of active service, one day of which was during wartime, 2) limited assets and income, 3) veteran was “not dishonorably discharged,” 4) the claimant is permanently and totally disabled (or over the age of 65), and 5) is in need of the regular aid and attendance of another person.

\textit{B. Active Service}

The first requirement for VA pension benefit eligibility is that the veteran must have completed at least 90 days of active military, naval, or air service, with at least one day of the 90 during a qualifying wartime period.\textsuperscript{24} The types of service that meet this requirement are relatively broad. Aside from actual combat duty, active military service includes full-time military service (other than active duty for training) or service as a cadet in a

\begin{itemize}
\item \textsuperscript{22} \textit{See e.g.}, 124 Cong. Rec. H38,261 (1978), statement of Rep. G.V. (Sonny) Montgomery.
\item \textsuperscript{23} In Illinois, for example, some elders qualify for in-home services through the HCBS waiver Community Care Program. The asset limit for the waiver, however, is $17,500 and an elder must use an in-home service provider certified by the state. 89 Ill. Admin. Code § 240.810, .1600. In contrast, a VA pensioner may have up to $80,000 in assets and has the flexibility to pay the caregiver of his or her choosing.
\item \textsuperscript{24} \textit{Id.} 38 U.S.C. § 1521(j) (Supp. II 2008). The active service requirement is met if the veteran serves at least 90 days of active service during war, serves during war and is discharged with a service-connected disability, 90 consecutive days of active service with at least one day during wartime, or an aggregate of 90 days served during separate periods of war.
\end{itemize}
U.S. military academy. Active duty for training normally does not qualify as “active service,” however there is an exception provided for those veterans who became disabled or died from an injury or disease resulting from their service.

Ordinarily, reserve duty does not qualify as “active service,” since the reservist’s full-time duty is usually considered active duty for training. However, the VA’s reference materials indicate that reserve duty may also qualify the veteran so long as the veteran completed 90 days of full-time service aside from the training component, and the service was for operational or support purposes. Similarly, most National Guard service does not qualify as active service for pension benefit eligibility. Guard service is not active federal service without an order from the President; otherwise, it is service in a state militia. In contrast, full-time commissioned officers of the Public Health Service, Coast and Geodetic Survey, Environmental Sciences Services Administration, and the National Oceanic and Atmospheric Administration do meet the active duty requirement, excluding time spent for training purposes.

Many other veterans are deemed to have met the active duty requirement, even if their service does not meet the “active duty” definition. The C.F.R. provides an extensive list of


26 The basic definition of “active duty for training” is “[a] tour of active duty which is used for training members of the Reserve Components to provide trained units and qualified persons to fill the needs of the Armed Forces in time of war or national emergency and such other times as the national security requires.” U.S. Dept. of Defense, Department of Defense Dictionary of Military and Associated Terms, Joint Pub. 1-02, at 4 (amended through Nov. 15, 2011), http://www.dtic.mil/doctrine/new_pubs/jp1_02.pdf. See also 38 C.F.R. § 3.6 (2009) for a complete listing of the types of service that constitute active duty for training.

27 38 C.F.R. 3.6(a) (2009).


29 Title 38 of the United States Code includes the Army National Guard and the Air National Guard in its definition of “reserve component.” 38 U.S.C. § 101(27). The definition of “active duty for training,” however, is broader for National Guard veterans than for reservists. Id. at § 101(22). For members of the National Guard, “active duty for training” encompasses duty as rifle range instructors when ordered by the President, required drills and field exercises, and attendance at a military service school. Id.at § 101(22)(C) (citing 32 U.S.C. §§ 316, 502-05). While such activities are considered active duty under the National Guard’s definition, they are not considered “active military service” for pension benefits eligibility purposes. Compare 38 U.S.C. § 101(21), “active duty” excludes “active duty for training,” with 32 U.S.C. § 101(12), “active duty” includes full-time training duty, but excludes full-time National Guard duty.


31 38 C.F.R. § 3.6(b)(2) (2009).
veterans “considered to have performed active … service” for benefits eligibility purposes.  

C. Qualifying Wartime Periods (WWI, WWII, Korea, Vietnam, Gulf)

The qualifying wartime period requirement is relatively straightforward, with little room for interpretation. At least one day of the veteran’s active service must be within a defined “period of war.” Periods of War applicable to today’s veterans include World War II, Korean Conflict, Vietnam Era, and the Persian Gulf Era.  

World War II service must occur between Pearl Harbor (December 7, 1941) and President Truman’s signing of Proclamation 2714 on December 31, 1946 (the official end of hostilities).  

The eligibility period for the Korean Conflict began with President Truman’s statement ordering U.S. forces to support the Korean government (June 27, 1950), and ended by Presidential proclamation on January 31, 1955.  

Qualifying dates for the Vietnam Era are divided into two categories — one span for veterans who served in the Republic of Vietnam, and another for those who served during the Vietnam Era without actually serving in the Republic of Vietnam. The applicable period for veterans who served in the Republic of Vietnam is February 28, 1961 through
May 7, 1975 (presidential proclamation).\footnote{37} For Vietnam Era veterans who did not serve in the Republic of Vietnam, the applicable dates are August 5, 1964 (Tonkin Resolution) through May 7, 1975.\footnote{38}

For pension eligibility purposes, Persian Gulf War and the War on Terror (Iraq and Afghanistan) are considered the same period of war.\footnote{39} This period begins with the Iraqi invasion of Kuwait on August 2, 1990, and continues to the present, as there has not yet been a presidential proclamation or law that sets an ending date. While this is the longest wartime period, significantly fewer veterans have served. The VA projects that there will be approximately 6,400,000 living Gulf/War on Terror veterans by year 2020.\footnote{40} This is a relatively small percentage of the estimated 2010 veteran population of 22 million.\footnote{41} Of the over 9 million veterans currently over 65 years of age, 306,340 receive VA pension benefits.\footnote{42} According to the VA’s projections, the number of senior veterans will decrease to around 6 million by 2036; thus fewer veterans will qualify for pension benefits in the foreseeable future.\footnote{43}

D. Not “Dishonorably Discharged”

Status as a veteran is a prerequisite to receiving VA benefits.\footnote{44} In order to qualify as a veteran, a person must have been discharged under “conditions other than dishonorable.”\footnote{45} The U.S. military assigns one of five discharge categories: 1) honorable; 2) discharge under other than honorable conditions; 3) general discharge; 4) bad conduct discharge; and 5) dishonorable discharge.\footnote{46} Although “dishonorable discharge” is an official designation from the military, the Secretary of Veterans Affairs has discretion to define discharge un-
der “dishonorable conditions,” and thus it is broader in scope.47 While a discharge under honorable conditions is binding on the VA, a discharge under “other than honorable conditions” may be considered a discharge under dishonorable conditions for VA purposes.48

Title 38 of the C.F.R. lists specific conditions of discharge that would make a veteran (or surviving spouse) ineligible for benefits, and thus these are de jure dishonorable: conscientious objectors who refused to comply with an order to serve, sentence of a general court-martial, resignation by an officer for the good of the service, deserters, or AWOL for a continuous period of 180 or more days.

The C.F.R. further describes conditions of release or discharge that are specifically considered dishonorable: acceptance of an undesirable discharge to escape sentence of court-martial, mutiny or spying, conviction of a felony, willful and persistent misconduct,49 or homosexual acts involving aggravating circumstances (or other factors affecting performance).50

Although these acts are specifically listed, the C.F.R. does not limit the definition of “conditions other than dishonorable” to the aforementioned conditions of release.51 In addition, the C.F.R. states that uncharacterized entry-level separations “shall be considered under conditions other than dishonorable,”52 and the Office of the General Counsel has held that such a claimant may still qualify as a veteran under Section 101(2) of Title 38 of the United States Code, even when his or her initial enlistment was voided by the service

---

47 See e.g., Camarena v. Brown, 6 Vet. App. 565, 566-568 (1994) (“[T]he regulation does not limit ‘dishonorable conditions’ to only those cases where a dishonorable discharge was adjudged.”).
48 38 C.F.R. § 3.12(a), (d)(4); see also Butler v. West, 12 Vet. App. 7, 8 (1998) (Kramer, J., concurring).
49 A determination of whether a discharge is based on willful and persistent misconduct is a fact-specific, and a court reviews it under the clearly erroneous standard. Struck v. Brown, 9 Vet. App. 145, 152 (1996).
50 Discharge under “Don’t Ask, Don’t Tell” does not necessarily preclude a person from receiving benefits.
51 The Air Force, for example, characterizes such a discharge as honorable or general unless evidence shows an act committed under one of the following circumstances: by force, coercion, or intimidation, with a person under 16 years of age, in violation of military superior-subordinate relationships, in public view, for compensation, or in a location subject to military control. U.S. Dept. of the Air Force, Publg.
52 No. AFI36-3208 Administrative Separation of Airmen § 5G (2004) (amended 2010). Language in the Code of Federal Regulations considers homosexual acts involving “factors affecting the performance of duty” as “dishonorable conditions.” 38 C.F.R. § 3.12(d)(5). The VA, however, is bound by a characterization of discharge under honorable conditions. 38 C.F.R. § 3.12(a). Thus, a former service member could be considered a veteran (for benefit eligibility purposes) even if there existed “factors affecting the performance of duty.” Some veterans discharged under the former “Don’t Ask, Don’t Tell” policy, which officially ended on September 20, 2011, received honorable discharges or general discharges “under honorable conditions.” Those veterans will be eligible for VA benefits in the future. Service members discharged for “homosexual acts,” or those discharged prior to the implementation of “Don’t Ask, Don’t Tell” in 1993 will need to appeal their discharge characterizations to be eligible for VA benefits. Prior to 1993, gay service members would be discharged under “other than honorable conditions,” and would thus be ineligible for most veterans benefits unless and until they successfully appeal their discharge status. See David S. Cloud & David Zucchino, Gay military members come out and celebrate, L.A. Times (Sept. 20, 2011), http://articles.latimes.com/2011/sep/20/nation/la-na-military-gays-20110921, and David McKean et al., Freedom to Serve: The Definitive Guide to LGBT Military Service 31, Service-members Legal Defense Network (updated July 27, 2011), http://sldn.3cdn.net/5d4dd958a62981eff8_v5m6bw1gx.pdf.
51 Camarena, 6 Vet. App. at 566.
52 38 C.F.R. § 3.12(k)(1).
E. Need for Aid and Attendance

After establishing the requisite military service, in order to receive the enhanced monthly pension, the claimant must demonstrate the need for regular “aid and attendance of another person.” The need for assistance of another person must be regular, but need not be constant. The C.F.R. defines the need for aid and attendance as “helplessness or being so nearly helpless as to require the regular aid and attendance of another person.” This requirement is met by establishing that the claimant meets one of the following criteria:

- Is a patient in a nursing home,
- Blind, or nearly blind,
- Significantly disabled as to need or require the regular aid and attendance of another person.

The Veterans Benefits Administration (VBA) uses several factors in determining the need for regular aid and attendance. A claimant need not prove each of them, as the VBA assesses the claimant’s condition as a whole. The factors include whether the claimant can:

- Dress or undress by himself or herself,
- Keep himself or herself neat and presentable,
- Adjust a prosthetic device (which needs frequent adjustment) without assistance,
- Feed himself or herself (due to loss of coordination or weakness),
- Attend to the wants of nature, and
- Protect himself or herself from the dangers of his or her daily environment.

A claimant must show an actual need for assistance from another person, meaning he or she must provide evidence showing that he or she is actually and currently receiving such assistance. Mere information that he or she requires daily assistance is necessary, but remains insufficient to prove a need for regular aid and attendance. Generally, a claimant should submit a physician’s affidavit indicating need as well as evidence of actual assistance (e.g., invoice from home health agency showing that the services were actually provided).

Although the claimant must prove the need for aid and attendance, there is no requirement to prove that the need be permanent. Official interpretation of the regulatory and statutory requirements indicates an increased pension based on the need for aid and attendance.

54 See infra, Part III. F., for a discussion about the evidence required to establish the need for aid and attendance.
55 38 C.F.R. § 3.351(b) (2009)
56 38 C.F.R. § 3.351(c)(1) (2009), “nearly so blind” means “corrected visual acuity of 5/200 or less or concentric contraction of the visual field to 5 degrees or less.”
58 38 C.F.R. § 3.352(a) (2009).
59 Id.
60 Discussed further, infra, Part III. G. 4.
attendance “may be awarded without regard to whether the need is permanent.” From a practical standpoint, however, many claimants must subtract the out-of-pocket cost of their aid and attendance (e.g., home caregivers) in order to meet the income qualifications for eligibility. Therefore, if the claimant’s need for aid and attendance ceases, so may the claimant’s pension award after an annual eligibility verification report (EVR) is submitted.

F. Permanent and Total Disability

An eligible claimant must prove that he or she is permanently and totally disabled, or is simply over the age of 65. If the claimant is permanently and totally disabled, the disability cannot have arisen from the claimant’s own willful misconduct. The claimant is considered permanently and totally disabled if he or she requires long-term nursing home care, is considered disabled for Social Security purposes, the claimant’s disability makes him or her unemployable for life, or the VA determines the claimant permanently and totally disabled. When a veteran’s permanent and total disability was service-connected, he or she could theoretically qualify for disability compensation and non-service-connected pension benefits. The C.F.R., however, prohibits such duplication of benefits and requires that the veteran formally elect either compensation or pension payments. According to the VA Reference Manual, the claimant will not automatically receive the higher benefit amount — he or she must elect between the two programs.

G. Limited Assets and Income

The VA will not award a pension if the claimant’s assets are reasonably sufficient to provide for his or her maintenance. Generally, a claimant cannot receive a pension benefit if his or her countable assets exceed $80,000, or if his or her countable income is equal to or greater than the maximum annual pension rate (MAPR). A claimant can reduce his or her countable income to qualify, chiefly by subtracting unreimbursed medical expenses.

1. Net Worth

The VA evaluates net worth by determining whether the claimant’s assets, without the VA pension, are adequate to meet his or her basic needs for a reasonable period of time. In determining whether a claimant’s assets are a bar to pension eligibility, the VA considers life expectancy, countable income, number of dependents, potential rate of depletion, liquidity of the assets, and unusual medical expenses. The $80,000 limit on a

62 See discussion on income and unreimbursed medical expenses, infra, Part III. G. 4.
64 Id. at (B).
65 Id.
66 38 C.F.R. § 3.701(a) (2010).
68 38 C.F.R. § 3.274(a), (c) (2009)
69 Id. at sbpt. iii, ch.1, § J.67.g.
70 38 C.F.R. § 3.275(d) (2009).
claimant’s assets is not a strict rule, but rather a guideline. As an example, a 65-year-old veteran with an $80,000 estate and $20,000 in annual medical expenses could be approved, while a 90-year-old with the same size estate could be denied due to excessive net worth. The VA’s procedures simply require a “formal net worth administrative decision” if the claimant has an estate of $80,000 or more. The takeaway here is that there is really no bright-line rule that determines a claimant’s eligibility based on his or her net worth — the key is whether a claimant can reasonably utilize his or her assets to meet his or her needs without VA assistance.

Certain assets are specifically excluded from the net worth calculation, such as the claimant’s primary residence and “personal effects suitable to … claimant’s reasonable mode of life.” Mortgages and encumbrances are also excluded when calculating an asset’s value. Additionally, the VA considers whether an asset can be easily converted into cash. To illustrate, assume claimant owns a lot with an assessed value of $50,000, but recently, property values in the area have dropped substantially. If the claimant can show that he or she is unlikely to receive more than $10,000 if he or she sold the property, then the property is worth only $10,000 for net worth calculation purposes.

Jointly owned assets are counted as part of the claimant’s estate to the extent of the claimant’s ownership share. From a practical standpoint, this distinction is irrelevant for assets owned jointly by a veteran and his or her spouse, as spousal assets are included in the net worth calculation. The joint asset rule becomes significant when a claimant owns property jointly with a non-dependent. The VA’s policy on jointly owned assets is a stark contrast to Medicaid requirements. In Illinois, the entire equity value of jointly owned resources is included in Medicaid eligibility determinations, unless the applicant can document that he or she cannot access the resource, or can prove that his or her legal interest is less than the total value. For liquid assets, such as joint bank accounts, the VA will include the claimant’s and dependent’s share in the net worth determination, whereas the Illinois Department of Human Services (DHS) will presume that the entire account balance is available to the applicant. To illustrate, assume that a veteran purchases a $10,000 certificate of deposit, and then adds his or her non-dependent nephew as joint owner. The VA’s policy is to consider $5,000 as available to the veteran for net worth purposes, while DHS will require information showing the reason the asset is held jointly, bank records, identification of depositors, or other documents proving that the applicant’s legal

---

71 Id. at sbpt. iii, ch.i, § 1.70.c.WARMS, supra n. 28, at pt. V, sbpt. i, ch.3, § A.3.c. However, net worth may be a bar to eligibility even when a claimant’s assets are worth significantly less than $80,000.
72 38 C.F.R. § 3.275(b).
73 Id.
74 See WARMS, supra n. 28, at pt. V, sbpt. iii, ch.1, § J, discussing how the VA determines the value of real estate.
75 38 C.F.R. § 3.275(a), 3.275(c), citing 38 C.F.R. § 3.271(d).
76 WARMS, supra n. 28, at pt. V, sbpt. i, ch.3, § A.1.f.
79 WARMS, supra n. 28, at pt. V, sbpt. iii, ch.1, § I.65.d.
interest is less than the total value.\textsuperscript{80} Further, such a transfer would be subject to the fiveyear look-back for Medicaid purposes, but the VA does not have a look-back period for transfers. The applicant’s net worth is determined at the time of application.

2. Income

An otherwise eligible veteran must also meet income guidelines in order to be entitled to VA pension benefits. A claimant’s countable income or income for VA purposes (IVAP) determines his or her eligibility. The VA determines IVAP by subtracting unreimbursed medical expenses\textsuperscript{81} from the claimant’s gross income. The initial step in arriving at IVAP is defining what is included in the gross income calculation. Basically, the VA uses the familiar IRS definition of gross income — “all income from whatever source derived,” unless specifically excluded.\textsuperscript{82} The specific exclusions for pension eligibility purposes include:

- unreimbursed medical expenses,
- welfare,
- maintenance,\textsuperscript{83}
- VA pension benefits,\textsuperscript{84}
- reimbursement for casualty losses,
- profit from the sale of property (unless in the course of business),
- veteran’s or spouse’s final expenses and just debts,
- educational expenses,
- child’s income,
- cash surrender value of life insurance (the portion representing a return of premiums),
- Medicare Part D assistance or savings, and
- Life insurance proceeds on the policy of a veteran.\textsuperscript{85}

When claiming income on a benefits application, there are a few key points to remember. First, the claimant must provide his or her gross income before any taxes or other deductions. With Social Security, for example, the claimant puts the total benefit amount on the application — without subtracting the Medicare deduction (but Medicare premiums are treated as unreimbursed medical expenses, thereby reducing countable income). Second, any interest income that the claimant receives (or expects to receive) must be included in the income calculation. For instance, if a claimant owns an interest-bearing account (e.g., mutual funds), he or she must include the interest income expected over the next 12 months. Third, if the claimant owns a tax-deferred retirement account, such as an IRA, any distribution from that account must be counted as income. The VA requires

\textsuperscript{80} See Medical Policy Manual, supra n. 78.
\textsuperscript{81} See infra, Part III. G. 4., for an in depth discussion of unreimbursed medical expenses.
\textsuperscript{82} 26 U.S.C. § 61; 38 C.F.R. § 3.271(a), “payments of any kind from any source shall be counted …. unless specifically excluded …”
\textsuperscript{83} “The value of maintenance furnished by a relative, friend, or charitable organization …. will not be considered income.” 38 C.F.R. § 3.272(b) (2009).
\textsuperscript{84} VA Pension payments (including non-service connected pensions) were not excluded from a claimant’s income until 1959. See Pension Act of 1959, Pub. L. No. 86-211 (1959).
\textsuperscript{85} See 38 C.F.R. § 3.272, for a complete listing of exclusions.
inclusion of the entire distribution as income, even when it reflects a partial return of principal.\textsuperscript{86} An exception to including IRA interest as income occurs if the claimant would incur a substantial penalty for withdrawing funds (e.g., before age 59\(\frac{1}{2}\)).\textsuperscript{87}

The countable income derived from jointly held accounts depends upon the relationship between the parties. When a veteran and spouse are joint owners on an income-producing asset, each spouse indicates his or her portion of the income on the application form, since income from each spouse is countable. When a claimant and a non-dependent(s) are joint owners of an income-producing asset, the claimant’s countable income derives from his or her pro rata ownership share of the asset.\textsuperscript{88}

3. Treatment of Trusts

A question that arises quite often is whether amounts in trust count as assets or income for VA purposes. Basically, inclusion as assets or income is a function of the claimant’s control over the funds in trust, and whether he or she derives benefit from the funds. VA precedent follows a three-part rule when determining whether property (including trust property) is counted in a claim for benefits: 1) actual ownership; 2) “such control over the property that the claimant may direct it to be used for claimant’s benefit;” or 3) actual allocation of the funds for claimant’s benefit.\textsuperscript{89} The VA Office of the General Counsel has issued several precedent opinions on the issue of trusts in determining VA benefit eligibility.

In 1990, the VA Office of the General Counsel held that “property held in a discretionary trust … is not countable until it is actually allocated for the claimant’s use, unless the claimant possesses such control … that the claimant may direct it to be used for the claimant’s benefit.”\textsuperscript{90} Thus, in a discretionary trust, any portion of the property made available for the veteran’s use is countable income for VA purposes. Since pension benefits are means tested, any income (unless specifically excluded) is counted, and net worth is counted to the extent that it can be reasonably expected to provide for the claimant’s care.

Irrevocable trusts for the benefit of someone not residing with the claimant are treated differently. Where a pension claimant inherited shares of stock and placed them into an \textit{inter vivos} irrevocable trust for the benefit of his or her grandchildren, the VA General Counsel held that the stock represented income to the claimant in the year received, but the trust assets were not countable as net worth because the claimant retained no right or interest in the property.\textsuperscript{91} The opinion cited Section 3.272 of Title 38 of the C.F.R., indicating that the receipt of assets, not their subsequent disposition, determines whether they

\begin{itemize}
  \item \textsuperscript{87} See Op. Gen. Counsel, Precedent 70-90 (U.S. Dept. of Veterans Affairs July 18, 1990), discussing countability of interest in an annuity account as income.
  \item \textsuperscript{88} 38 C.F.R. § 3.272(d) (2009).
  \item \textsuperscript{89} See Op. Gen. Counsel, Precedent 72-90 (U.S. Dept. of Veterans Affairs July 18, 1990). For property held as a life estate, the General Counsel has ruled that such property is countable as part of a claimant’s net worth because a life tenant retains an ownership interest and exclusive possession and control during the claimant’s life. Op. Gen. Counsel, Precedent 15-92 (U.S. Dept. of Veterans Affairs July 15, 1992).
  \item \textsuperscript{90} \textit{Id.}
\end{itemize}
are counted as income.\textsuperscript{92} Thus, for such non-recurring income, the claimant could reapply for benefits the following year. For a potential pension applicant, recall that there is no look-back period for the disposition of assets; therefore an \textit{inter vivos} irrevocable trust for the benefit of a person’s children or grandchildren may be a method of reducing a person’s net worth to become eligible for benefits in the future.

For special needs trusts (SNTs or OBRA ’93 trusts), the VA considers the funds held in trust when determining a claimant’s net worth.\textsuperscript{93} In a 1997 precedent opinion, the VA General Counsel reasoned that the VA should include funds in an SNT as part of her net worth “if trust assets are available for use for the claimant’s support.”\textsuperscript{94} The facts of the opinion state that an incompetent surviving spouse became the beneficiary of a testamentary trust, the terms of which gave the trustee sole discretion to provide funds for the surviving spouse’s comfort. Specifically, the General Counsel held that a self-funded irrevocable trust to preserve estate assets by limiting expenditures to special needs, while maximizing eligibility for governmental resources, is considered in calculating a claimant’s net worth.\textsuperscript{95}

While the aforementioned VA General Counsel Opinion specifically addresses funds for the claimant’s benefit held in SNTs, it is silent on whether a spouse’s SNT would count against the couple’s net worth limit. Since funds expended from an SNT must be used for the sole benefit of the spousal beneficiary, the trustee has no discretion to disburse funds for the veteran’s care.\textsuperscript{96} Applying the three-part rule discussed in the 1990 opinion, funds held in a properly drafted SNT for the spouse’s benefit would not count against the couple’s net worth, but any amounts disbursed for the spouse’s care would be included in the couple’s countable income. Further, wording in the C.F.R. would appear to exclude funds held in the spouse’s SNT because spousal net worth should only be counted if it is “reasonable that some part of the corpus … be consumed for the veteran’s maintenance.”\textsuperscript{97}

4. Overview of Unreimbursed Medical Expenses

Often, a claimant’s gross income exceeds the MAPR; thus making him or her ineligible for pension benefits. Thus, a claimant may offset gross income by subtracting his or her unreimbursed medical expenses, arriving at IVAP. Unreimbursed medical expenses are deductible if they exceed 5 percent of the MAPR for the basic pension (without aid and attendance rating).\textsuperscript{98} To be deducted, unreimbursed medical expenses must be 1) actually paid by the veteran or spouse,\textsuperscript{99} 2) within the 12 months of the effective award date, 3) incurred by the veteran, spouse, surviving spouse, or dependent for whom the claimant

\textsuperscript{92} Id.
\textsuperscript{94} Id.
\textsuperscript{95} Id.
\textsuperscript{97} 38 C.F.R. § 3.274(a) (2009).
\textsuperscript{98} In 2010, unreimbursed expenses are deductible if they exceed $591 annually for a single veteran (5 percent of $11,830) and $774 for a veteran with dependents (5 percent of $15,493). See 38 C.F.R. § 3.272(g) (1)(ii), (2)(iii) (2009).
\textsuperscript{99} Id. This means actual payment by the claimant, regardless of when the debt was incurred.
has an obligation to support, and 4) must exceed 5 percent of the applicable MAPR.\textsuperscript{100}

The scope of allowable deductions is quite broad. A claimant can deduct caregiver expenses,\textsuperscript{101} assisted living fees, nursing home expenses, health care premiums, prescription drugs, medical alert devices, incontinence products, and even vitamins, supplements, and over-the-counter drugs.\textsuperscript{102} Usually, unreimbursed medical expenses are only deductible from income once they are actually paid. This presents a problem for initial applicants, as an applicant may have just recently developed the need for aid and attendance. For example, assume a claimant with an annual income of $40,000 enters an assisted living facility on March 1, actually pays the $3,600 monthly service out-of-pocket, and then applies for pension benefits on April 1. In this situation, he or she would be technically ineligible for the pension; however, the VBA has a provision for such a situation. Some unreimbursed medical expenses may be reimbursed prospectively if they are “consistently recurring.”\textsuperscript{103} Thus, this hypothetical claimant should claim prospective unreimbursed medical expenses of $43,200 to show his or her expected expenses for the next 12 months.\textsuperscript{104}

For caregiver services provided by an individual, it is best to formalize the arrangement between the caregiver and claimant by using a simple contract agreement.\textsuperscript{105} Further, the parties should be advised that payments to the caregiver could be taxable income. An attorney should also advise the parties to keep accurate records of payments made to the caregiver and hours of service provided, as the VBA may request proof at a later date. Additionally, complete and accurate records are vitally important if a client could potentially apply for Medicaid in the future. A client would want to minimize any possibility that such caregiver payments could result in a penalty period.

5. Spousal and Dependent Eligibility

Pensions for non-service-connected disabilities are either categorized as live pensions or death pensions. Live pensions are those where a veteran is claiming pension benefits based on his or her own service, while eligibility for death pensions arises after the veteran is deceased. Surviving spouses and dependents are eligible to apply for death pension benefits.

A surviving spouse must meet additional requirements in order to qualify. First, the

\textsuperscript{100} Id.
\textsuperscript{101} Id. at § D.3. To deduct caregiver, assisted living, or nursing home costs prospectively, the claimant must provide appropriate documentation with the initial application for benefits. For assisted living or nursing home fees, a claimant should submit verification from the facility showing anticipated fees, services provided, and how the claimant pays out-of-pocket. This also applies where a home health agency supplies the services. The verification should be on the facility’s letterhead and signed by an administrator.

\textsuperscript{105} The agreement should include, at a minimum, the services to be provided, the amount paid for the services, hours that service is provided, location of the services, full names of the parties, and the date the contract was entered into. See WARMS, supra n. 28, at pt. V, subpt. i, ch.3, § D.13.i.
marriage must be valid and the surviving spouse must have been married to the veteran for at least one year, or less than one year if the couple had a child together. Second, the surviving spouse must have been married to the veteran at the time of his or her death. Third, the surviving spouse must have remained unmarried after the veteran’s death. Finally, the veteran and surviving spouse must have lived together continuously from the time of marriage until the veteran’s death.

Usually, a marriage is valid for VA purposes when the couple was legally married under the laws of the state where they resided at the time of the marriage. The surviving spouse must establish the validity of the marriage in order to be entitled to pension benefits. This is accomplished by including a statement of marriage on the benefits application, which includes details about all of the veteran and surviving spouse’s marriages. The statement of marriage indicates the date and place of each marriage, type of marriage (ceremonial, tribal, common law, etc.), reason the marriage ended (death, divorce), and the date and place the marriage ended. The claimant should also include a copy of the marriage license or certificate showing his or her marriage to the veteran.

IV. EFFECT OF OTHER PUBLIC BENEFITS ON PENSION CLAIMS

A. Medicaid

Since most veterans seeking aid and attendance pension benefits are over the age of 65, it is vitally important to view such benefits within the context of a comprehensive long-term care plan. If it is likely that a client will need long-term care in the foreseeable future, and also likely that he or she could qualify for Medicaid payments, an attorney

106 38 C.F.R. 3.54(a) (2009).

107 One exception to this rule arises where the subsequent marriage was annulled. In the case of an annulment, the surviving spouse is ineligible for benefits during the period of remarriage, but becomes eligible once the state officially annuls the marriage. Op. Gen. Counsel, Precedent 3-95 (U.S. Dept. of Veterans Affairs Feb. 1, 1995).

108 38 C.F.R. 3.1(j) (2009). One exception is a marriage deemed valid under state law, but invalid for federal purposes under the Defense of Marriage Act. 1 U.S.C. § 7 (2006); See also 38 C.F.R. § 3.52 (2009), a spouse must be of the opposite sex.


110 Id. A copy of the final divorce decree suffices for prior marriages ending in divorce. Proof of death can be established in several ways, such as an official death certificate or a copy of the coroner’s report. If the statement of marriage provides conflicting dates or evidence regarding a prior marriage, then the claimant may be required to submit proof that a prior marriage was dissolved. Also, if the surviving spouse is unable to produce a marriage certificate (as in the case of a common law marriage or tribal marriage), then he/she may prove validity by alternate means. Secondary evidence of marriage includes an affidavit from the clergyman or magistrate who officiated or affidavits from at least two witnesses to the ceremony. If common law marriage is recognized in the claimant’s jurisdiction, he or she may establish its validity by producing statements of persons in the community who believed that the parties were spouses, joint bank statements, lease agreements, or other means tending to show continuous cohabitation and holding each other out publicly as husband and wife. The VA has similar internal procedures for establishing the validity of tribal marriages or transgender marriages. See WARMS, supra n. 28, at pt. III, subpt. ii, ch.5, § B.
must use due care when transferring assets to qualify for VA pension benefits. Also recall that one tool for long-term care planning — an SNT — does not reduce the countable net worth for VA purposes, and that distributions or rights to distributions from a discretionary trust may be considered under certain circumstances.111

Further, the VA reduces pension benefits to $90 per month for Medicaid recipients residing in long-term care facilities.112 One exception to this reduction occurs when the veteran’s spouse receives long-term care through Medicaid while the veteran remains in the community.113 While the veteran would continue to receive his or her pension, such payments could count as nonexempt unearned income in some, if not all, states.114

B. Social Security Income (SSI)

For Social Security Income (SSI) eligibility, the portion of VA aid and attendance pension benefits resulting from “unusual medical expenses” is not considered countable income.115 The portion of the pension that does not relate to medical expenses would be considered income based on need (IBON) for SSI purposes, and would reduce an SSI payment.116 For VA pension eligibility, the VA excludes from countable income SSI and other government benefits based on financial need.117 This policy difference is easily explained by the intent behind each program — VA pensions are designed to provide veterans an income above the poverty level,118 whereas SSI is “intended to be a program of last resort.”119 Thus, the Social Security Act requires an SSI applicant to “take all appropriate steps to pursue eligibility for other benefits,” including VA pension benefits.120

V. APPLICATION PROCESS

A. Note on Powers of Attorney (POAs)

It is important to note that the VA does not recognize general powers of attorney (POAs) executed under state laws.121 The claimant may appoint a VA accredited attorney

111 See supra Part II. G. 3., Treatment of Trusts.
112 38 C.F.R. § 3.551(i); See also 89 Ill. Admin. Code § 120.61(e), allowing veterans or surviving spouses a $90 monthly income disregard.
114 89 Ill. Admin Code § 120.330, .335, .379 (2010).
115 20 C.F.R. § 416.1103(a)(7), (b)(1) (2010), excludes assistance provided under any Federal program “whose purpose is to provide social services,” and “[p]ayments from the [VA] resulting from unusual medical expenses” from countable income for SSI eligibility purposes; See also Social Security Online, Program Operations Manual (POMS) § SI 00830.308, VA Aid and Attendance and Housebound Allowances (Sept. 9, 2011), https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830308 [hereinafter POMS].
116 Social Security Online, POMS, SI 00830.170, Income Based on Need (Dec. 13, 2007), https://secure.ssa.gov/apps10/poms.nsf/lnx/0500830170 (“Income based on need is counted as income dollar for dollar, unless it is totally excluded by statute …”).
120 Id.
121 WARMS, supra n. 28, at pt. I, ch.3 § A.
or veterans service organization to represent him before the VA by completing VA Form 21-22 or 21-22a.\footnote{122} Similarly, the VA will not necessarily allow a state court-appointed guardian to file a claim on behalf of an adjudicated disabled claimant, nor will it automatically allow the guardian to be the claimant’s representative payee for pension benefits.\footnote{123} In the case of an incompetent claimant, the VA has broad power to select and appoint a fiduciary to receive pension payments on the claimant’s behalf.\footnote{124} The claimant should, even if adjudicated incompetent, sign each application document to the best of his or her ability.\footnote{125} The VA allows incompetent claimants to prosecute claims for benefits, even if a fiduciary is ultimately appointed to receive the payments.\footnote{126}

B. Informal Claims

An informal claim is defined as “[a]ny written communication or action indicating an intent to apply for one or more benefits … from a claimant … [or] authorized representative …”\footnote{127} The chief benefit of submitting an informal claim is that once the VA determines eligibility, the claimant will receive retroactive payments from the first day of the next month after the VA receives the informal claim.\footnote{128} For example, assume that the VA received an informal claim on January 5, 2010, the formal claim on May 5, 2010, and approved the pension payments on June 15, 2010. Also assume that the amount awarded was $500 monthly. In July 2010, the veteran would receive an initial payment of $2,500 (for February through June) and his or her monthly payment of $500.

At a minimum, the informal claim must identify the benefit sought;\footnote{129} however, it is recommended that the informal claim include specific information about the claimant and the benefits he or she seeks. Also, if the informal claim is submitted by the claimant’s authorized representative, evidence of this appointment must be received with the informal claim.\footnote{130} The recommended format for an informal claim is to use the approved VA Form 21-4138.\footnote{131}

\footnote{122} See discussion \textit{infra}, Part V. C. 2. A non-accredited individual may represent one claimant before the VA. WARMS, supra n. 28, at pt. I, ch.3 § A.
\footnote{125} The claimant may sign with a mark or thumbprint. 38 C.F.R. § 3.2130 (2009); \textit{see also} WARMS, supra n. 28, at pt. III, sbpt. ii, ch.1, § C.11, discussing validity of claimant signatures.
\footnote{126} WARMS, supra n. 28, at pt. III, sbpt. v, ch.9 § B.
\footnote{127} 38 C.F.R. § 3.156(a) (2009).
\footnote{128} \textit{See} 38 U.S.C. § 5110 (2006), effective award date shall be “fixed in accordance with the facts found” but no “earlier than … receipt of application therefore”; 38 C.F.R. § 3.156(a) (2009), formal claim received within one year from the date of the informal claim is considered filed on the date of receipt of the informal claim; and 38 C.F.R. § 3.31 (2009), payments may not be made before the first day of the month following the month in which the award became effective.
\footnote{129} Id.
\footnote{130} WARMS, supra n. 28, at pt. III, subpt. ii, ch.2, § D.15.a; 38 C.F.R. § 3.156(b). For attorneys, VA Form 21-22a must be submitted with the informal claim to authorize representation of the claimant before the VA. \textit{See also} U.S. Dept. of Veterans Affairs, VA Form No. 21-22a, \textit{Appointment of Individual as Claimant’s Representative} (June 2009), http://www.vba.va.gov/pubs/forms/VBA-21-22A-ARE.pdf.
After completion, the informal claim and representation form must be sent to the VA Regional Office serving the claimant’s area. It is wise to send the informal claim using a traceable means, such as certified mail. This will be helpful in case the VA later claims that they did not receive the informal claim by a specified date.

C. Formal Claims

A formal claim must be submitted within one year of the informal claim; otherwise, the original award date is ineffective and the claim process starts anew. As with the application process for many other government benefits, the VA requires copious and specific applicant information; including financial, medical records, and marriage history.

1. Primary Form

The primary form for a veteran claimant (VA Form 21-526) is distinct from the surviving spouse’s form (VA Form 21-534), but each gathers essentially the same information about the claim. Most of the form is self-explanatory, but there are a few “traps” to watch out for. Incorrect or inaccurate information on this form could result in a delay — or denial — of pension benefits. First, be sure to use the veteran’s name exactly as it appears on his or her military discharge records — and do so consistently on all correspondence with the VA. For example, if the veteran’s name on the discharge records states “Walter G. Veteran,” but you write “Walt George Veteran Sr.” on the forms, the VA may request clarification on this “name change” from the claimant. This process could create additional delays on the benefit approval process. If the veteran indeed served under a different name, indicate this on the form and include proof of the name change.

to use where the VA has not published a form germane to the actual requested action. The Statement in Support of Claim can be used to file an informal claim, apply for an increase, submit a Notice of Disagreement, submit additional evidence, or for many other objectives related to the veteran’s claim. The claimant should include the veteran’s name exactly as it appears on the military discharge records, as well as the veteran’s social security number. The claimant must sign the form, date it, and include his or her address and contact information. Also recall that an informal claim must “indicate an intent to apply for one or more benefits.” Thus, the intent should be clear and specific: “I am the veteran’s surviving spouse. Please accept this document as my informal claim for death pension benefits. I believe that I am eligible for pension benefits with an aid and attendance allowance, as well as prepayment of prospective unreimbursed medical expenses, because I have limited income and high out-of-pocket medical expenses due to my poor health.”

132 For a list of VA Regional Offices, see U.S. Dept. of Veterans Affairs, Contact Veterans Benefits Administration, http://www.vba.va.gov/bln/21/ro/rocontacts.htm (accessed Nov. 4, 2010).


134 See WARMS, supra n. 28, at M23-1, pt. I, ch.6, describing VA the process used to adjust a veteran’s name.

135 Id. at ch.11 (“All correspondence or documents … indicating the need for a change of name, received in the Mail Activity … will be forwarded to the Adjudication Division … After review and approval by an adjudicator … a [change of name] transaction will be processed.”).
Second, the VA requests certified military separation records (DD214 or its analogue) related to the veteran’s active service. Many veterans keep their original documents for a lifetime, but it is understandably common for the documents to be lost or missing. Ordering certified copies of service records is accomplished by completing a VA Form SF180 and sending it to the National Personnel Records Center (NPRC) in St. Louis. Alternatively, a claimant may use the “eVetRecs” application to complete an online request.

The third potential trap occurs on the recently updated VA Form 21-526 for veteran claimants. Whereas VA Form 21-534 for surviving spouses (and the previous version of VA Form 21-526) asks specifically whether the claimant is applying for an aid and attendance allowance, the words “aid and attendance” do not appear anywhere on the updated VA Form 21-526. Rather, the current VA Form 21-526 asks whether the veteran needs “the regular assistance of another person” or is “generally confined to the immediate premises.” Thus, the claimant must mark “yes” to this question if he or she wishes to apply for the aid and attendance allowance.

2. Supporting Forms

In addition to the primary form, a complete formal application will include several other VA forms to support the claim. First is the aforementioned VA Form 21-22a, which is necessary for an attorney to represent a claimant before the VA. This form must be submitted with the formal application if it was not submitted previously with the informal claim. Second is the VA Form 21-4142, which is basically a HIPAA waiver to allow doctors that the claimant lists to release medical information to the VA for the purposes of processing the pension claim.

Third is the Medical Expense Report, VA Form 21-8416. The purpose of this form is to itemize the claimant’s (and spouse’s) unreimbursed medical expenses. Although the

137 National Archives & Records Admin., eVetRecs: Request Copies of Military Personnel Records, https://voretrecs.archives.gov/VeteranRequest/home.asp (accessed Oct. 26, 2011). Only veterans or next-of-kin may request records from eVetRecs. Authorized representatives must use the SF180. While the VA has a duty to assist a claimant in locating such records, it is recommended that the claimant order a copy from the NPRC prior to submitting the formal application. According to the NPRC’s website, 70 percent of records requests are processed within 10 days. If the VA must request a claimant’s records, this added step could increase the time required to approve pension benefits. The VA’s reference materials indicate that a claims processor may wait up to 60 days for a response from another federal agency before following up with another request. Thereafter, the processor may wait an additional 30 days for a response to the follow-up request. When the claimant requests the records himself or herself, he or she could follow up on the request much sooner if a timely response is not received. Veterans Claims Assistance Act of 2000, 38 U.S.C. § 5103A (2006 & Supp. III 2009). National Archives & Records Admin., Start Your Military Service Record Request (DD Form 214 & SF-180), http://www.archives.gov/veterans/military-service-records/ (accessed Oct. 28, 2010). WARMS, supra n. 28, at pt. I, ch.1, § C.d.
138 Form 21-534, supra n. 133 at 4.
139 Form 21-526, supra n. 133 at 7.
primary form (VA Form 21-526 or 21-534) includes space for medical expenses, VA Form 21-8416 provides more space for itemization. If this form is submitted with the application, the claimant should note on the primary form that medical expenses are listed separately. The claimant should list all prospective, recurring unreimbursed medical expenses that he or she expects to pay over the next 12 months.

Fourth, the claimant must submit a medical evaluation, VA Form 21-2680, with the complete formal application. The purpose of VA Form 21-2680 is to provide the VA with medical evidence of the claimant’s need for the regular aid and attendance of another person. On the form, the claimant’s physician answers questions related to the claimant’s medical conditions/diagnoses, ability to perform Activities of Daily Living (ADLs) with or without regular assistance, ability to manage his or her finances, need for nursing care, and ability to leave his or her house without assistance.

While physicians are specially trained to provide the appropriate medical diagnoses, many are unaware of the concise wording that must be included on the form to prevent the VA from incorrectly denying benefits to an eligible claimant. Assume, for example, that the physician writes “BTA amputation, weakness of the upper extremities, and prostate cancer” as the claimant’s complete diagnosis and also indicates that the claimant is unable to feed himself or herself, bathe, prepare his or her own meals, or leave the house without assistance. Also assume that the claimant resides in an assisted living facility, the facility provides his or her required assistance, and that he or she cannot afford to remain in the facility without the VA pension. While this diagnosis would meet the definitional requirements of the regular need for aid and attendance, the VA could deny the medical expense deduction for the assisted living fees, and thus deny the pension claim based on financial ineligibility. The reason here is that unless the physician indicates that the claimant must reside in a protected environment, the VA will not allow him to deduct the assisted living fees as unreimbursed medical expenses. For the hypothetical claimant with cancer, weakness, and a BTA amputation, it would be quite feasible for the physician to indicate the need for a protected environment because the claimant is a fall risk.

Another consideration regarding completion of the VA Form 21-2680 is inclusion of a dementia diagnosis or indicating that the claimant is unable to manage his or her own financial affairs. The VA rating agencies have sole authority to determine competency for pension benefit purposes and may require the appointment of a fiduciary to receive the claimant’s benefits. While the fiduciary process is not fatal to benefit approval, it may delay the approval process by several months.

When the VA receives clear and convincing evidence of a claimant’s incompetence (i.e., physician includes a dementia diagnosis on the VA Form 21-2680), it will notify the claimant that it proposes to make an incompetency determination. Then, the claimant may

---

141 U.S. Dept. of Veterans Affairs, VA Form No. 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance (June 2008), http://www.vba.va.gov/pubs/forms/vba-21-2680-are.pdf [hereinafter Form 21-2680].
142 WARMS, supra n. 28, at pt. V, subpt. iii, ch.1, § G.43.h.
143 38 C.F.R. § 3.353(a), defining mental incompetency as lacking the mental capacity to contract or manage one’s own financial affairs, § 3.353(b), granting VA rating agencies the sole authority to determine competency for veterans benefit purposes; See generally WARMS, supra n. 28, at pt. XI, providing a complete description of the VA Fiduciary Program.
request a hearing to rebut the evidence regarding incompetency. Thus, a physician should use discretion in indicating a diagnosis of “dementia” when a claimant simply has a mild cognitive impairment that does not affect his or her ability to manage his or her financial affairs. Such a diagnosis should only be included if there is an official finding of mental incapacity. If a claimant is competent, the physician should not inadvertently provide evidence to the contrary which could cause financial detriment.  

3. Additional Documentation

In addition to the required forms, claimants applying for pensions with an aid and attendance allowance must submit documentation on home caregivers and assisted living facilities, or a nursing home affidavit (if the claimant is a patient in a skilled or intermediate nursing facility). If the claimant wishes to prospectively deduct other recurring unreimbursed medical expenses, he or she should also include documentation of those expenses. For instance, appropriate documentation for recurring prescription costs would be a pharmacy printout showing the claimant’s out-of-pocket expenses over the previous six-month period. A claimant should include statements for medical insurance premiums (i.e., Medicare Part C or D supplements) to deduct these as recurring expenses.  

When the claimant is a surviving spouse, additional documentation must be submitted. First, the surviving spouse must include a copy of the veteran’s death certificate. Second, she must submit proof of marriage to the veteran.

D. Claimant’s Death and Accrued Benefits

When working with WWII-era clients, it is not uncommon for a claimant to die while a VA pension application is pending. Should this occur, it is important to notify the VA in a timely fashion to prevent an overpayment of pension benefits. The claimant’s surviving spouse or children, however, may be entitled to receive accrued pension payments dating from the effective award to the claimant’s date of death. Often, such eligibility is dependent upon the timing of events — the date the VA received a claim for pension benefits vis-a-vis the date of the claimant’s death.

There are four key requirements that must be met prior to payment of accrued benefits: 1) a claim for benefits must be pending on or before the date of the claimant’s

---

144 A good way to assist physicians who are unfamiliar with VA procedures is to provide both a blank 21-2680 and a pre-filled sample 21-2680 to edify them as to the specific requirements of VA medical examinations.

145 See supra Part III. G. 3., discussing caregiver agreements and documenting assisted living facility expenses.

146 U.S. Dept. of Veterans Affairs, VA Form No. 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance (Mar. 2010), http://www.vba.va.gov/pubs/forms/VBA-21-0779-ARE.pdf. To deduct nursing home fees as unreimbursed medical expenses, the physician must indicate on the 21-2680 that the claimant requires nursing home care. See Form 21-2680, supra n. 141.

147 Where insurance premiums are deducted from a retirement pension (without a separate premium statement), the claimant should include a recent statement from his or her pension account. For Medicare deductions from Social Security payments, the claimant must include his or her most recent Social Security award letter.

148 See discussion of Spousal and Dependent Eligibility supra Part II G. 5.

(2) benefit payments must be “unpaid and due” at the time of the claimant’s death; 151 3) the claimant must have survived at least one month beyond the effective award date; and 152 4) the applicant must file a claim for accrued benefits within one year of the claimant’s death.

An eligible person must file an official claim for accrued benefits or to be substituted as the claimant on a pending claim. Any person eligible to apply for accrued benefits is also eligible to request to be substituted as the claimant. 153 Also, the applicant must be eligible to receive the accrued benefits. Normally, the veteran’s children or surviving spouse qualify. 154 Deciding whether to apply for accrued benefits, as opposed to requesting to be substituted, depends upon the status of the claim at the claimant’s death. If the VA awarded benefits prior to the claimant’s death, but had not yet paid, the applicant should apply for accrued benefits under Title 38, Section 5121. 155 If the VA had only received an informal claim (pending claim) prior to the claimant’s death, then the eligible person should request to be substituted under Title 38 Section 5121A, since he or she could submit additional evidence to support the original claim. 156

If the claimant submitted a formal claim before death, but the VA had not decided the claim, the applicant might consider either option. One reason to proceed under Section 5121 is that regulations and procedures are in place, which provide an attorney some guidance. If the VA received enough evidence prior to the claimant’s death to decide in favor of the claimant, Section 5121 may be the preferred method. The Secretary of Veterans Affairs has not yet issued regulations or formal guidance on Section 5121A substitution, so proceeding under this method might be avoided unless the VA had little evidence in its

150 38 C.F.R. § 1000(d)(4) (2009). Evidence of a pending claim, formal or informal, is necessary before eligibility for accrued benefits arises. Prior to 2008, eligibility for accrued benefits was contingent upon evidence already in the VA’s possession at the time of the veteran’s death. Thus, if the VA received an informal claim — without evidence of income, need for A&A, or unreimbursed expenses — there would be no basis to approve the underlying pension claim, and therefore no accrued benefits. This “evidence in possession” requirement was effectively liberalized after passage of the Veterans Benefits Improvement Act of 2008. Pub. L. No. 110-389, 122 Stat. 4145, 4151 (2008). This Act permits an eligible person to complete the deceased claimant’s claim for the purpose of receiving accrued benefits. 38 U.S.C. § 5121A (2006 & Supp. III 2009).

151 Id. at § 1000(a).

152 Recall that benefits are not payable until the first day of the month after the effective award date. Further, the effective date for discontinuance of pension benefits due to the death of the payee is the last day of the month before death. For example, assume that the VA receives the claimant’s informal claim on October 10 (the effective award date). Benefits would be payable beginning on November 1. If the claimant died on November 30, his or her pension would be effectively discontinued on October 31, and no unpaid benefits would have accrued. If the claimant had died one day later, on December 1, one month of unpaid benefits would have accrued, since his or her pension would be effectively discontinued on November 30. 38 C.F.R. § 3.500(g) (2009); see also WARMS, supra n. 28, at pt. VIII, ch.3, § 1.5.b (“Accrued benefits are not payable for the month of death.”).


154 WARMS, supra n. 28, at pt. VIII, ch.3, § 1.5.b, c.


possession prior to the claimant’s death.157

VI. IMPLICATIONS FOR ATTORNEYS

A. Accreditation

An attorney must receive VA accreditation before representing claimants.158 The first step in the accreditation process is to complete the Application for Accreditation as a Claims Agent or Attorney to the Office of the General Counsel.159 To remain accredited, an attorney must complete a minimum of three hours of CLE courses related to Veterans Law and procedure within the first year of accreditation, an additional three CLE hours within three years of accreditation, and three CLE hours every two years thereafter.160

B. Prohibition on Attorney Fees

An accredited attorney is prohibited from charging a fee “for services provided before the date on which a notice of disagreement is filed with respect to the case.”161 In other words, preparation of benefits claims must be provided on a pro bono basis, and attorneys can only charge fees after a notice of disagreement is filed for a denied claim.162 This fee prohibition only applies to the “preparation, presentation, or prosecution” of a claim before the VA, and an attorney may charge fees for representation before there exists a specific claim for benefits.163 If no actual claim exists, an attorney need not be accredited, and may charge fees when she simply counsels and educates a client about potential eligibility for veterans benefits. Once a client expresses intent to apply for veterans benefits, however, the fee prohibition and accreditation requirements take effect.164

Basically, the stated policy behind the attorney fee prohibition is to protect veterans from the threat that unscrupulous attorneys could “charge excessive fees for their services,”165 and to preserve the VA’s “non-adversarial adjudicative process.”166 Arguably, paid legal representation is unnecessary prior to the appeal stage because the VA has a duty to assist claimants in obtaining evidence, and because claimants are given the benefit

162 38 C.F.R. § 14.636(c) (2009).
163 See 38 U.S.C. § 5904(a), accreditation applies only to the “preparation, presentation, or prosecution” of claims.
of the doubt when “there is an approximate balance of positive and negative evidence.”167

While the VA’s duty to assist and the non-adversarial nature of benefits claims would (theoretically) negate the need for an attorney during the claim process, practical realities of the process indicate the need for increased attorney involvement. The VA’s duty to assist is met when it makes “reasonable efforts to help a claimant obtain evidence necessary to substantiate the claim.”168 For example, assume a claimant applies for benefits due to his or her need to reside in an assisted living facility for assistance with ADLs and submits a statement from his or her doctor showing a “reasonable probability” of entitlement to an A&A rating. The VA could determine that the statement is insufficient to allow the increased A&A rating and request an additional examination. To fulfill the reasonable effort to assist, the VA will send the claimant a letter requesting an examination for A&A or Housebound status, a basic overview of the requirements for an A&A rating, and a citation to the section of the C.F.R. that lists the A&A requirements. This assistance will not, however, explain that the claimant’s doctor must write “needs to be in a protected environment” before the claimant’s assisted living fees may be deducted as unreimbursed medical expenses.169 Thus, even though the VA met its duty to assist, the claimant could be denied eligibility based on excess income because he or she did not submit evidence articulating the need to live in a protected environment.

While the goal of attorney fee prohibition is to preserve the non-adversarial nature of VA proceedings, this unfairly presumes that all attorney representation is adversarial in nature. VA benefits laws are quite complex, and it is unlikely that the average veteran is able to navigate the myriad forms and apply 200-page C.F.R. provisions to efficiently and successfully submit his or her claim. An attorney assisting in this capacity is more of a liaison between the client and the VA.

With regard to the idea that veterans need to be protected from attorneys charging excessive fees, this presumes that attorneys are inherently unscrupulous, do not act in their clients’ best interests, and that non-attorneys have not discovered loopholes in the fee prohibition. For example, some companies will sell annuities to veterans to bring their net worth below the $80,000 threshold while purporting to provide VA application assistance on a pro bono basis. While there is nothing inherently unethical about selling annuities to veterans, the primary focus in this process becomes selling the annuity — the veterans’ best interests are secondary, if existent. The salesman is not obligated to explain to the claimant that this annuity could preclude him from receiving Medicaid coverage for the next five years.

Absent the fee prohibition, attorneys would be more likely to assist veteran claimants at the initial stages of the process. Further, a knowledgeable Elder Law attorney will fully apprise the veteran of his or her options — and candidly explain whether VA benefits will serve the client’s best interest based on a thorough assessment of his or her medical needs, financial situation, family support, and expectations for the future.

168 38 C.F.R. § 3.159(c) (2009).
169 WARMS, supra n. 28 at pt. V, subpt. iii, ch.1, § G.43.
VI. CONCLUSION

Seniors are facing unprecedented challenges when planning for their long-term care needs. People are living longer, are more likely to need long-term care, and will face higher health care costs. Recent eligibility restrictions to Medicaid benefits amplify these challenges. The VA pension program with an aid and attendance allowance can serve as a lifeline to prevent some seniors from choosing between impoverishment and adequate care.

The pension program, however, presents its own set of challenges. Although the goal of the VA pension is to provide veterans and surviving spouses some income security, this will not be achieved without changes to the status quo. For starters, the program is not well publicized, and many veterans are unaware of this earned benefit. Even when potential claimants know about the program, a complex and arcane application process prevents many otherwise eligible veterans from successfully receiving benefits.

Access is further obfuscated by the misguided prohibition on attorney fees. While the Veterans’ Claim Assistance Act (VCAA) provides some assistance, and veteran service organizations often assist with applications, many veterans need the assistance of a qualified attorney to maximize the chance of a successful claim. Attorneys can work with the claimant and the VA in a non-adversarial manner to ensure that veterans receive the benefits that they earned. This arrangement could have the added benefit of decreasing the VA’s administrative costs by ensuring complete applications and efficient evidence gathering, and by reducing the backlog of appeals.

Some could argue that liberalization of the attorney fee prohibition and simplification of the claim process would make the non-service-connected pension program economically unsustainable, owing to the increased number of claimants. The fact is, however, that the population of age-eligible veterans is projected to decrease by one-third over the next 20 years.170

If Congress and the VA are unable to achieve the original goal of the non-service-connected pension program — ensuring elder veterans an income above the subsistence level without resorting to welfare — then Elder Law attorneys should not be prohibited from earning an income when providing critical assistance to veterans.

170 U.S. Dept. of Veterans Affairs, supra n. 43.
REVERSE MORTGAGE INTRODUCTION

By E. Spencer Bates, Esq.

This issue of NAELA Journal features two articles about reverse mortgages. Both articles acknowledge the dichotomous opinions reverse mortgages invoke. At the same time, both authors argue that elders and Elder Law practitioners should take a middle view with regards to these products. Reverse mortgages are neither a panacea for economically ravaged seniors nor a nefariously crafted tool transforming seniors into profit-centers. The articles illustrate that reverse mortgages present Elder Law professionals with another tool to assist elders and that practitioners need to understand these products in order to effectively counsel their clients regarding the opportunity and risk offered by a reverse mortgage.

Paul V. Black’s article, “Reverse Mortgages and the Current Financial Crisis,” is an excellent launching point for Elder Law practitioners who are unfamiliar with the mechanics of reverse mortgages. Black breaks down reverse mortgages in a step-by-step guide that demystifies the complexities of the reverse mortgage transaction and provides a primer on the corresponding federal and state regulations pertaining to reverse mortgages. With this foundation established, Black argues that reverse mortgages offer financially strapped seniors a viable option to access the equity in their homes without necessitating monthly payments. However, Black is quick to highlight the corresponding risks of reverse mortgages coupled with often confusing terms and marketing. In particular, Black outlines that the inherent complexity of reverse mortgages have enabled unscrupulous lenders to engage in predatory lending practices. While Congress has attempted to remedy these abuses, Elder Law professionals should understand these products to properly counsel their clients.

Robert Cannon’s article, “Keeping Grandma Off the Street,” also acknowledges the opportunity reverse mortgages present and speaks to the Elder Law policy advocate. Cannon argues that the Federal Housing Administration’s (FHA) current interpretation of the reverse mortgage laws is erroneous and results in a lost opportunity for seniors facing foreclosure to remain in their homes. Cannon’s statutory analysis argues that such a result is against public policy and that the FHA has incorrectly divined Congress’ intent on the issue of subordinating existing mortgages to a reverse mortgage. Cannon closes his article with an empirical analysis detailing foreclosed seniors in Massachusetts who could have benefited from a reverse mortgage if not for their existing (foreclosed) mortgage. This study provides a set of “hard numbers” that demonstrates to policy makers and skeptical Elder Law professionals alike that reverse mortgages could provide an attractive alternative to help keep some seniors in their homes, especially if the FHA reconsiders its subordination policy.

Both articles argue that the reverse mortgage deserves a place in the Elder Law practitioner’s tool kit. While the particular nature of a reverse mortgage presents risks and generates skepticism, the authors suggest that when properly educated and counseled many elders can indeed benefit from a reverse mortgage transaction.

E. Spencer Bates, Esq., Northampton, Mass., is a member of the NAELA Journal Editorial Board.
I. Introduction

Home Equity Conversion Mortgages (HECM) or “reverse mortgages” have been available to American seniors since their introduction in 1988. In 2009, the Federal Housing Administration (FHA) limited their practical use by clarifying a prohibition of subordination of the deficiency balances of prior mortgages to HECM loans.¹ The effect is that many seniors, who have a current mortgage balance in excess of what they qualify for under the HECM program, either must negotiate a full forgiveness of the deficiency

amount or be unable to take advantage of the HECM program. For those seniors facing foreclosure, this can be a life-changing event. Are there alternatives and is the clarified FHA policy in the best interest of the American public? A survey of foreclosures in six Massachusetts Registry Districts analyzes whether permitted subordination could have increased the probability of seniors saving their homes.

II. OVERVIEW OF HECM PROGRAM

The most common type of reverse mortgage is the Home Equity Conversion Mortgage (HECM). The HECM reverse mortgage is an FHA insured mortgage program that allows qualified senior homeowners a vehicle to access the equity in their home. The history and an overview of the mechanics of the HECM program are detailed in Paul Black’s article found elsewhere in this publication. This article focuses on that set of seniors who technically qualify for a reverse mortgage but pragmatically cannot make use of a reverse mortgage since they owe too large a balance on the mortgage(s) currently encumbering their home. Many of these seniors now face foreclosure.

III. WHEN A SENIOR OWES TOO MUCH

The FHA requires that the HECM reverse mortgage constitutes a first lien. As such, seniors who still owe money on their home mortgage at the closing must pay off predecessor secured loans by a lump sum from the reverse mortgage or by using their own funds. A number of seniors seeking a HECM reverse mortgage have current mortgages. In 2006, 47 percent of seniors obtaining a reverse mortgage reported having a current

---

2 Until 2007, there were also the Fannie Mae Home Keeper Reverse Mortgage and a proprietary Jumbo reverse mortgage offered by Financial Freedom, a private company that was a subsidiary of the failed Indy Mac Bank and, until it recently closed, was also a subsidiary of One West Bank. Both products were discontinued in the wake of the nationwide implosion of real estate values and difficulty of placing Jumbo reverse mortgages in the secondary market. Changes made to the FHA HECM reverse mortgage program also made redundant significant aspects of the Fannie Mae Home Keeper. As a practical matter, only the HECM program is available to seniors applying for a reverse mortgage, although one company has recently introduced a new jumbo program. See Jumbo Reverse Mortgages: A Dying Breed, HULIQ (Sept. 17, 2008), http://www.huliq.com/2818/68681/jumbo-reverse-mortgages-dying-breed.


4 There are two mortgages recorded at the time of a HECM closing. The first secures the Lender while the second secures HUD. Although described as first and second mortgages, it is more appropriate to think of these as parallel first mortgages as the second mortgage is used by HUD to step into the Lender’s shoes in the event that the Lender fails, does not make payments to the senior, or assigns the HECM to HUD. Assignments occur under an Assignment of Insurance option when the amount paid out to a senior, plus all accrued interest, reaches 98 percent of the Principal Limit.

Can HECM Reverse Mortgages Keep More Seniors from Becoming Homeless?

Spring 2012

Of those seniors, 48 percent reported incomes below $30,000. For most of these seniors, their home is their single largest investment. By some estimates home values across the United States have plummeted by 30 percent since 2006. Other estimates place the number of homeowners with mortgage balances greater than the value of their homes at 25 percent. Concurrently, mortgage delinquency rates have approached a record 15 percent. A number of these delinquencies arise out of subprime mortgages; and seniors were not an exception to the subprime bubble with an estimated 41 percent of subprime mortgages currently encumbering homes owned by seniors. As of 2007, the number of senior homeowners over age 62 who were either delinquent or in foreclosure, was 177,037 or 7.3 percent of all consumers in that category. Simultaneously, the number of HECM reverse mortgages closed has plummeted with a 45 percent drop in the number of FHA HECM endorsements since 2009.

A HECM reverse mortgage is not a valid option for these seniors. Although they technically qualify under the FHA regulations pertaining to reverse mortgages, the HECM program will not make enough funds available to them to satisfy their existing mortgage. Of those seniors, 48 percent reported incomes below $30,000. For most of these seniors, their home is their single largest investment. By some estimates home values across the United States have plummeted by 30 percent since 2006. Other estimates place the number of homeowners with mortgage balances greater than the value of their homes at 25 percent. Concurrently, mortgage delinquency rates have approached a record 15 percent. A number of these delinquencies arise out of subprime mortgages; and seniors were not an exception to the subprime bubble with an estimated 41 percent of subprime mortgages currently encumbering homes owned by seniors. As of 2007, the number of senior homeowners over age 62 who were either delinquent or in foreclosure, was 177,037 or 7.3 percent of all consumers in that category. Simultaneously, the number of HECM reverse mortgages closed has plummeted with a 45 percent drop in the number of FHA HECM endorsements since 2009.

A HECM reverse mortgage is not a valid option for these seniors. Although they technically qualify under the FHA regulations pertaining to reverse mortgages, the HECM program will not make enough funds available to them to satisfy their existing

7 Id. at 68.
11 Press Release, Delinquencies Continue to Climb in Latest MBA National Delinquency Survey, Mortgage Bankers Association (Nov. 19, 2009), http://www.mortgagebankers.org/NewsandMedia/PressCenter/71112.htm (accessed Jan. 11, 2011). In the third quarter of 2009, “[t]he combined percentage of loans in foreclosure or at least one payment past due was 14.41 percent on a non-seasonally adjusted basis, the highest ever recorded in the MBA delinquency survey.”
12 Kristopher Gerardi, Adam Hale Shapiro & Paul S. Willen, Subprime Outcomes: Risky Mortgages, Homeownership Experiences, and Foreclosures, Federal Reserve Bank of Boston Working Paper 07-15 (2007), http://finance.wharton.upenn.edu/~rlwctr/Willen2.pdf. This reports that borrowers who purchase their homes with subprime mortgages have almost a 20 percent chance of losing them to foreclosure, a figure that is approximately seven times larger than those who use the prime mortgage market.
13 See also Elderly in the Subprime Market, Consumers Union Southwest Regional Office (Oct. 2002), http://www.consumersunion.org/finance/elderly-rpt1002.htm (accessed Jan. 11, 2011). This report notes that the subprime mortgage penetration is greater for neighborhoods with an older population.
mortgage. Lenders will not offer a HECM to these seniors because the FHA will not provide insurance coverage for these notes.\textsuperscript{16} Seniors in this situation face foreclosure. This is particularly evident in states where the housing depression is pronounced.\textsuperscript{17} Although some media reports have focused on homeowners walking away from properties that are “underwater,”\textsuperscript{18} relatively few choose this option.\textsuperscript{19} It is reasonable to assume that the percentage of seniors who ”walk away” is even less than the general population given that many seniors, having owned their homes for many years and being on fixed incomes, have few viable alternatives on where to live.\textsuperscript{20} In 2007, home equity was 26 percent of household wealth among all seniors and 59 percent among the low-income elderly.\textsuperscript{21} These seniors simply lack the ability to walk away from their home.

Underwater seniors faced with foreclosure might believe that they could reach an agreement with their current lender to subordinate the difference between their mortgage balance and the net proceeds available to them from a HECM lump sum. If a lender receives a significant portion of the balance due them and a stream of secured payments for the balance, then it stands to reason that the lender may be inclined to opt for this arrangement.\textsuperscript{22}

\begin{itemize}
  \item \textsuperscript{16} Interview with Bruce Albright, \textit{infra} n. 24.
  \item \textsuperscript{19} Diana Olick, \textit{Treasury: Jingle Mail a Myth}, CNBC (June 26, 2009), http://www.cnbc.com/id/31570460 (accessed Jan. 11, 2011). Olick quotes Michael Barr, Treasury’s Assistant Secretary for Financial Institutions, as saying: “We don’t see in the data borrowers who are walking away because they can or because their homes are underwater. We do see borrowers who are unable to make the payment.”
  \item \textsuperscript{20} G. Thomas Kingsley, Robin Smith & David Price, \textit{The Impacts of Foreclosures on Families and Communities}, The Urban Institute (May 2009), http://www.urban.org/UploadedPDF/411909_impact_of_forclosures.pdf. The authors note that the “... elderly are particularly vulnerable — financially, physically, and emotionally — to such major disruptions as foreclosure implies, and strategies for supporting them may differ from those for younger families.”
  \item \textsuperscript{21} Joint Center for Housing Studies of Harvard University, \textit{supra} n. 10.
\end{itemize}
This strategy, however, is not permitted. Mortgagee Letter 2009-49 prohibits subordinated liens to a HECM reverse mortgage. With the exception of federal or state judgment liens, “any excess balance due on an existing lien must be paid in full, forgiven, or otherwise extinguished prior to or at closing of the HECM loan transaction.” The FHA has, in the past, permitted HECM subordination despite the seemingly explicit prohibition established in Mortgagee Letter 2009-49. Mortgagee Letter 2006-20 (clarified by Mortgagee Letter 2009-49) stated:

Current FHA policy permits an existing lien of record against real estate, which serves as collateral for an FHA-insured HECM loan, if the following two conditions are satisfied.

1. The subordinate lien does not intervene between the first and second HECM liens.
2. A lien against a[n] HECM borrower’s property, which is subordinate to the FHA-insured HECM first and second liens, cannot arise or be connected with obtaining a[n] HECM loan. FHA regulations at 24 CFR 206.32(a) provide that there shall be no outstanding or unpaid obligations incurred by the HECM borrower in connection with the HECM transaction. Once a[n] HECM loan is endorsed, however, the HECM mortgagor is not restricted from seeking a home equity loan, or engaging in another type of real estate financing transaction which would require an additional lien to be subordinated to the HECM first and second liens.

Reverse mortgage lenders had thus, until the issuance of Mortgagee Letter 2009-49, interpreted Mortgagee Letter 2006-20 to mean that an existing mortgage could be subordinated to a HECM as that obligation was rarely created in conjunction with the HECM loan. Subordinating an existing first mortgage was accepted practice by underwriters.23


Sarah Hulbert, CEO, Senior Financial Corp., a brokerage based in Renton, Wash. says: “The [HUD] guidance appears to change its previous stance with regards to existing subordinate liens [although] HUD historically has always insured these loans.” As a result, Hulbert tells RMD: “One major lender is saying it’s [still] okay to re-subordinate and another huge lender says [the opposite].” Meg Burns, director, Office of Single Family Program Development at HUD, says “there has been no change in policy. We know that some lenders are claiming that we previously permitted subordinates,” she acknowledges, “but we did not. We issued this guidance because we were concerned with that rumor circulating and wanted to clarify the policy — yet again.”

Sherry B. Apanay, Senior Vice President, Generation Mortgage Company: “I agree with Sarah, it has always been my understanding that HUD would not allow you to “create” a new lien (taking 3rd position) in order to make the HECM work. But when an existing lien holder is willing to take a 3rd lien position behind a HECM what is the risk to HUD? GMC will adhere to HUD’s
They relied on the explicit permission in Mortgagee Letter 2006-20. Underwater seniors, therefore, stood to benefit from this prior interpretation as these seniors could avoid foreclosure by obtaining a HECM reverse mortgage and using the funds provided by this mortgage to reduce the balance on their original mortgage.

So what changed? This analysis looks at two prongs. The first is FHA’s interpretation of 24 CFR 206.32(a) — the federal regulation authorizing these mortgagee letters. The second prong is public policy arising from the current economic crisis, specifically a concern over the viability of the insurance funds backing the HECM program and the desire to not help subprime lenders who put seniors at risk. The examination of both of these elements suggests that the current interpretation of Mortgagee Letter 2009-49 is incorrect.

A. First Prong: Analysis of 24 CFR 206.32

The FHA’s current position is that a deficiency subordination would represent an outstanding or unpaid obligation incurred in connection with the HECM transaction:

In order for a mortgage to be eligible under this part, a mortgagor must establish to the satisfaction of the mortgagee that:

(a) After the initial payment of loan proceeds under § 206.25(a), there will be no outstanding or unpaid obligations incurred by the mortgagor in connection with the mortgage transaction, except for repairs to the property required under § 206.47 and mortgage servicing charges permitted under § 206.207(b); and

(b) The initial payment will not be used for any payment to or on behalf of an estate planning service firm.

24 CFR 206.32 arose from the provisions of the Senior Citizens Home Equity Protection Act enacted into law in 1999 by the 105th Congress. When this Act was enacted, the reverse mortgage program had gone through a 10-year start-up pilot program so that, by 1999, a lot of experience had accumulated and Congress enacted substantive changes in response to these historical experiences. Congress introduced several pieces of legislation addressing HECM reverse mortgages.

---

24 As part of the research, the author conducted interviews with Margaret Burns of the Federal Housing Admin., and Bruce Albright of the U.S. Dept. of Housing and Urban Dev., Office of General Counsel. Ms. Burns, until recently, was Director of the FHA Office of Single Family Housing, which is the FHA’s primary liaison with the reverse mortgage industry. She is now Senior Associate Director for Congressional Affairs and Communications with The Federal Housing Finance Agency. Attorney Albright was part of the team involved in drafting Mortgagee Letter 2009-49. The author is deeply grateful for the generous time given by both.

25 The author defines “deficiency subordination” as the subordination to the first and second liens, representing a HECM reverse mortgage, of the difference between the amount that a senior borrower owes for current mortgage loan(s) on their home and the amount of net HECM funds they would qualify for based on their age, interest rate, and current home value.


One of Congress’ primary concerns was the proliferation of “estate planning services” firms in association with reverse mortgages. These firms would market freely available information about reverse mortgages and then charge seniors for that information. Their fees would be high and typically would take the form of a payment from the reverse mortgage proceeds or after the reverse mortgage was secured by a subordinated lien. In response, the Department of Housing and Urban Development (HUD) issued Mortgagee Letter 97–07, prohibiting FHA-approved lenders from involvement in HECM mortgages referred by estate planning firms. Two estate planning firms sued seeking a preliminary injunction to require HUD to withdraw the mortgagee letter. These firms posited that HUD failed to follow the appropriate notice and comment rulemaking procedures. A temporary restraining order was issued on March 26, 1997, followed by a preliminary injunction on April 11, 1997. As a result, Mortgagee Letter 97–07 was withdrawn.

Congress’ response was the Senior Citizens Home Equity Protection Act — the underpinning for 24 CFR 206.32. Currently, FHA interprets 24 CFR 206.32 so that section (a) (….no outstanding or unpaid obligations incurred by the mortgagor in connection with the mortgage transaction…) is independent of section (b) (….initial payment will not be used for any payment to or on behalf of an estate planning service firm). The author suggests that this separation of the two sections for the purposes of rules formulation was not the legislative intent but rather the two sections should be read as a unified whole. Using this interpretation the author suggests that the correct interpretation of 24 CFR 206.32 is that it only applies to any outstanding or unpaid obligations incurred by the mortgagor in connection with the reverse mortgage transaction that are obligations created to pay for estate planning services.

1. Legislative History and Review of Congressional Testimony and Public Comment

The conclusion that Congress intended that 24 CFR 206.32 be read as a unified whole is based on two analyses: 1) a review of the Congressional testimony for the Senior Citizens Home Equity Protection Act leading up to 24 CFR 206.32, including the summary of the final rule found at 24 CFR Volume 26 and HUD’s responses to the public comments to that rule; and, 2) an analysis of whether judicial liens that are allowed to be


subordinated to a HECM under current FHA policy31 are of any substantive difference from other pre-existing liens.

The Congressional Record has testimony on the Senior Citizens Home Equity Protection Act by several legislators. Although the bill contained the language found in both sections (a) and (b) of 24 CFR 206.32, virtually all the testimony was only about the language found in section (b), specifically concerning the use of estate planning services.32 This included testimony by Sens. Kerry,33 D’Amato,34 Dodd,35 Bryan,36 and Sar-

---

31 Ltr. from Stevens, HUD Mortgagee Letter 2009-49, supra n. 1. HM 2009-49 states in part:

II. Allowable Subordinate Liens at HECM Origination. The following subordinate liens are allowed. 1. State and Local Court Judgments and Judgment Liens. FHA does not require a prospective HECM mortgagor to satisfy an unpaid or local court-ordered judgment prior to or at closing, although the mortgagee may impose such a requirement. Liens against the real estate resulting from outstanding state or local court judgments must be satisfied and removed or subordinated to the HECM first and second liens at closing. 2. Federal Judgments and Debts. A Federal judgment or debt must be paid-in-full or a satisfactory repayment plan between the prospective mortgagor and the Federal agency owed must be in place prior to closing of the HECM. In addition, a prospective HECM mortgagor’s credit report must be reviewed to check for any claims, defaults, or debts owed to the Federal government, and any existing debts against the real estate that will serve as collateral for the HECM. Any delinquent Federal debts or liens against the real estate must not be in excess of the mortgagor’s net principal limit, unless the mortgagor has a separate source of funds from which to draw and pay those debts. Liens against the real estate resulting from outstanding Federal obligations must be satisfied and removed, or subordinated to the first and second HECM liens at closing.

32 See Senior Citizen Home Equity Protection Act, supra n. 27.


35 Senior Citizen Home Equity Protection Act, supra n. 27, http://origin.www.gpo.gov/fdsys/pkg/CREC-1997-04-25/pdf/CREC-1997-04-25-pt1-PgS3712-2.pdf (accessed Jan. 11, 2011). Sen. Dodd: “The bill …. will protect senior citizens who have worked hard, struggled to save, and built decent homes for their families…. But what happens, of course, when something like this comes along, there are always the thugs who try to take advantage of people. This is nothing new. They are always out there. They run around and go door to door, literally, Mr. President, where these elderly people live and rip them off, as the chairman pointed out passionately this morning…. As a result of the chairman’s efforts this morning and the unanimous support that I think we are going to have from all of our colleagues here, we are going to slam the door on these scam artists--loan sharks is really what they are.”

Testimony was given by 11 legislators, who all addressed only the issue of fees for estate planning services; and none testified on the provision of not allowing outstanding obligations. The testimony of Sen. Carol Mosely-Braun very specifically shows that the legislation was in response to the Court issuance of the injunction in favor of the estate planning services firms.\footnote{Senior Citizen Home Equity Protection Act, supra n. 27, http://origin.www.gpo.gov/fdsys/pkg/CREC-1997-04-25/pdf/CREC-1997-04-25-pt1-PgS3712-2.pdf (accessed Jan. 11, 2011). Sen. Moseley-Braun: “….. I do not believe we can sit idly by while senior citizens are charged excessive fees for seeking to access the equity in their homes … Unfortunately, there are some who are taking advantage of seniors and charging them excessive fees to complete the reverse mortgage transactions, including fees of up to 10 percent of the loan amount. The Senior Citizen Home Equity Protection Act is not complicated legislation. There are only two provisions. The second provision provides that the HUD secretary has the authority to impose restrictions to ensure that a lender does not charge excessive, or unwarranted costs to the borrower for providing a reverse mortgage. This is a basic protection that allows HUD to police the bad actors that are ruining reverse mortgages as an option for too many seniors. HUD tried to address the problem, but a court ruled that the department had to go through its normal procedure to issue a rule governing fees charged by the advisers. Formal rulemaking can take as long as six or seven months. We do not have six or seven months. Every day seniors face the prospect of losing part of the equity in their homes because these scams are allowed to continue. This legislation will put an end to the scams.” (emphasis added).}

The only record that addresses section (a) of 24 CFR 206.32 (unpaid or outstanding obligations) is found in the response to public comments on the introduction of the rule promulgated in 24 CFR 26, which was entitled “Home Equity Conversion Mortgages; Consumer Protection Measures.” In introducing the rule, the FHA referred to the withdrawal of Mortgagee Letter 97-07 and also stated that this rule was in response to the recent Congressional action in passing the Senior Citizens Home Equity Protection Act. The final rule, dated February 18, 1999, received eight public comments. Comment 3 and the FHA’s response to that comment, makes it clear that the prohibition against unpaid obligations was tied to estate planning services firms. Specifically:

3. Section 206.32-No Outstanding Unpaid Obligations
Comment: A commenter supported Sec. 206.32(b) forbidding use of initial HECM payments to pay estate planning service firms, but opposed Sec. 206.32(a), which prohibits mortgagor obligations that are incurred in connection with the mortgage transaction but will not be paid off at closing (except for certain repairs or mortgage servicing charges). The commenter interpreted this as precluding later use of

\^citizens are being charged excessive fees by so-called estate planners who provide information on reverse mortgages and charge 8 percent to 10 percent of the loan…. senior citizens across the country are being charged scandalous fees for information that can be obtained free from HUD…. The Senior Citizen Home Equity Protection Act will protect senior citizens receiving a HUD home equity conversion mortgage from further exploitation by these predator lenders.”
HECM proceeds to pay outstanding bills that may have been part of the impetus for obtaining the HECM.

Response: This section does not prevent HECM proceeds from being used to pay bills that were incurred without any connection with the mortgage transaction (for example, pre-existing medical bills), or prevent use of HECM proceeds to pay obligations incurred after the closing. The section targets only those who charge excessive fees in connection with obtaining the HECM. (emphasis added)

Other than this single comment and response, there is nothing else in the record specifically addressing Section 206.32(a). This comment and response leaves no interpretation other than that the prohibition against “outstanding or unpaid obligations incurred” in connection with the mortgage transaction applies only to payments such as estate planning services by firms incurred simultaneous to the HECM.39 Indeed the reference to the use of HECM proceeds to pay pre-existing medical bills is analogous to the payment (if only in part) of a pre-existing mortgage obligation. Just like a medical bill, a pre-existing mortgage obligation is not incurred as part of the reverse mortgage transaction but is, instead, an impetus for obtaining the HECM.

2. Are Judicial Liens — Which are Permissibly Subordinated to HECMs under Current FHA Policy — Substantively Different from Other Liens?

Mortgagee Letter 2009-49 allows subordination of state and local court judgments and judgment liens as well as federal judgments and debts. Mortgagee Letter 2006-20 defines these liens as:

A judgment is a court’s final determination of the rights and obligations in a case. A money judgment is a judgment for a specific sum of money and is subject to immediate execution, whereas a judgment lien is a lien imposed against the judgment debtor’s property. A judgment lien gives the judgment creditor the right to seize the debtor’s assets (i.e., real property) to secure a judgment, or sell the assets to satisfy the judgment.

The FHA does not mandate that state court liens be paid but allows them to be subordinated to the HECM first and second mortgages at closing. If not subordinated, then these liens against the real estate must be satisfied and removed. Likewise, the FHA allows a lien against the real estate resulting from outstanding federal obligations to be subordinated to the first and second HECM liens at closing. Similar to the requirement for state judgments, if not subordinated they must be satisfied and removed, or a satisfactory repayment plan between the senior and the federal agency owed must be in place prior to closing of the HECM.

39 The FHA authors envisioned this restriction as applying to other companies, such as home improvement contractors, targeting seniors in addition to estate planning service firms. Interview with Bruce Albright, _supra_ n. 24.
Although the language of the mortgagee letter is not explicit, the FHA limits the definition of state and federal liens as liens or judgments for taxes. Setting aside for the moment that 24 CFR 206.32 does not carve out a special exception for state and federal judgments or liens, one potential justification for allowing these subordinations, but not for other types of liens, is that tax liens take priority over garden variety liens. This, however, is not always so. Courts make a distinction in determining the priority of federal tax liens by examining 1) if the non-tax lien is first in time and 2) if that non-tax lien is choate or perfected. To resolve the question of priorities, the Supreme Court has stated that federal law controls.

Although states can grant liens to judgment creditors on a debtor’s property for state purposes, before such liens are granted priority over federal tax liens they must meet the federal test of “choateness.” Courts have stated that only “choate state-created liens take priority over later federal tax liens ... while inchoate liens do not.” To determine whether a non-tax lien has a superior right over federal tax liens, a two-pronged analysis is used. First, the court determines if a state’s law grants a lien to the judgment creditor for state law purposes. Second, the court must decide if the state-created lien is choate prior to the filing of the notice of federal tax lien. If both these elements are satisfied, then the state non-tax lien takes priority over the federal tax lien. In short, a garden-variety lien can take priority over a federal tax lien if it is both recorded against the property first in time and is perfected.

Likewise, federal tax liens do not necessarily take priority over recorded mortgages even if a mortgage is recorded later in time. Although, in general, a tax lien in favor of the United States is not extinguished by a non-judicial sale of property there is an exception. A federal tax lien may be extinguished when timely notice is provided to the IRS and the foreclosing party does not, before the sale, receive from the IRS “written notification of the items of information which are inadequate.” If so, the notice operates

40 Interview with Bruce Alright, supra n. 24: “State and federal judgment liens are tax liens only.”
43 Id.
46 26 U.S.C. § 7425(b) (“a sale of property on which the United States has or claims a lien ... shall ... be made subject to and without disturbing such lien or title”).
47 26 U.S.C. § 7425(e)(1); 26 C.F.R. § 301.7425-3(d)(1)(i)-(iv) (detailing particular items to be included in notice to IRS of non-judicial foreclosure sale).
48 26 C.F.R. § 301.7425-3T(d)(2).
to “extinguish the government’s lien once the sale [is] consummated.”

Clearly tax liens, as defined by the FHA, state and local court judgments and judgment liens as well as federal judgments and debts, do not have an absolute and inviolable priority over non-tax liens. As such, if not given such deference by courts in the context of tax enforcement, it is difficult to support an argument that they should be given such deference in the context of a HECM.

B. Second Prong: Analysis of Public Policy

The FHA has two primary public policy concerns in both drafting and implementing HECM reverse mortgage regulations. The first is that the HECM program is, at its primary level, an insurance fund. The FHA believes that permitting subordination of existing liens may, if a senior defaults, trigger a foreclosure impacting the HECM secured position and so, in turn, cause a claim against the insurance fund. Default could come both from failure to make payments on the subordinated loan and also from failure to make property tax or insurance payments, which is a default of an insured HECM.

Currently, the insurance fund is in a tenuous position. FHA insured loans have grown from 3 percent of the mortgage market to almost 30 percent of the market in 2009. The FHA has four insurance funds: Mutual Mortgage Insurance (MMI), General Insurance (GI), Special Risk Insurance (SRI), and Cooperative Management Housing Insurance (CMHI). These are funded from various sources including premiums, fee and interest income, Congressional appropriations, and borrowing from the Treasury. The HECM program, as a result of the Housing and Economic Recovery Act of 2008 (HERA), is currently insured through the MMI fund, although prior to 2009 it was insured through the GI Fund. The strength of the MMI fund is determined, in part, by the MMI capital ratio that is detailed in Section 205 of the National Housing Act. This requires a capital

---

49 Whiteside v. United States, 833 F.2d 820, 822 (9th Cir.1987) (defect in notice of sale to IRS by trustee cured when IRS failed to object and preserve its rights and thus lost lien); See also Tompkins v. United States, 946 F.2d 817, 821 (11th Cir.1991) (proper notice of non-judicial foreclosure sale divests property of government lien).


53 Housing and Economic Recovery Act of 2008, supra n. 3.

54 Id. See also 24 CFR Ch. II (4–1–03 Edition), § 206.102 (60 FR 42761, Aug. 16, 1995).

55 The ratio compares the “economic net worth” of the MMI Fund to the balance of active, insured loans. Economic net worth is a net asset position (after booking the present value of all expected future revenues and net claim expenses) plus the current cash resources. The estimate of economic net worth used in the capital ratio calculation is based on an annual, independent actuarial analysis of the future perfor-
Can HECM Reverse Mortgages Keep More Seniors from Becoming Homeless?

Spring 2012

ratio of at least 2 percent for the MMI Fund. As of 2009, the MMI fund had fallen to a ratio of 0.53 percent due to both continuing economic weakness and continuing decline in housing prices. In response, the FHA has taken a number of corrective measures, including the reduction of the HECM principal limit factor by 10 percent.

The second concern is that the FHA does not want to see subprime lenders rewarded for questionable actions that target seniors. If deficiency subordination were permitted, a subprime lender could, in essence, be paid in full as they would receive a lump sum from the HECM for a substantial portion of the balance due and then the differential amount over a period of time as a stream of monthly payments made by the senior. The gist of the FHA policy is that institutions that place seniors at risk through inappropriate subprime mortgages should be penalized in the form of loss of funds in excess of the HECM principal loan amount.

1. Would Permitting Partial Subordination Put the Insurance Fund at any more Risk?

A claim against the insurance fund occurs when a property secured by a HECM is foreclosed and the foreclosure proceeds are less than the HECM balance. Foreclosure occurs in two circumstances. The first is when a HECM becomes due because of either the death of all the senior borrowers or all the senior borrowers have not lived in the residence for 12 consecutive months. At that point, the seniors’ estates or representatives can endeavor to sell the property or may satisfy the HECM lien with a replacement mortgage or other funds. In the event of a sale, the FHA permits an arms-length sale of the property to a third party for 95 percent of the appraised value of the home if the value is less than the HECM balance. The deficiency balance becomes a claim against the fund. If the estate or representatives either fail or refuse to sell the home within 12 months of either triggering event then the property may be foreclosed. The second circumstance is when the senior borrowers fail to stay current with property taxes or homeowner insurance premiums, thus triggering a foreclosure.


56 MMI Fund Actuarial Review, supra n. 55.

57 For a very good discussion of the risk facing FHA and the HECM insurance pool, see New View Commentary, The Trouble with HECMs: FHA’s Bumpy Road to Grandma’s House, New View Advisors (June 15, 2009), http://newviewadvisors.com/commentary/the-trouble-with-hecms-fhas-bumpy-road-to-grandmas-house/.

58 Interview with Meg Burns, supra n. 24: “Seems to us that the [subprime] lienholder should agree to some level of debt forgiveness. It is frustrating that seniors were put in this position.”

59 FHA allows an automatic six-month period of time to sell or pay off the HECM after a triggering event and then two additional three month extensions upon written application.

Beginning the analysis, what would be the different impact on the insurance fund for a home foreclosed for less than the HECM balance when the HECM was the only mortgage lien as opposed to a home that was also encumbered by a mortgage subordinated to the HECM? An example of both scenarios is instructive here.

If we assume a home appraised for $200,000 but with a HECM balance owed of $250,000, then the sellers can receive a HECM mortgage discharge by payment of $190,000 or 95 percent of the value. This leaves a HECM deficiency of $60,000, which is then a claim against the fund. In the alternative, those sellers could allow the property to proceed to foreclosure with either the same result or a higher claim against the fund if the final foreclosure bid price was less than the 95 percent level.

If that same home also had a further lien subordinated to the HECM with a balance of $20,000, the sellers, assuming the subordinated lien holder would not release them, would not be able to obtain a release for the 95 percent value but could allow the property to proceed to foreclosure. Once again, the amount of the claim against the insurance fund would be the difference between the HECM balance and the successful bid amount at the foreclosure sale or, in short, the same result as if the home had gone to foreclosure with only the HECM as a mortgage obligation.

The fact that there is also a subordinated lien on the secured home does not create any greater claim against the fund since that subordinated lien is wiped out by the foreclosure sale of the priority HECM. The amount due for the subordinated lien may create a deficiency claim against the senior borrower (or their estate) individually, but is of no consequence to the fund. In short, the only effect of the subordinated lien is that it makes unlikely that seniors or their estates could avail themselves of the option of an arms-length sale to a third party for the 95 percent value. Indeed, from the point of view of the insurance fund, the amount of the claim may be diminished since a subordinated lien holder might possibly bid in the HECM balance in an attempt to preserve its security and portfolio the property until values recover.

2. A Balancing of Harms — Is the FHA Subordination Prohibition in the Best Interest of Seniors?

The FHA does not want to see subprime lenders rewarded for questionable actions that target seniors.61 If a subprime lender were allowed to receive a lump sum from the HECM and then subordinate the remainder of its lien balance in exchange for monthly payments on that balance, they would become whole — a reward for questionable behavior.

But what is the outcome without partial subordination? If a senior can no longer afford to make payments on the subprime mortgage then, eventually, the subprime lender will foreclose. In that scenario, the bid price on the house may be its full value but more likely some liquidation percentage of that value. This, however, likely creates a deficiency for which the senior is individually liable in states with deficiency actions. In short, the result is a homeless senior facing a deficiency judgment, which, if the senior is able to pay, makes the subprime lender whole. If the senior is unable to pay, she faces the bur-

61 Interview with Meg Burns, supra n. 24.
den of collection activities against him or her or the unappealing route of a bankruptcy filing. In a bankruptcy, the most likely outcome would be a Chapter 13 plan, which pays out unsecured creditors some reduced percentage amount of their balance over a period of time. In this outcome, the subprime lender is not made whole but does see additional funds above the amount received at foreclosure.

What is the outcome if partial subordination is allowed? Here a lump sum from the HECM pays off a percentage of the subprime mortgage balance. The difference is subordinated and the senior either, in one scenario, continues to make the full monthly payments or, in a second scenario, negotiates a smaller monthly payment (a re-amortization strategy). In this second scenario, the senior remains in the home and has better cash flow (and a better chance of success in paying off the subordinated debt). In the first scenario, the senior remains in the home and has some chance of paying off the subordinated mortgage if he or she can sustain the full payments. If he or she cannot, however, then the subordinated lender has two options.

The first option is to declare the now diminished balance due and pursue a collection action against the senior. In this scenario, the senior remains in the home but suffers the indignity of the collection process or a bankruptcy where the original lender may be paid out over time under a Chapter 13 filing. This is the same current result due to a HECM not being practically possible because of the subordination prohibition, only now with a senior not being homeless. The second option for the subordinated lender is to begin a foreclosure action against the senior. In this scenario, however, that lender would need to bid in the full amount due on the HECM balance since the HECM has priority in title and that lender cannot deliver good title to a third party without fully satisfying the HECM. As such, it is unlikely that the subordinated lender would choose a foreclosure route as it would, in essence, be giving back money it has already been paid from the HECM lump sum. If this unlikely event did take place, there would be no claim against the insurance fund. Under this course of events, the likelihood of the senior remaining in the home is enhanced. On balance, the very real potential harm to a senior — homelessness — is far greater than any benefit a subprime lender would receive as a reward for questionable lending practices.

IV. AT THE FRONTLINE OF FORECLOSURES – A SURVEY OF SENIORS LOSING THEIR HOMES AND THE IMPACT OF THE MORTGAGEE LETTER 2009-49

Allowing subordination seems to enhance the likelihood that a senior, saddled with a subprime mortgage in excess of the value of her home, will be able to remain in the home. But what is the real cost? To assess that question, we conducted a survey of foreclosed seniors to determine the extent of debt that would have needed to have been subordinated to save their homes.

A. Description of Survey Method

To determine the consumer impact of the prohibition of mortgage subordination under Mortgagee Letter 2009-49, a limited survey was designed to measure the effect a
The mechanism of deficiency subordination may have had upon a group of seniors who were foreclosed. The study examined property records in 2009 at six Registry Districts in Massachusetts. The surveyors chose these districts as each were areas where the implosion of house values has been most noticeable in Massachusetts and also have either a high blue-collar background senior population or were retirement areas with a high senior population. The study examined property records in 2009 at six Registry Districts in Massachusetts.

The examination identified each residential foreclosure for a given year and then cross-referenced the previous owners of those foreclosed properties with a commercially acquired list to identify the ages of the previous owners. This allowed the development of a subset of seniors who were foreclosed but who would have qualified for a HECM reverse mortgage. Only first lien mortgages were reviewed.

The property records list the amount of the foreclosure bid at the time of auction, which is a realistic indication of what was either owed to the foreclosing financial institution or what that institution would have been willing to accept for the property in a short-payoff negotiation. Each property was then cross-referenced against the tax assessor’s records of its municipality to determine its assessed value as of the time of foreclosure. Based on this assessed value and the age of the previous homeowners, a calculation was performed to determine the amount each of those foreclosed owners would have been qualified to receive from a HECM reverse mortgage. This calculation was deducted from the final amount bid in at the foreclosure to determine what amount would need to

64 The public records of six registry districts in Massachusetts (Barnstable County, Bristol County South Fall River District, Middlesex Northern District, Middlesex Southern District, Worcester Northern District, and Worcester Southern District) were used to compile these records. The districts chosen for the survey were based upon the online availability of public property records and the percentage of seniors in their population compared to other areas of the state. This was a limited survey. To determine whether a subordinate deficiency program would be applicable on a national scale, research would need to be conducted on property records in multiple states, which is beyond the scope of this article.

65 Redacted were properties where the foreclosure was that of a reverse mortgage.

66 If there were multiple owners with at least one age 62 or over, then the assumption was made that those borrowers would have rationally elected to transfer the property solely into the name of the age-eligible borrower in order to save the property from foreclosure.

67 In 2009, the six registry districts examined recorded 3,089 residential property foreclosures of which 171 were senior homeowners or approximately 5.5 percent. It was not possible to distinguish from the property records whether a foreclosed property was a primary residence or a second home but the percentage of second homes in the United States is only 3 percent and so such overlap is statistically insignificant. See Historical Census of Housing Tables, Vacation Homes, U.S. Census Bureau, http://www.census.gov/hhes/www/housing/census/historic/vacation.html (accessed Jan. 11, 2011).

68 Although a tax assessment does not give the appraised value of the property, assessed values have commonly become “full assessments” meaning that they are based on comparable indicia to a full appraisal. See Irving Saunders Trust v. Board of Assessors of Boston 533 N.E.2d 234 (1989) stating that assessors must use highest and best use methods to determine property value (“In determining fair market value, the board must determine ‘the highest price which a hypothetical willing buyer would pay to a hypothetical willing seller in an assumed free and open market.’”).

69 These calculations were determined by using the HECM calculator made available from the National Reverse Mortgage Lenders Association at http://rmc.ibisreverse.com/default_nrmla.aspx. To determine the amount a HECM reverse mortgage would make available to a senior, inputs were made for age and home value. Of the resulting selections, the HECM fixed interest rate was chosen as it results in the highest available amount and requires a full draw down of all available funds which is necessary in a deficiency situation. The HECM calculator results were as of December 2010.
be subordinated to a HECM as a deficiency balance if subordination were permissible. Finally, a calculation was made on this deficiency amount to determine what a monthly payment would have been on that debt over both a three-year and five-year period at a competitive interest rate.

B. Results of Survey

The first striking observation of this data is that 157 of the foreclosed mortgages (or 90 percent of the study sample) originated between the years of 2003 and 2007. This period coincides with the rapid rise of subprime lending, suggesting that seniors were not immune to the siren call of subprime lenders.

Of the 171 foreclosures of seniors identified, 25 qualified for HECM funds in excess of the foreclosure bid, suggesting that 15 percent of these foreclosed seniors could have kept their homes simply by availing themselves of the HECM program. Possible reasons they did not include lack of qualification because the home was not a primary residence, foreclosure after death of the senior, not knowing about or reluctance to participate in the HECM program, or that the property was subject to further mortgages, satisfaction of which would not have been possible with the amount of HECM funds available. Examination of property records was limited to only the mortgage that was foreclosed and did not include any other mortgages encumbering a property although, when that did appear, the lender on the junior mortgage was often also the same as the lender on the foreclosed mortgage.

The study then looked at the payment a senior would make on a subordinated deficiency balance over a three-year and five-year period at an interest rate of 6.5 percent. This was then compared to a calculated payment reasonably likely to have been due on the foreclosed mortgage. There is no data available to determine the income of these foreclosed seniors, but some extrapolations can be made about whether a partial subordination and renegotiated payment plan for the differential balance may have kept these seniors in their homes. First, it is reasonable to assume that they all received or were eligible for Social Security income. The average Social Security payment for seniors in the United States is $1,100 per month. That suggests that for 14 percent of these seniors, a renegotiated payment plan for the deficiency amount, either for three years or five years, may have resulted in a monthly payment at 30 percent or less of the average Social Security payment.

The survey next looked at what these seniors were likely paying on the foreclosed mortgage. See Table 2, which lists the face amount of each mortgage and a calculation of the likely monthly payment based on the term of years stated in each mortgage. The recorded mortgages are silent about the interest rate so we assumed an interest rate for

---

73 Table 2 and all the other tables referenced in this article can be found at http://bit.ly/zvd4h6.
74 In Table 2, supra n. 73, where the term of years was not stated in the mortgage instrument, a term of 30 years was assumed.
75 In Massachusetts, interest rates are stated in the promissory note that accompanies mortgages and are not
each mortgage based on an index of average floating mortgage rates for high risk, sub-prime\textsuperscript{76} mortgage loans for the year the mortgage was issued and a 30-year amortization.\textsuperscript{77} As shown in Table 2, this extrapolation suggests that 74 percent of these seniors might have had a payment on a subordinated deficiency balance, for either a three-year or five-year term, that was less than the payment they were likely responsible to make on the foreclosed mortgage. As these are results from assumed interest rates and with no data on the actual income of these seniors, one cannot make a determination whether a subordinated differential arrangement would have saved these specific seniors from foreclosure but it does raise the suggestion that a monthly payment on a differential amount, even in a shortened period of three to five years, might have been favorable to the cash flow of more than 70 percent of them and so allowed them to remain in their homes.

V. IS THERE AN ALTERNATIVE? A SUGGESTED MEANS TEST FOR DEFICIENCY SUBORDINATION

The Federal Reserve has published guidelines and standards for determining what percentage of a household’s income should be dedicated to a mortgage payment.\textsuperscript{78} As part of the application process in obtaining a HECM reverse mortgage, seniors are required to submit a HUD Form Application.\textsuperscript{79} Although income is not a factor in determining eligibility for a HECM reverse mortgage, the HECM application obtains this information. In short, a HECM lender has information to determine what percent of a senior’s income would need to be paid in the event of a subordinated differential mortgage and the resulting monthly payment. Just as lenders in the “forward mortgage” arena now apply standards of allowable percentages of household income towards a mortgage payment, a HECM lender could make the same determination in the event of subordination.\textsuperscript{80}

One avenue that the FHA may consider in making a rule on this issue is a standard

\textsuperscript{76} See supra n. 70, at Panel D for historic mortgage rates. Where the date of the mortgage preceded sub-prime instruments, we used the historic 30-year fixed-rate mortgage found at Freddie Mac, \textit{30-Year Fixed-Rate Mortgages Since 1971}, http://www.freddiemac.com/pmms/pmms30.htm (accessed Jan. 7, 2011).

\textsuperscript{77} A 30-year amortization was used based on the assumption that higher risk subprime borrowers would rationally seek the lowest monthly payment, and also because, where the term was stated in the mortgage, the majority was a 30-year term. We did not assume interest-only “teaser” rates since we wanted to determine the percentage of difference between a termed subordination deficiency payment and what a senior borrower would have been paying on a truly amortized first mortgage.


\textsuperscript{79} The HUD HECM Handbook 4235.1 (Rev 1), Section 4.7 A, requires the Borrower complete and submit the HUD Uniform Residential Loan Application (URLA) and HUD/VA Addendum (Form HUD 92900-A). These forms collect information on the senior’s income.

\textsuperscript{80} The HECM industry has undergone significant changes in the last year with the exit of two of the largest HECM lenders, Bank of America and Wells Fargo. Wells Fargo’s exit was specifically based on the restrictions associated with reverse mortgages that make it difficult to determine seniors’ abilities to meet the obligations for payment of property taxes and homeowners’ insurance. In short, Wells Fargo was seeking to use a senior’s income information just as this paper suggests that this information be used to determine ability to pay a subordinated deficiency. See News Release, \textit{Wells Fargo Home Mortgage Discontinues Home Equity Conversion Mortgages}, Wells Fargo (June 16, 2011), https://www.wellsfargo.com/press/2011/20110616_Mortgage.
that determines the senior borrower’s ability to repay a subordinated differential obligation to final maturity according to its terms, taking into account the borrower’s total monthly housing-related payments (including principal, interest, taxes, and insurance, commonly referred to as PITI) as a percentage of the borrower’s gross monthly income (referred to as the debt-to-income or DTI ratio). If, for example, that percentage of PITI to DTI is less than 30 percent of the payments necessary for a negotiated subordinated deficiency then subordination of a differential mortgage amount, modified to meet these standards, would be permissible.\footnote{\textsuperscript{81}}

VI. \textbf{Conclusion: Further Research Needed}

The upshot of a new rule allowing subordination in limited circumstances might mean a greater percentage of seniors being able to take advantage of the HECM program to avoid foreclosure and remain in their homes. The cost of senior homelessness is far greater than the cost of a rule change, especially within the constraint of a reasonable and prudent standard ratio of monthly payments to the senior’s household income. Further research beyond the limited study presented here would need to expand to nationwide databases and to examine the effect of junior mortgages encumbering seniors’ homes.

\footnote{\textsuperscript{81} HUD may also consider this information to determine if a senior has the ability to maintain tax and insurance payments. Currently, FHA is struggling with a number of defaults on HECM reverse mortgages emanating from the failure of seniors to keep current their taxes and homeowner’s insurance. \textit{See} Lemar Wooley, \textit{FHA Issues Guidance for Reverse Mortgage Borrowers and Lenders Dealing with Outstanding Property Tax and Insurance Debts}, U.S. Dept. of Housing and Urban Dev., Press Release No. 11-001, http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2011/HUDNo.11-001. Reverse mortgage lenders are now making a limited financial determination of a senior’s eligibility for a HECM based on their ability to pay property taxes and homeowners insurance.}
REVERSE MORTGAGES AND THE CURRENT FINANCIAL CRISIS

By Paul V. Black, Esq.

I. INTRODUCTION ................................................................. 87
II. THE ECONOMIC AND DEMOGRAPHIC CONTEXT OF REVERSE MORTGAGES .......... 87
III. HOW A REVERSE MORTGAGE TRANSACTION WORKS ........................................... 92
IV. POSSIBLE RISKS FOR BORROWERS IN REVERSE MORTGAGE TRANSACTIONS .......... 97
V. STATE APPROACHES TO REVERSE MORTGAGE REGULATION ................................. 104
VI. FEDERAL REGULATION OF REVERSE MORTGAGES ........................................... 108
VII. CONCLUSION ........................................................................... 111

I. INTRODUCTION

In the current financial crisis, many baby boomers find themselves facing their greatest challenge yet: how to fund their retirement, long-term care, and other needs with diminished investment income, endangered pensions, and often modest government benefits. Fortunately, reverse mortgages enable many aging homeowners to borrow against the equity in their home in exchange for offering the home as collateral. Yet the operation, risks, and regulation of such a loan transaction — which occur at a very vulnerable time in a borrower’s life — remain a mystery to many lawyers who advise aging clients. This article seeks to educate the Elder Law community on the most relevant features of reverse mortgages.

Section II of this article introduces the economic and demographic context of reverse mortgages, and outlines key financial challenges faced by older consumers, many of whom were “aging into debt” long before the onset of the current financial crisis. Section III explains the basic mechanics of the reverse mortgage loan transaction, outlines borrower requirements, and describes the fees, interest costs, and insurance premiums that comprise the cost of the reverse mortgage loan to the borrower. Section IV unveils some potential risks of reverse mortgages for borrowers, including predatory lending tactics, possible loss of Medicaid eligibility, the now-prohibited “bundling” reverse mortgages with deferred annuities, and the possible consequences of misunderstanding some of the most basic features of a reverse mortgage loan. Section V highlights some of the most interesting state approaches to reverse mortgage regulation. Section VI surveys current federal regulation of reverse mortgages and explores how the nascent Consumer Financial Protection Bureau (CFPB) will likely play a significant but as yet unclear role in regulating reverse mortgages.

II. THE CURRENT ECONOMIC AND DEMOGRAPHIC CONTEXT OF REVERSE MORTGAGES

Traditionally, the “three-legged stool” of retirement income for many Americans has consisted of government benefits, a defined-benefit pension plan, and personal savings. Yet, as defined-benefit pension plans (in which employers pay retirees a fixed monthly...
pension income) are being largely replaced by defined-contribution plans (in which workers contribute up to a certain maximum amount each month towards their retirement), many workers find themselves with lower pension income. When coupled with significant declines in stock prices, many retiring workers have found that one or more of these three “legs” is simply too short to provide stable income for long-term care and other needs late in life.¹

Home values have also slipped significantly in the past five years, with a staggering loss of more than $9 trillion of home equity wealth in the United States since 2006.² Even so, home equity remains one of the largest and most widespread forms of wealth for aging Americans. As a joint project of the U.S. Census and the Department of Housing and Urban Development, the most recent American Housing Survey, compiled in 2009, noted that just over 12 million Americans aged 65 and older had no mortgage debt, and that the median value of their homes was roughly $150,000.³ Further, it noted that 252,000 homeowners 62 years of age or older already had a reverse mortgage on their homes.⁴ While the number of older Americans with mortgage debt has likely increased (and the value of their homes has most often decreased) since then, home equity remains one of the few sizeable assets that most aging homeowners possess.

While a handful of private institutions were issuing reverse mortgage loans as early as the mid-1970s, the federal government’s introduction of the Home Equity Conversion Mortgage (HECM) in the late 1980s created the first nationwide reverse mortgage product.⁵ Fannie Mae’s decision to buy reverse mortgages from other (private) lenders created a large secondary market for these products, and shortly thereafter, private lenders such as Transamerica HomeFirst, Financial Freedom Senior Funding Corporation, and Household Senior Services introduced their own reverse mortgage products. Fannie Mae’s own reverse mortgage product, HomeKeeper, emerged in 1996, but was discontinued in 2008.⁶ While only 157 federally insured reverse mortgages were issued in 1997,⁷ that number

---

¹ See e.g., Mike Dorning, Early Claims Soar for Social Security Retirement Benefits, Chicago Tribune (May 27, 2009), http://articles.chicagotribune.com/2009-05-27/news/0905270147_1_older-workers-early-retirement-center-for-retirement-research. This article notes that, while record numbers of workers (often recently laid-off) are seeking Social Security benefits, they might find that applying for the benefits early (at age 62 instead of age 66) reduces the amount of benefits by as much as 25 percent.


³ U.S. Census Bureau, American Housing Survey National Tables: 2009 Using Census 2000-based Weighting, Table 3-15, http://www.census.gov/housing/ahs/data/ahs2009.html (accessed Nov.18, 2011). Appendix A-5 notes that “data for the elderly include information on all households with householders 65 years or older,” but that the Housing and Urban Development definition is broader, as it includes all households with householders 62 years of age or older, or with a disability.

⁴ Id.

⁵ Ralph J. Rohmer & Fred H. Miller, Truth in Lending, 439 (Robert A. Cook, Alvin C. Harrell, & Elizabeth Huber eds., ABA, Mar. 2000, currently out of print).


grew to 114,692 by federal fiscal year 2009, but then declined to 79,106 for federal fiscal year 2010. In 2011, several major reverse mortgage lenders — including Seattle Bank, Bank of America, Financial Freedom, and Wells Fargo — left the reverse mortgage business. Why? Declining home values are only one reason.

Recent news articles and studies of the reverse mortgage market paint a picture of a market that is increasingly populated by troubled consumers, and will likely continue to remain so, or even worsen, over the next several years. In October 2008, a report from Golden Gateway Financial summarized reverse mortgage data in dire terms: “Nationally, individuals exploring a reverse mortgage are increasingly older, with lower home values, and a greater percentage of them are saddled with an existing mortgage on their homes.”

The current financial crisis has well-documented roots in the complexity of the modern mortgage securitization process, most notably in the eagerness of Wall Street to securitize bank-offered subprime loans. But even before the subprime mortgage meltdown, American consumers were all too often “aging into debt.”

Aging Americans today have a longer life expectancy than their age peers of 20 to 30 years ago, but largely rely on fixed incomes that are often insufficient to pay for out-

---


In June 2008, the Center for Economic and Policy Research (CEPR) published a similarly sobering study exploring the impact of three possible scenarios (housing prices remaining equal to their March 2008 levels or falling 10 percent or 20 percent respectively) upon household wealth by wealth quintile. See Dean Baker & David Rosnick, The Housing Crash and the Retirement Prospects of Late Baby Boomers, Center for Economic and Policy Research (June 2008), http://www.cepr.net/index.php/publications/reports/the-housing-crash-and-the-retirement-prospects-of-late-baby-boomers/ (June 2008).

10 In particular, the current financial crisis can be largely attributed to the gradual replacement of a relatively “horizontal” mortgage lending system (in which the lender qualified the borrower, ascertained the value of the property, issued a mortgage, and collected the monthly payments) with a much more “vertical” mortgage lending system, in which government-sponsored enterprises (such as Fannie Mae and Freddie Mac) led to a liberalization and geographic disconnectedness of lending practices. In this newer mortgage lending system, a host of privately held entities — from mortgage brokers to loan servicers to credit rating agencies — quickly found that they could make handsome profits by disconnecting and then specializing in small parts of the overall lending process. While certain players in this market, such as mortgage brokers, were paid when deals were closed, and thus rewarded chiefly upon the volume of transactions they processed, other players, such as investment bankers, were rewarded based upon the growing demand for their ability to create and issue mortgage-backed securities whose rates of return were often higher than those of other, more traditional investment vehicles, such as stocks and bonds. See Charles E. Daye, Stripping Off Market Accountability: Housing Policy Perspectives on the Crises in the Financial System, 12 N.C. Banking Inst. 105 (Mar. 2009); see also Eamonn K. Moran, Wall Street Meets Main Street: Understanding the Financial Crisis, 13 N.C. Banking Inst. 5 (Mar. 2009).

of-pocket health care costs, energy bills, property taxes, essential maintenance, and other non-discretionary expenses. These consumers use credit cards as a “plastic safety net” to make such purchases.\textsuperscript{12} Between 1992 and 2001, the average credit card debt of Americans ages 65–69 rose by more than 217 percent to nearly \$6,000.\textsuperscript{13} Even more than the many younger consumers who also face mounting credit card debt, however, seniors are not likely to pay it down because so many rely upon a fixed income.\textsuperscript{14} Sadly, this mounting credit card debt has contributed to a skyrocketing rate of bankruptcy filings among elderly consumers. AARP’s Consumer Bankruptcy Project found that from 1991–2007, while the number of bankruptcy filings by those under age 54 dropped significantly (by at least 20 percent for each age range bracket), the number of filers age 55–64 rose 40 percent, the number of those ages 65–74 rose 125 percent, and the number of filings by those 75–84 rose a staggering 433 percent.\textsuperscript{15}

Unprecedented high levels of debt among aging consumers are also reflected in the increasing home equity debt of older Americans. Between 1989 and 2001, the percentage of total debt owed by homeowners 65 and older that could be attributed to mortgage debt increased from just over 50 percent to 70 percent, reflecting a trend in which more aging homeowners are still paying off their mortgage, often because they have borrowed heavily against their home equity.\textsuperscript{16} A September 2008 study by the Center for Retirement Research at Boston College found that 30 percent of homeowners ages 50–62 have already borrowed against the equity in their homes, and that these same homeowners would likely continue to be burdened with mortgage debt and likely face a decrease in their net worth as they approach retirement.\textsuperscript{17} In particular, the study noted that from 2001–2008, the decline in housing values and increased debt led the net worth of such homeowners to fall 14 percent.\textsuperscript{18} In states with significantly above-average home prices, such as California, the outlook is even more troubling. Higher home prices (and the resulting non-traditional forward mortgage products offered) mean that the forward mortgage debt of senior citizens in California is 50 percent greater than the national average.\textsuperscript{19}

Opinions on the use of reverse mortgages to prevent foreclosure have shifted over time from skepticism toward greater acceptance. A February 2006, article for the \textit{Wall

\begin{itemize}
  \item \textsuperscript{12} Loonin & Renuart, \textit{supra} n. 11, at 168.
  \item \textsuperscript{13} \textit{Id.} at 168-173.
  \item \textsuperscript{15} Christine Degas, \textit{Bankruptcy Rising Among Seniors}, USA Today (June 16, 2008), http://www.usatoday.com/money/peri/retirement/2008-06-16-bankruptcy-seniors_N.htm.
  \item \textsuperscript{16} Loonin & Renuart, \textit{supra} n. 11, at 171-172.
  \item \textsuperscript{18} Munnell & Soto, \textit{supra} n. 17, at 20.
  \item \textsuperscript{19} For an overview of California’s Mortgage Debt Relief Law (and comparisons with the related federal mortgage debt relief law), \textit{see} State of California Franchise Tax Board, \textit{Mortgage Forgiveness Debt Relief Extended}, http://www.ftb.ca.gov/aboutftb/newsroom/mortgage_debt_relief_law.shtml (updated Apr. 13, 2010).
\end{itemize}
Street Journal warned that reverse mortgages “aren’t a way to keep you out of foreclosure,” and instead recommended more traditional possible solutions such as forbearance or loan modification. Yet a December 2007, Wall Street Journal article on the same topic noted that using reverse mortgages to prevent foreclosure, is “relatively novel but gaining popularity among Legal Aid attorneys and housing advocates around the country.” The latter article cites the work of Atlanta Legal Aid Society attorney William Brennan Jr., who pioneered a process for using reverse mortgages to pay subprime lenders, which encourages lenders to take the cash proceeds from a reverse mortgage instead of foreclosing on older homeowners. The National Reverse Mortgage Lenders Association provides its members with detailed talking points on the use of reverse mortgages to prevent foreclosure. Similarly, the National Consumer Law Center encourages troubled homeowners to explore reverse mortgages as one of many possible ways of preventing foreclosure, but encourages consumers to be vigilant for possible fraud and to closely scrutinize the terms and fees of any particular loan offer. Yet many seniors who might be most in need of a reverse mortgage in these circumstances cannot qualify for such a loan, often because of insufficient equity in the home or existing loans against equity. As detailed by Robert Cannon in his article, “Keeping Grandma Off the Street” in this issue of NAELA Journal, recent Federal Housing Authority statutory, regulatory and policy requirements prohibiting subordination of existing mortgage liens in conjunction with federally insured reverse mortgages have kept many seniors from using a reverse mortgage loan to avoid foreclosure.

Interestingly, survey data from HUD and AARP indicated that in 2007 (when the housing bubble remained mostly intact), the top reason cited by homeowners interested in reverse mortgages was “to respond to emergencies,” a factor cited by 78 percent of respondents. Fifty percent cited the need for additional money to pay everyday expenses; 40 percent of respondents cited a desire to pay off their existing (forward) mortgage, and 29 percent expressed interest in using reverse mortgage proceeds to pay for property tax and insurance expenses. In light of the myriad reasons why a senior might inquire about a reverse mortgage, it is critical that Elder Law attorneys understand the mechanics of a reverse mortgage transaction.

26 Id.
III. HOW A REVERSE MORTGAGE TRANSACTION WORKS

A reverse mortgage transaction can be explained with varying degrees of complexity. A simple explanation is that a reverse mortgage is a loan to a homeowner secured by a lien on the house, much like a home equity line of credit, with the difference being that reverse mortgage applicants need not satisfy a monthly income level because the borrower does not have to make monthly payments on the loan. A reverse mortgage is, by definition, a non-recourse loan; that is, homeowners have no personal liability for repaying the loan, even if the amount borrowed by the homeowner exceeds the equity in the home. Under the terms of the federal regulation governing reverse mortgages (discussed in detail in Section VI, infra) the loan is not payable until one of several “maturity events” occurs: The borrower dies; ceases to use the home as a principal residence (usually defined as a period of absence of 12 consecutive months); sells or otherwise transfers ownership interest in the home securing the loan; or violates the terms of the loan agreement by failing to maintain the home or pay property taxes. As in the case of a traditional “forward” mortgage, the borrower retains title to the house and can thus bequeath it as desired. However, the devisee would then be responsible for paying off any outstanding loan balance at the time of the homeowner’s death.

Qualification criteria for reverse mortgages insured by the Federal Housing Authority and offered by the Department of Housing and Urban Development, which currently make up 98 percent of the reverse mortgage marketplace, and are known as Home Equity Conversion Mortgages (HECMs), are relatively straightforward. Potential borrowers need to be at least 62 years old and live in a single-family home that meets HUD’s minimum property standards (for building design, materials, durability, and other factors). Borrowers must also be homeowners rather than renters. But recent U.S. Census data indicates that nearly 80 percent of Americans aged 65 and older are currently homeowners. Any remaining home purchase mortgage payments must therefore be repaid prior
to receiving any HECM proceeds, or be paid from the initial proceeds of the HECM. Before closing, potential borrowers are also required to attend loan counseling sessions that briefly explain the financial and legal responsibilities of entering into a reverse mortgage agreement, but usually do not discuss the suitability of the product for the borrower’s needs or discuss other options that may be available.34

Borrowers can opt to receive the proceeds of their HECM in lump-sum form, as a line of credit (payable upon demand until exhausted), as monthly payments for the remainder of their natural life (“tenure”), or as a monthly payment for a term of years chosen by the borrower. In addition, a “modified tenure” option combines the monthly payments for life with the credit line option for as long as the borrower remains in the home, and a “modified term” option combines monthly payments for a term of years with the line of credit.35

HECMS have several different itemized costs, including an origination fee, third-party closing costs, a mortgage insurance premium, a servicing fee, and interest, each of which merits brief explanation. Origination fees for HECMs are paid to lenders for educating the client, analyzing a prospective borrower’s eligibility, and processing the loan application, and are currently capped at $2,500 or 2 percent of the maximum claim amount of the mortgage (MCA), whichever is greater, with an ultimate cap of $6,000.36 Third-party closing costs, including a required appraisal of the home securitizing the reverse mortgage loan, a title search and title insurance, recording fees, credit checks, mortgage taxes, and possible surveys and inspections, will vary with the value of the home and the price of such services by area, but a total of $2,300–$3,500 is common.37

Mortgage insurance premiums (MIPs) are paid to the Federal Housing Authority (FHA), which then guarantees that a borrower will receive the promised loan amounts regardless of how long the resident remains in the home, what happens to the value of the home, or a lender’s ability to make payments. Such a broad guarantee does not come cheaply to the borrower, who must pay the MIP in two parts: An “up-front” payment of 2 percent of the home’s value, and an annual 1.25 percent MIP, which is factored into the monthly interest rate charged for the loan.38 Both are payable out of the reverse mortgage loan proceeds, and are used not to make a profit for the HECM program, but rather to ensure that the borrowers who live the longest and whose home values grow the least (or

34 Ltr. from Prescott Cole, Coalition to End Elder Financial Abuse (CEASE), to Sen. Claire McCaskill, Chair, Special Senate Committee on Aging, at 3 (Dec. 12, 2007), http://aging.senate.gov/events/hr185pc.pdf.
decline) can still receive their loan amounts. While the MIP thus represents a substantial cost to the reverse mortgage borrower, it provides a degree of protection unmatched by non-HECM, non-governmentally insured loans, and helps to explain why more than 90 percent of reverse mortgage loans to date have been federally insured HECMS.

For seniors interested in a reverse mortgage but not needing to borrow as much money, one of the most exciting and cost-effective options is the new HECM Saver program, which began in October 2010. The HECM Saver program essentially eliminates the mortgage insurance premium (MIP), charging only 0.01 percent of a home’s value. Consider that the MIP on a $250,000 house under a traditional (HECM Standard) loan would be $5,000. Under the HECM Saver program, the homeowner would only pay $25 instead, a substantial savings.\(^{39}\) Yet under the HECM Saver program, a senior can, depending on age, borrow between 10 percent and 18 percent less than the FHA’s standard reverse mortgage.\(^{40}\) The primary reason for the creation of the HECM Saver program was that the pre-October 2010 MIP of 0.5 percent was under-insuring the loss of home equity that was occurring in a time of falling home prices.\(^{41}\) By raising the mortgage insurance premium on HECM Standard loans to 1.25 percent and then introducing the HECM Saver, the FHA was seeking to bolster its insurance funds “by increasing the costs of the standard product and by expanding the market with a lower risk alternative.”\(^{42}\) In short, those who need to borrow less will benefit from the HECM Saver program, but homeowners whose borrowing needs can only be met by an HECM Standard will now find themselves paying substantially more.\(^{43}\)

Servicing fees payable to lenders for administrative tasks such as sending the payment check are paid using a “service fee set-aside” (SFSA) in which the FHA-capped monthly fee amount of $30 or $35 is multiplied by the number of months until the borrower would reach age 100. Obviously, few borrowers live to turn 100, so the total set-aside amount nearly always overstates the amount of service fees paid on a loan. Significantly, the set-aside amount is deducted from the amount of available loan proceeds available to the borrower, and borrowers cannot earn interest on this amount.\(^{44}\)

The calculation of interest costs in a reverse mortgage loan is perhaps the most commonly misunderstood (and most important) cost component of a reverse mortgage. In a traditional “forward” mortgage to purchase a house, the outstanding principal balance owed by the borrower shrinks as the borrower makes payments over time. In turn, the


\(^{42}\) Fuscaldo, supra n. 40. The explanation quoted is that of Don Redroot, strategic policy advisor for AARP’s Public Policy Institute.

\(^{43}\) Id.

percentage of each monthly payment that is applied towards interest will decrease over time as the borrower makes payments and diminishes the amount of principal upon which interest is paid. In a reverse mortgage transaction, however, the stream of payments is reversed; that is, the lender is paying the borrower. Thus, the outstanding total balance owed by the borrower will not shrink, but rather grow over time. This growth of the outstanding total balance owed will occur whether a reverse mortgage borrower elects to receive a lump-sum amount up front (in which the amount of principal does not change, but interest still accrues over time) or whether the borrower elects to receive payments over time, either as monthly payments or as a line of credit (in which cases both the amount of loan principal and the amount of interest payable would increase over time.) While nearly all HECM lenders charge adjustable interest rates, the rate is tied to the current one-year Treasury Security rate, and cannot be increased more than 2 percent per year or 5 percent over the life of the loan. Alternately, an HECM lender can charge a lower rate adjustable every month, similarly tied to the one-year Treasury rate, and limited to a 10 percent cap on the life of the loan. Yet regardless of the interest rate, reverse mortgages will always be “rising debt” loans.45

Historically, the up-front costs of acquiring an HECM Standard (the origination fee, third-party closing costs, initial MIP) and the ongoing costs (the monthly MIP premium, servicing fee, and interest) could add up to 6-10 percent of the value of the home securing the loan. Yet even before HECM introduced the HECM Saver, many HECM lenders have been willing to waive their loan origination fees and servicing fees, so that borrowers can tap into more equity and keep initial loan costs considerably lower.46 In October 2010, journalist Tara Siegel Bernard of the New York Times provided a helpful side-by-side comparison of how a hypothetical borrower (65 years old, and seeking a lump sum rather than a line of credit or other option) would fare under the current HECM Standard versus HECM Saver programs:

If a 65-year-old borrower with a home valued at $400,000 were to apply for a standard reverse mortgage with a fixed rate of 5.06 percent, he would be eligible for about $255,000. But he would also owe an upfront mortgage premium of $8,000, and roughly $3,600 in other closing costs, which means he would ultimately receive a lump sum of about $243,000, according to ReverseVision, a reverse mortgage software company.

This assumes that the lender waived the origination fee and a servicing fee (lenders can charge an origination fee of 2 percent of the first $200,000 of your home’s value, plus an additional 1 percent for amounts over that, though the total is limited to $6,000). The continuing mortgage premium and interest would be tacked onto the loan balance each month.

If the same homeowner applied for a Saver reverse mortgage, he would be eligible to receive $212,800. But after deducting a $40 up-front mortgage premium, and $3,600 in closing costs, he would get about $209,000.  

Significantly, while Ms. Bernard cautions that her calculations for HECM Saver loans exclude any servicing or origination fees, she notes that it is “unclear if lenders will waive them as they have with the standard reverse mortgages.”

While the variety and depth of associated costs means that traditional reverse mortgages are not always cheap to obtain, it is important to recall that, before the widespread availability of reverse mortgages, aging homeowners in the United States had essentially only two options to remedy a shortfall in savings needed to pay for costs incurred later in life. The first, long-term care insurance, was a cost-effective option for younger persons, but too costly for many seniors to purchase because the monthly premiums would be prohibitively expensive.  

While NAELA currently encourages younger, healthier individuals to obtain long-term care insurance, it specifically recommends against using reverse mortgage proceeds to do so, noting that there is a mismatch between the ideal age for purchasing long-term care insurance and that required for reverse mortgage eligibility, and that “paying for this prohibitively expensive [long-term care] insurance through a reverse mortgage is like using credit cards to pay off a home loan,” because the senior is “paying for an expensive product with an expensive loan.”  

The second traditional option that predates reverse mortgages is for the homeowners to sell their home to pay for nursing home expenses. This option is one, which many seniors have found to be emotionally draining, socially uprooting, and altogether less attractive than “aging in place” by remaining in their homes.

What about homeowners whose home value exceeds the federal government’s nationwide reverse mortgage loan limit, which remains at $625,500. Before the financial crisis, many companies offered proprietary products often called “jumbo” reverse mortgages to serve these homeowners. Until its demise in 2008, Lehman Brothers was the largest issuer of securities based on “bundles” of thousands of such private reverse mortgages. Yet by 2010, non-HECM proprietary products made up less than 2 percent


48 Id.


50 Id.

51 A July 2008 AARP Public Policy Institute report noted that 87 percent of Americans age 50 or older want to receive long-term care in their own homes. AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, In Brief 161 (July 2008), http://assets.aarp.org/rgcenter/il/inb161_ltc.pdf.

of the reverse mortgage marketplace.\textsuperscript{53} Faced with reduced home values, concerns about the solvency of private banks, and a limited secondary market for reverse mortgages because few Wall Street firms are currently willing to purchase such “bundles” of reverse mortgages, very few private lenders now offer such “jumbo” reverse mortgages for homeowners.\textsuperscript{54}

So what makes reverse mortgages an attractive product in spite of their high cost? First, there are no restrictions on how homeowners can spend their reverse mortgage proceeds, enabling reverse mortgage holders to pay for health care items not covered by Medicare and Medicaid, such as eyeglasses, dentures, additional in-home care, or essential overhead expenses such as home repairs, utility bills, and homeowner’s insurance. Some homeowners even use the proceeds of their reverse mortgage to pay off their current “forward mortgage,” leaving them the remainder as spendable income. Second, there is no tax upon the proceeds because the borrowers are (at least initially) “borrowing” against their home equity. Similarly, unless homeowners choose to receive their reverse mortgage proceeds as a lump-sum advance, there is no effect on their Social Security or Medicare benefits.\textsuperscript{55}

An August 2005 article in \textit{Eye on Elder Issues} (a NAELA electronic newsletter discontinued in June 2008) noted that many “aggressive planners” argue that reverse mortgages should be mandatory for many aging homeowners.\textsuperscript{56} Yet NAELA responded that “this policy would not be in the best interest of older persons or of society as a whole,” and that “home equity should be considered a supplement to Social Security, Medicare, and Medicaid — not a replacement.”\textsuperscript{57} Requiring homeowners to use reverse mortgages to pay premiums for long-term care insurance would likely preclude many seniors on tight budgets from maintaining their home and paying insurance as required by the reverse mortgage loan agreement, which potentially leads the senior borrowers to violate their loan agreement and lose their homes as a result.\textsuperscript{58}

\section*{IV. Possible Risks for Borrowers in Reverse Mortgage Transactions}

While there are very detailed analyses of lender-side risks that might be of interest


\textsuperscript{54} At present, major players in the “jumbo” reverse mortgage market include Generation Mortgage (based in Atlanta) and RBC (Royal Bank of Canada). Readers should recall that privately offered products such as these “jumbo” reverse mortgage loans are, by definition, not federally insured HECMs, and will have their own methods of calculating costs and fees. Regarding the HECM loan limit, The American Recovery and Reinvestment Act of 2009 (signed into law by President Obama on Feb. 17, 2009) approved the loan limit increase of $625,500, and HUD Mortgagee Letter 2009-07 (issued Feb. 24, 2009) initially made this loan limit increase effective until Dec. 31, 2009, thus enabling many seniors with higher-priced homes but reduced retirement savings to tap into more of their home equity.

\textsuperscript{55} Alsip, \textit{Texas’ New and Improved Reverse Mortgage}, supra n. 38, at 1077. Alsip noted that homeowners choosing a lump-sum advance should nevertheless seek counseling to confirm their continued uninterrupted eligibility for Medicaid benefits if retaining the lump-sum advance as a liquid asset.

\textsuperscript{56} Natl. Acad. of Elder Law Attys., \textit{Reverse mortgages can help pay for senior health care}, supra n. 49.

\textsuperscript{57} Id.

\textsuperscript{58} Id.
to those representing lenders,59 the likelihood that Elder Law practitioners will have clients who have or are considering a reverse mortgage makes borrower-side risk an area of more common concern. For the borrower, the risks of a reverse mortgage are not usually a function of the reverse mortgage product, itself. Rather, they are related to the deceptive, abusive, and often-illegal practices of a small number of reverse mortgage lenders. While deceptive lending practices are continually met with industry, consumer, and regulatory efforts to root them out, a review of some of the most troublesome past practices, and the response on all of these fronts, remains instructive.

In its December 2007 hearings on reported financial abuses in the reverse mortgage industry, the United States Senate Special Committee on Aging received written statements and heard testimony from numerous victims of financial abuse and from concerned Elder Law attorneys who highlighted several areas of particular concern.60 Especially troubling to several participants at the hearing was the lack of certification, background checks, or sufficient training required of reverse mortgage loan counselors, the very individuals who are often in the best position to protect the borrower against unscrupulous lending practices, questionable financial decision-making, or both. For the first two decades of the HECM program (1987-2007), HECM counseling was often limited to a phone interview confirming that the potential borrowers understood the terms of the loan transaction. There was no face-to-face meeting to ensure that the reverse mortgage product being considered was suitable for the needs and financial circumstances of the borrower.61 In her testimony before the Senate Special Committee, Margaret Burns, who served as director of Single Family Programs at the FHA under George W. Bush, noted that funding for reverse mortgage loan counseling consisted of only $3 million per year spread over more than 100,000 transactions, and was “severely inadequate.”62 Critics of the old counseling process, such as AARP Strategic Policy Advisor Donald Redfoot, in-


61 Ltr. from Cole to McCaskill, *supra* n. 34. Cole, Senior Staff Attorney for California Advocates for Nursing Home Reform, recommended on behalf of the Coalition to End Elder Financial Abuse that “[j]ust as it has been determined to be good public policy to have a suitability requirement for financial investors,” the current counseling system should be “expanded to include a suitability component whereby the counselor asks the senior a series of questions to learn why they are taking the loan.” In particular, Cole recommended that “[c]ounselors should be able to suggest alternatives to reverse mortgages, and to inquire as to what the senior intends to do with the funds. The suitability criteria should contain a set of inquiries whose responses would lead the counselor to disapprove a loan where appropriate.” This view ultimately reflecting Cole’s belief that “reverse mortgages…should only be used as a last resort.” See also U.S. Senate Special Comm. on Aging, *Reverse Mortgages, supra* n. 60. In a more limited recommendation, Donald Redroot, Strategic Policy Advisor for AARP’s Public Policy Institute, recommended as his final written recommendation that “state and federal agencies should develop new cost disclosures and suitability standards for reverse mortgages that are used to purchase investments, annuities, and long-term care insurance.” Redroot’s recommendations may be more limited because AARP has played an early and significant role in providing training for HECM reverse mortgage counselors.

62 U.S. Senate Special Comm. on Aging, *Reverse Mortgages,* *supra* n. 60, Statement of Margaret Burns, Director, FHA Single Family Program Dev., U.S. Dept. of Housing and Urban Development.
sisted that “counselors should serve as an independent source of unbiased information for consumers and should not have conflicts of interest.”

In response to these criticisms and the concerns of other elder advocates and consumers, HUD issued numerous Mortgagee Letters to clarify reverse mortgage counseling procedures. On May 6, 2008, Mortgagee Letter 2008-12 established new fee guidelines for reverse mortgage counseling, most notably that 1) counseling agencies must inform clients of the fee structure (capped at $125) in advance of providing services; 2) a client must not be turned away because of an inability to pay; and 3) the counseling agency may not withhold counseling or the Certificate of HECM Counseling (required to obtain a reverse mortgage loan) based on a client’s failure to pay. In contrast to the old practice of allowing non-HUD approved reverse mortgage brokers to participate in the HECM program, Mortgagee Letter 2008-24, issued on September 16, 2008, prohibits non-HUD approved lenders from originating HECM products. On March 27, 2009, HUD issued Mortgagee Letter 2009-10, which mandated significant changes to the reverse mortgage counseling process. Not only must the borrower, not the lender, now initiate the contact to the counseling agency to help ensure that counseling is “provided by an independent third party that is neither directly nor indirectly associated with the mortgage transaction,” but reverse mortgage lenders must also now “provide every client with a list of no fewer than 10 HUD-approved counseling agencies that can provide HECM counseling, five of which must be in the local area and/or state of the prospective HECM borrower, with at least one agency located within reasonable driving distance for the purpose of face-to-face counseling.” Further, reverse mortgage counselors are now required to review a client’s unique financial situation during a counseling session, and provide budgetary analysis based on the client-provided income, assets, debts, and monthly expenses. More recently, other HUD Mortgagee Letters have clarified that only individuals on a HUD-approved roster could counsel potential reverse mortgage borrowers. Such new

63 U.S. Senate Special Comm. on Aging, Reverse Mortgages, supra n. 60, Statement of Donald Redroot, PhD, Strategic Policy Advisor, AARP Public Policy Institute.


67 Id.

68 Id.

69 Ltr. from David H. Stevens, Asst. Sec. for Housing-Fed. Housing Commnr., U.S. Dept. of Housing and Urban Dev., Mortgagee Letter 2009-10 (Nov. 6, 2009), http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_14700.pdf. ML 2009-47 clarifies further requirements that reverse mortgage counselors must meet, and enables HUD to remove a counselor from the HUD-approved roster for numerous reasons, including failure to comply with training requirements or failure to “provide information to clients on options other than HECMs, the financial implications of an HECM, the tax consequences of an HECM, and any other information required by HUD or requested by the applicant.” Significantly, 2009-47 also provides that “[c]ounselors may also be removed from the Roster for providing misrepresentations or fraudulent statements; for promoting, representing, or recommending any specific lender;
requirements, if properly enforced, will go a long way towards ensuring that a potential reverse mortgage borrower is well-advised.

Even so, borrowers who have completed the loan counseling and begun receiving the proceeds can still lose their Medicaid eligibility if they retain the loan proceeds (often from a lump-sum loan) as an asset in a bank or other account rather than spend them in the month of receipt.\textsuperscript{70} In a written statement to the Senate Special Committee on Aging, seasoned California Elder Law attorney Prescott Cole noted that the enactment of the Deficit Reduction Act of 2005 (DRA’05) not only limits the amount of equity that a prospective Medicaid recipient can have in his home and still qualify, but DRA’05 also expressly encourages seniors to eliminate their excess home equity by taking out a reverse mortgage.\textsuperscript{71} To Cole, such language is “a form of unwarranted commercial endorsement” of reverse mortgages that is both “unprecedented” and possibly even misleading, given that “most seniors won’t be staying in nursing homes long enough to exhaust their equity and therefore will never qualify for long-term Medicaid.”\textsuperscript{72} Cole further warned that the DRA’05 endorsement of reverse mortgages is often cited by unscrupulous lenders to promote products that not only fail to meet the borrower’s needs, but even result in a deliberate theft of the borrower’s home equity.

One possible home equity theft scenario involves unmarried seniors (usually women, whether single or widowed) who may be bound for a nursing home in the near future. The equity that a reverse mortgage removes from the home simply converts to assets that

\textit{or for any other reason HUD determines serious enough to justify an administrative action.”} (emphasis added) \textit{See also Ltr. from David H. Stevens, Asst. Sec. for Housing-Fed. Housing Commr., U.S. Dept. of Housing and Urban Dev., Mortgagee Letter 2010-37 (Nov. 8, 2010), http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_14696.pdf. The requirement that lenders provide potential borrowers with a list of approved counseling agencies was further clarified in ML 2010-37.}

\textsuperscript{70} While Medicare is able to provide for lifetime maximum 180 days of consecutive hospitalization or skilled nursing care, it generally does not pay for “custodial care,” such as that provided by nursing homes, but rather only for medically necessary skilled nursing facility or home health care. In contrast, Medicaid provides a long-term care benefit, but in many states, a recipient must “spend down” nearly all other liquid assets until their assets are less than a state-determined standard of eligibility, which is currently 133 percent of Temporary Assistance to Needy Families. At present, an individual in the lower 48 states must have an income less than $1,207 to qualify. \textit{See} 2010 Poverty Guidelines, https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf (accessed Nov. 18, 2011). In contrast, in income cap states, “medically needy” eligibility requires that an individual income not exceed 300 percent of the Supplemental Security Income (SSI) monthly benefit for a single person. While there was no increase in the Consumer Price Index from the third quarter of 2008 to the end of 2011, there is a 3.6 percent cost of living adjustment (COLA) in SSI for 2012, such that a qualifying individual would receive $698 and a or $1,048 for a qualifying individual with a spouse) in 2012, \textit{See also} SSI Federal Payment Amounts in 2012, http://www.ssa.gov/oact/cola/SSI.html (accessed November 18, 2011). As such, in 2012, individuals in income-cap states seeking medically needy eligibility for Medicaid must make less than $2,094 per month.

\textsuperscript{71} Ltr. from Cole to McCaskill, \textit{supra} n. 34, at 3.

\textsuperscript{72} \textit{Id.} Citing California’s Office of Statewide Health Planning and Development, Cole notes that “within 90 days after admission, 70 percent of seniors who go into nursing homes will be discharged either because they go home, are sent to an assisted living facility, or die.” Cole further states his belief that “[b]ecause reverse mortgages are generally unsuitable for long-term care estate planning, the federal government should not be recommending them.”
would be used to pay for the senior’s nursing home expenses. Whether those assets are received as a lump sum or as a line of credit, if those assets are retained in a bank account instead of being spent in the month of their receipt, the reverse mortgage proceeds would exceed the Medicaid asset limit ($2,000 in liquid assets for an individual or $3,000 for a couple) and thus trigger a spend-down requirement.  

Second, should a borrower remain in a skilled nursing facility for 12 months, the reverse mortgage loan, itself, will be due, possibly forcing a single borrower (with no “community” spouse living in the house) to have to sell the house to pay off the lender. Third, the senior will receive the “residue equity” left over after the house is sold and the reverse mortgage lender is paid. This equity now becomes part of the senior’s liquid assets. It can easily exceed Medicaid asset limits, again triggering a spend-down requirement, which leads Cole to argue that “the senior would have been better off financially if she had never taken a reverse mortgage.”

Equally disastrous for some past borrowers was the improper “bundling” of reverse mortgages with other financial products, such as deferred annuities, which tied up the proceeds of the reverse mortgage for several years before a borrower could access them without paying a significant penalty. Here, Cole noted that the lender’s fees and insurance requirements result in a total cost of approximately 6 percent for a reverse mortgage (which, for many borrowers, would be a rather conservative estimate of the overall cost). In the early 2000s (and even more so in today’s era of historically low interest rates), Cole noted it was “impossible for a deferred annuity to generate interest that would offset the true costs of the reverse mortgage.”

In 2007, one member of the Senate Special Committee on Aging, Claire McCaskill (D-MO), proposed the Reverse Mortgage Proceeds Protection Act (S. 2490) that would prohibit reverse mortgage lenders from requiring seniors to purchase an annuity with the proceeds of the reverse mortgage. The bill became law as part of the Housing and Economic Recovery Act (HERA) and the Foreclosure Prevention Act of 2008. Further, a handful of lawsuits filed in 2006 and 2007 against the nation’s then-largest reverse mortgage lender, Financial Freedom Senior Funding Corporation, sought remedies for the disastrous results of reverse mortgage/annuity combination sales.

---

74 Most reverse mortgages include an “acceleration clause” under which the loan becomes due if the borrower ceases to use the collateralized house as a primary residence for 12 months or longer.
75 Ltr. from Cole to McCaskill, supra n. 34, at 3. To its credit, the National Reverse Mortgage Lenders Association does point out on its Question & Answer page that any liquid assets in excess of these amounts will still leave a borrower ineligible for Medicaid. See NRMLA, About Reverse Mortgages, supra n. 44.
76 Ltr. from Cole to McCaskill, supra n. 34, at 3. Cole provides an example that shows the dangers of using a reverse mortgage to purchase a deferred annuity. A senior taking out a reverse mortgage to finance a $100,000 ten-year deferred annuity, for example, would, after ten years, owe $183,000 on the $100,000 reverse mortgage loan, and, along with additional fees, will have spent about $200,000 to buy a $100,000 deferred annuity.
77 Id.
A much more common danger in reverse mortgage transactions is that non-disclosure and/or misunderstanding of certain key loan terms will result in unwanted surprises for the borrower. Nearly all reverse mortgage products contain an acceleration clause that speeds up repayment in the event that the borrower is absent from the home for specified periods (often 12 months) due to illness, or if liens are put on the home without the lender’s permission (as first lien-holder), or even if property is transferred out of the borrower’s name.\(^8^0\)

Significant issues arise when one spouse in a reverse mortgage loan is 62 or older (and thus old enough to qualify for an HECM loan), but the other spouse is not yet 62. The first concerns the non-recourse nature of HECM loans. Must a surviving spouse who was not 62 at the time the HECM loan was executed (and thus not a borrower) pay the full mortgage balance owed to keep the home when that balance exceeds the value of the house, itself? For the first two decades of HECM lending, the answer was “no.” As originally promulgated in 1994, The HUD Handbook on Home Equity Conversion Mortgages provides that:

“The HECM is a “non-recourse loan.” This means that the HECM borrower (or his or her estate) will never owe more than the loan balance or value of the property, whichever is less; and no assets other than the home must be used to repay the debt.”\(^8^1\) (emphasis added)

Yet HUD abruptly reversed this “whichever is less” approach in December 2008, when it promulgated Mortgagee Letter 2008-38, which stated that an heir, including a surviving spouse who was not named on the mortgage, must pay the full HECM loan balance to keep the home, even when the balance exceeds the value of the property (emphasis added).\(^8^2\) In response to this significant policy change, in March 2011, AARP filed suit against HUD in the U.S. District Court for the District of Columbia. The suit was filed on behalf of three non-borrowing spouses who were unable to pay the full loan when their borrower-spouses passed away, and who were thus facing foreclosure.\(^8^3\) AARP’s suit

---


82 Ltr. from Brian D. Montgomery, Asst. Sec. for Housing-Fed. Housing Commnr., U.S. Dept. of Housing and Urban Dev., Mortgagee Letter 2008-38 (Dec. 5, 2008), http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_20411.doc (accessed Nov. 11, 2011). This letter sought to clarify the “non-recourse” nature of HECM Loans. ML 2008-38 states: “Some program participants mistakenly infer ... that a borrower (or the borrower’s estate) could pay off the loan balance of a HECM for the lesser of the mortgage balance or the appraised value of the property while retaining ownership of the home. This is not correct ... Non-recourse means simply that if the borrower (or estate) does not pay the balance when due, the mortgagee’s remedy is limited to foreclosure and the borrower will not be personally liable for any deficiency resulting from the foreclosure.”

asserts that these three spouses were a small number of a much larger class of surviving non-borrower spouses who faced HECM foreclosure actions. In April 2011, in what HUD dubiously claims was not a response to the AARP lawsuit, HUD issued Mortgagee Letter 2011-16,84 which rescinded Mortgagee Letter 2008-38, and ostensibly returned to the “whichever is less” rule from the 1994 HECM Handbook.

AARP’s lawsuit against HUD also raised a second and closely related question: Can a non-borrowing surviving spouse (who did not hold title with the borrower on the forward mortgage as joint tenants with rights of survivorship) be considered a “homeowner” for purposes of the HECM loan? This question arises from the varying interpretations of “homeowner” in an HECM statute addressing the displacement of homeowners:

“The Secretary may not insure a home equity conversion mortgage under this section unless such mortgage provides that the homeowner’s obligation to satisfy the loan obligation is deferred until the homeowner’s death, the sale of the home, or the occurrence of other events specified in regulations of the Secretary. For purposes of this subsection, the term “homeowner” includes the spouse of a homeowner.”85

On its face, this statute presents no ambiguity. Both spouses can be homeowners. But a significant latent ambiguity arises because the statute does not address whether a non-borrowing spouse can be considered a homeowner and thus receive the enumerated protections. Had the District Court for the District of Columbia sided with AARP and decided that a non-borrower surviving spouse was in fact a homeowner, then non-borrower surviving spouses who faced foreclosure could receive the protections afforded by the statute. This did not happen. Instead, in July 2011, AARP’s lawsuit against HUD on behalf of three surviving spouses facing foreclosure was dismissed without prejudice for lack of standing.86 The court stated that the relief sought by the plaintiffs would not redress their injuries because HECM lenders, not HUD, were the parties exercising contractual foreclosure rights against non-borrower surviving spouses.

Some reverse mortgages also include possible penalties if the borrower decreases or discontinues the number or amount of payments, thus discouraging a borrower for borrowing less money, borrowing less often, or both. Many reverse mortgage loan agreements also contain shared appreciation clauses that give the lender the right to divide with the homeowner or devisee any proceeds from the sale of the home that are attributable to an increase in property value during the life of the loan.87 Yet as acknowledged in an article in Reverse Mortgage Daily, a widely read online news source for the reverse mortgage lending industry, false or misleading advertising claims promulgated by unethical

and/or uninformed lenders generate increased scrutiny from consumer groups, Congress, and governmental agencies (such as the GAO), and thus merit an industry-wide avoidance of certain claims or language identified as misleading.88

V. STATE APPROACHES TO REVERSE MORTGAGE REGULATION

As the use of reverse mortgages grew in the decade before the current financial crisis, state legislatures, especially those in high-population states such as California, became increasingly responsive to consumer complaints and concerns about unscrupulous lending practices in the reverse mortgage market. Reverse mortgage lending has slowed over the past two to three years. Yet demands upon state legislatures to address consumer’s concerns about disclosure requirements or unscrupulous reverse mortgage sales or lending practices will remain.89 The decline of traditional and subprime mortgage lending in the current financial crisis means that some traditional forward mortgage loan officers may seek to transition to reverse mortgage lending, yet may initially lack detailed knowledge about reverse mortgage transactions and the laws that govern them.90 Nearly all reverse mortgage lenders will be serving seniors whose retirement savings have been substantially reduced due to market downturns. Over the past two decades, states have taken a number of different approaches to the regulation of their respective reverse mortgage marketplaces.

In response to concerns about loss of valuable federal public benefits, such as Med-
icaid, Supplemental Security Income, and Nutritional Assistance (food stamps), many state legislatures have chosen to exclude reverse mortgage loan proceeds from the income and assets that would otherwise be considered in determining an individual’s Medicaid eligibility.\(^9^1\) Preserving federal benefits for the seniors who receive them is good policy not only for the seniors, but also for the states, themselves. After all, seniors who lost eligibility for such federal benefits would then presumably turn to state government programs to try to meet their needs.

State legislatures have a unique opportunity to regulate reverse mortgage counseling for non-HECM loans, which make up only 2 percent of the current reverse mortgage market. Such loans are, by definition, not governed by federal HECM counseling requirements. Some states require that potential reverse mortgage borrowers complete counseling; other states only require that the potential borrower be informed that such counseling is available.\(^9^2\) Perhaps wary that counseling alone may be insufficient, at least two states have sought to grant rescission power to reverse mortgage purchasers. A 2009 legislative measure in Minnesota, SF 489, would have allowed borrowers to rescind a reverse mortgage agreement within 30 days of signing it, but was vetoed by the governor in spite of ardent support from the state’s attorney general.\(^9^3\) In 2009, however, the Washington state legislature granted purchasers of non-HECM (proprietary) reverse mortgages in its state the same rescission rights as those enjoyed by HECM purchasers under federal law.\(^9^4\)

\(^9^1\) As an example, the following language occurs in both Colorado law (C.R.S.A. § 11-38-110, initially passed in 1992) and California law (Cal.Civ.Code § 1923.9, initially passed in 1997):

\(\text{(a) To the extent that implementation of this section does not conflict with federal law resulting in the loss of federal funding, reverse mortgage loan payments made to a borrower shall be treated as proceeds from a loan and not as income for the purpose of determining eligibility and benefits under means-tested programs of aid to individuals. (b) Undisbursed reverse mortgage funds shall be treated as equity in the borrower’s home and not as proceeds from a loan [here California adds: resources, or assets] for the purpose of determining eligibility and benefits under means-tested programs of aid to individuals.}

For even earlier examples, see Massachusetts M.G.L.A. 19A § 36: (originally passed in 1989); South Carolina § 29-4-50 (originally passed in 1984); Minnesota M.S.A. § 256.99 (originally passed in 1979). These last two laws were before HECMs were available, but presumably in response to seniors obtaining reverse mortgage loans from state or private lenders.

\(^9^2\) See e.g., Hawaii’s reverse mortgage counseling requirements at HRS § 506-10: “Prior to accepting an application for a reverse mortgage loan, a lender shall refer every borrower to counseling from an organization that is a housing counseling agency approved by the United States Department of Housing and Urban Development, and shall receive certification from the counselor that the borrower has received counseling.” Contrast this approach with that of Colorado at C.R.S.A. § 11-38-11, which allows a prospective borrower to waive the counseling: “No reverse mortgage shall be made by a lender unless the loan applicant attests, in writing, that the applicant has been advised by the lender to obtain independent counseling regarding the advisability of such applicant’s entering into a reverse mortgage transaction and that such applicant has either obtained such counseling or waived such counseling in writing”; or with Indiana’s approach at IC 24-4.4-2-503, which simply requires that a potential borrower be presented with brochure about the availability of HUD-certified housing counselors. See also North Carolina N.C.G.S.A. § 53-269 (state-supervised training requirements for all reverse mortgage counselors).


\(^9^4\) See Washington State’s RCW 31.04.520: “The borrower in a proprietary reverse mortgage transaction has the same right to rescind the transaction as provided in the truth in lending act, Regulation Z, 12
Matching the level of protection afforded by federal law to purchasers of HECMs and applying it to proprietary reverse mortgages was a safe bet.

In contrast, a smaller group of states has even entered the reverse mortgage market as participants, or at least has the statutory authority in place to do so. Connecticut has long provided its own state-funded reverse mortgage program, the Reverse Annuity Mortgage (RAM) program, which offers a reverse mortgage income stream to seniors 70 or older over a term of either five or 10 years. Borrowers must have annual incomes of $81,000 or less, and can receive a loan of up to 70 percent of the appraised value of their homes, as long as the loan amount does not exceed $417,000.\(^{95}\) Both of these approaches (state-provided reverse mortgages versus significant rescission power in the hands of consumers) have their appeal. Not every state is able to offer its own state-funded reverse mortgage program, and few have contemplated the rescission powers that Minnesota considered and Washington granted to reverse mortgage borrowers.

Yet significant preemption issues arise whenever state laws directly or impliedly conflict with existing federal law, or touch upon fields in which there is already comprehensive federal law in place.\(^ {96}\) In a much criticized ruling by the Office of the Comptroller of the Currency in January 2004, laws passed by numerous states to address an “epidemic” of predatory lending were rendered largely ineffective because many of their requirements ran afoul of the National Banking Act, which was originally passed in 1864.\(^ {97}\) Even so, as evinced by California’s 2006 passage of reverse mortgage law Chapter 202, and the many other state statutes requiring more detailed reverse mortgage counseling, state legislatures continue to pass laws to combat abusive lending practices in their respective

\(^{95}\) Connecticut Housing Finance Authority, Reverse Annuity Mortgage Program, http://www.ctreversemortgage.com/email_process.html (accessed Nov. 12, 2011). Other states have similar but often unused statutory authority: See OCGA 50-26-17(b): “The [Georgia Financing & Housing] Authority may issue bonds for reverse equity mortgages to enable the elderly to maintain a decent and appropriate residence while providing necessary cash for living expenses”; see also Illinois 20 § 3805/7.27 § 7.27: “The [Illinois Housing Development] Authority may offer non-recourse reverse mortgage loans to qualified borrowers…”; see also Indiana 28-15-11-9: “The authority may develop a model reverse annuity mortgage conforming to the requirements of this chapter, and may offer reverse annuity mortgages to qualified participants.”; see also Iowa I.C.A. § 16.53 (language identical to Indiana); Maine’s Elderly Homeowner Home Equity Loan Guarantee Fund at 30-A M.R.S.A. § 4942; Montana 90-6-504; New Jersey 46:10B-18.

\(^{96}\) For an impressive but disturbing overview of how one law, the Home Owners’ Loan Act of 1933 (which refinanced home loans and thus prevented foreclosure for more than 1 million homeowners during the Great Depression), has been used to pre-empt and thus nullify significant portions of state-promulgated laws on mortgage lending and even usury in states such as California, Georgia, and New York, see C.F. Muckenfuss III & Robert C. Eager, Preemption Under the Home Owners Loan Act, Gibson, Dunn & Crutcher, LLP, http://www.gibsondunn.com/fstore/documents/pubs/Home_Owners_Loan_Act_Preemp.pdf (accessed Nov. 12, 2011).

\(^{97}\) For perhaps the most comprehensive critique of this OCC ruling, see Nicholas Bagley, The Unwarranted Regulatory Preemption of Predatory Lending Laws, 79 N.Y.U. L. Rev. 2274 (Dec. 2004), which argues that courts should not categorically defer to agency decisions to preempt state laws, and that “[b]ecause the predatory lending laws only minimally affect national bank lending powers, do not impose costs on the national banking system, and do not generate spillover effects, they do not interfere with national banks in a way that can justify the OCC’s wholesale preemption.”
reverse mortgage marketplaces. In doing so, states continue to challenge the notion that federal law provides a ceiling for consumer protections in the lending marketplace.

Some scholars have focused upon the need to curb pre-emption of those federal lending regulations that are already in place to protect consumers. Deanne Loonin of the National Consumer Law Center and Elizabeth Renuart of Albany Law School have argued that “there should be no federal preemption of any aspect of a credit relationship without equivalent, meaningful, and enforceable regulation of that aspect at the federal level,” and that, “at a minimum, laws of general application; banking and lending laws enacted pursuant to federal statutory law; and anti-predatory lending laws” should remain in force.

More realistically, and in direct response to recent funding cuts to legal aid programs, Loonin and Renuart recommend expanding legal representation to older consumers through existing legal aid and pro bono programs, and note that while “consumer and debt problems are among the most commonly reported by elders …. many legal services and pro bono programs have not yet made consumer law a priority service area.” Even absent more specific state statutes to protect them, seniors who believe they are victims of predatory lending can still pursue traditional common law causes of action, such as breach of fiduciary duty, fraud, and deceit.

98 For an overview of the 2006 passage of California reverse mortgage law Chapter 202, see Leslie Ramos, Chapter 202: California Provides Further Protection For Seniors Contemplating Reverse Mortgage Loans, 38 McGeorge L. Rev. 45 (2007). The Assembly Committee on Banking & Finance, Committee Analysis of SB 1609, at 5 (June 26, 2006) notes that the law was created not “to stifle or hinder reverse mortgages,” but to combat abuse and ensure that seniors have all the relevant information needed before entering into such a complicated and possibly life-changing transaction.” Even with such laws on their side, however, consumers may encounter a statute of limitations problem, as when one plaintiff’s claims against a reverse mortgage lender were barred by the statute of limitations, “because the claims arise out of the terms of the RM agreement and Providential’s full disclosure of those terms at the formation of the agreement made discovery of any injury possible with the exercise of reasonable diligence.” In footnote 32, Ramos also provides a list of state statutes requiring reverse mortgage counseling: Haw. Rev. Stat. § 506-10 (Supp. 2005); Mass. Gen. Laws Ann. chi. 167E, § 2 (West 1999 & Supp. 2006); Minn. Stat. Ann. § 47.58, subd. 8 (West 2002); N.C. Gen. Stat. § 53-269 (West 2003); see also Haw. Rev. Stat. § 480-2 (1993 & Supp. 2005) (making a violation unlawful and subject to civil penalties). For an overview of numerous pre-financial crisis state responses to both perceived and real reverse mortgage lending abuses, see Kelly Burke, Elderly risk losing homes in reverse mortgage trap, Sydney Morning Herald (Feb. 28, 2007), http://www.smh.com.au/news/national/elderly-risk-losing-homes-in-reverse-mortgage-trap/2007/02/27/1172338624566.html.

99 Loonin & Renuart, supra n. 11.

100 Id. at 194.

101 There are effective ways of preventing financial fraud against the elderly that, while more limited in scope, also have the benefit of not requiring such a comprehensive legislative approach. Scholar Nathaniel Nichols has noted that notaries can play a significant role in preventing fraudulent transactions, but observes that only three states — Florida, Georgia, and Washington — currently have notary statutes whose provisions suggest that notaries assess the competency of the signer prior to notarizing a document. See Nathaniel C. Nichols, Home Alone: Home Mortgage Foreclosure Rescue Scams and the Theft of Equity, 11 J. Afford. Hous. & Community Dev. L. 280, 291 (Spring 2002). In particular, Nichols recommends the use of the mini-mental status examination (MMSE), which is widely used by physicians to assess the cognitive capacity of geriatric patients. In response, many seniors might appreciate the role of notaries in trying to protect them from signing documents when they are not in a condition to exercise their best judgment, but also express doubts about the propriety and qualification of a notary to assess
VI. FEDERAL REGULATION OF REVERSE MORTGAGES

Outside of legal and financial regulatory circles, few people have probably heard of either Regulation Z, which implements the Truth in Lending Act (TILA), or of the Home Ownership and Equity Protection Act (HOEPA). Yet any borrower or lender in nearly any credit transaction has been subject to the protections or requirements of TILA, and any reverse mortgage borrower is afforded important protections by HOEPA. For anyone advising current or potential reverse mortgage borrowers, a basic understanding of these and other regulations, as well as their interaction with similar laws promulgated by the states is vital.

Regulation Z’s TILA-based requirements for reverse mortgages are similar to those for other mortgage transactions. In addition to requiring that all key terms be provided in clear and conspicuous type on the loan document, that the document be integrated as a complete and final contract between the parties, and that the borrower can retain a copy of the loan document, it specifies that there is no requirement that a borrower actually complete a reverse mortgage loan transaction upon signing the application. The Federal Trade Commission asserts that reverse mortgages are still exempt from most of HOEPA’s broader requirements (because HOEPA only applies for mortgage interest rates exceeding 8 percent, and targets specific “forward” mortgage practices such as balloon payments). Yet since HOEPA’s enactment in 1994, reverse mortgages lenders have been required to meet HOEPA requirements to provide consumers with “adequate information” that goes beyond the general disclosure requirements for open-end credit transactions (in which a borrower can re-borrow against the principal paid thus far) and closed-end transactions (in which the borrower must repay the amount borrowed, along with any interest and capacity using the MMSE. After all, the variety of approaches to assessing competency and capacity, and the often episodic nature of cognitive impairments common in older adults (such as Alzheimer’s) have left medical professionals and probate court judges, among others, incredibly careful about making such determinations. For an excellent brief overview of some problems in determining competency and capacity in older adults, see Marshall B. Kappa, Measuring Client Capacity: Not So Easy, Not So Fast, 13-SUM NAELA Q 3 (Summer 2000), and other related articles in the same issue.


103 Official Staff Commentary of the Board of Governors of the Federal Reserve System at 73 FR 44522-01, 2008 WL 2900878 (F.R.). The summary of the commentary on the numerous amendments to Regulation Z made in 2008 also provide a clear statement of regulatory purpose of Regulation Z as a whole: The goals of the amendments are to protect consumers in the mortgage market from unfair, abusive, or deceptive lending and servicing practices while preserving responsible lending and sustainable homeownership; ensure that advertisements for mortgage loans provide accurate and balanced information and do not contain misleading or deceptive representations; and provide consumers transaction-specific disclosures early enough to use while shopping for a mortgage.

finance charges, by a specified future date).\textsuperscript{105} Most significantly, the lender must provide a table of total-annual-loan-cost (TALC) rates, which represent a good faith projection of the total cost of the reverse mortgage to the borrower.\textsuperscript{106} By definition, all costs and charges must be included, whether they are finance charges or not.\textsuperscript{107} The high initial costs of a reverse mortgage mean that TALC rates are normally highest in the first several years of the loan.\textsuperscript{108} Should a creditor be entitled to additional compensation in the form of a portion of home equity or property appreciation (which a creditor will sometimes request as reciprocation for charging a reduced interest rate or even not charging interest), the projected total cost of credit must include this portion.\textsuperscript{109}

Further, the Real Estate Settlement Procedures Act (RESPA) of 1974, which governs closing costs and settlement procedures, requires that borrowers (eventually including reverse mortgage borrowers) receive disclosures of loan costs at key steps in the lending process. Extensive November 2008 amendments to RESPA further require lenders to provide a standard Good Faith Estimate (GFE) that clearly discloses key terms and lending costs.\textsuperscript{110} Even then, recent changes by the Federal National Mortgage Association (Fannie Mae) that allow for higher margins for reverse mortgage lenders mean that even though the borrower signs a disclosure form from the lender which states the maximum amount the borrower can receive, that amount may change in the time between when a borrower submits an application and the time the loan is actually funded.\textsuperscript{111}

While federal regulation of reverse mortgages abounds, and numerous federal agencies, including the Department of Justice, SEC, and the FBI have investigated and prosecuted instances of mortgage and securities fraud, including “reverse mortgage scams,”\textsuperscript{112} HUD remains the primary federal agency promulgating regulations for reverse mortgages, and HUD fulfills this responsibility primarily through its promulgation and enforcement of Mortgagee Letters. Yet a still nascent federal entity, the Consumer Financial Protection Bureau (CFPB), may soon assume significant regulatory responsibilities over reverse mortgage lending. The Bureau began operation on July 21, 2011, one year after

\textsuperscript{106} Rohmer & Miller, supra n. 5, at 439.  
\textsuperscript{107} See the Commentary to Regulation Z, 12 USC § 226.33(c)(1)-1.  
\textsuperscript{108} Rohmer & Miller, supra n. 5. The National Center for Home Equity Conversion provides an excellent online reverse mortgage eligibility and cost calculator, http://reverse.org/reverse-mortgage-calculator/ (accessed Nov. 12, 2011).  
\textsuperscript{109} Regulation Z, 12 USC § 226.33(c)(3); Commentary § 226.33(c)(3)-1. Recent news of federal bailouts of the U.S. financial system, in particular, the $700 billion “Emergency Economic Stabilization Act of 2008” (H.R. 1424) has enabled the $300 billion “Housing and Economic Recovery Act of 2008” or “HERA” (H.R. 3221) to go largely unnoticed. HERA seeks to curb the very abusive and deceptive home mortgage practices that led to the subprime mortgage crisis itself.  
President Obama signed the Dodd–Frank Wall Street Reform and Consumer Protection Act. On January 4, 2012, President Obama exercised his recess appointment powers to name former Ohio Attorney General Richard Cordray as the new head of the Consumer Financial Protection Bureau. While Cordray has wasted no time exercising his regulatory powers to investigate matters from bank overdraft fees to reverse mortgage lending, the larger debate about the expansive powers of the CFPB continues. In early February 2012, the CFPB began to reveal its plans for rulemaking practices in general and its oversight of the mortgage industry in particular. While the Bureau is still developing its regulatory muscles, it will likely focus its attention first upon the largest lenders (of traditional and reverse mortgages), and then upon those with a disparate number of complaints compared to lenders of similar size. CFPB’s earliest language about reverse mortgages has already prompted the first of many comments in what will remain a spirited debate about the Bureau’s role in regulating and possibly reshaping HECM products. Even more broadly, the Bureau includes an Office of Financial Protection for Older Americans, a development that has likewise been met with both celebration and skepticism.

113 The preamble of the Dodd-Frank Act states it is “[a] bill to promote the financial stability of the United States by improving accountability and transparency in the financial system, to end ‘too big to fail,’ to protect the American taxpayer by ending bailouts, to protect consumers from abusive financial services practices, and for other purposes.” For full text and legislative history of Dodd-Frank Wall Street Reform and Consumer Protection Act (Pub.’s. 111-203, H.R. 4173), see http://www.govtrack.us/congress/bill.xpd?bill=h111-4173 (accessed Nov. 18, 2011).

114 President Obama originally nominated Harvard Law Professor Elizabeth Warren to lead the CFPB, but her history of outspoken criticism of business practices in the U.S. financial industry assured that her nomination met with strident opposition from many Republicans in the House of Representatives. Fearful of the impact of a potential Warren appointment to head the CFPB, Rep. Spencer Bachus (R-Ala.) even proposed a bill that would have CFPB leadership distributed among a committee of five persons rather than centralized under one agency director. For an overview of Bachus’ bill, H.R. 1121, which did not pass, see http://1.usa.gov/xQRUDD. For an article describing President Obama’s recess appointment of former Ohio Attorney General Richard Cordray to head the CFPB, see Helene Cooper and Jennifer Steinhauer, Bucking Senate, Obama Appoints Consumer Chief, N.Y. Times (Jan. 4, 2012), http://nyti.ms/yupmm8 (accessed Feb. 28, 2012). Some Republicans claim that Cordray’s appointment was unconstitutional because the Senate was holding minutes-long sessions in early January for the sole purpose of avoiding a Senate recess during which appointments could be made. See Richard Cordray, Consumer Financial Protection Bureau, Touts Enforcement Powers, Huffington Post (Jan. 4, 2012), http://www.huffingtonpost.com/2012/01/24/richard-cordray-consumer-bureau_n_1228519.html (accessed February 28, 2012).


116 Mary Griffin, Older Americans and the CFPB (May 25, 2011), http://www.consumerfinance.gov/older-americans-and-the-cfpb/ The language is as follows:

Americans aged 62 and older are eligible for reverse mortgages. If you are over 62 and own a home, you can borrow against the equity of that home in small amounts over time. Repayment is due when you no longer own the home or are absent for 365 days. This can help create a steady income during retirement, but it creates a large debt load. Reverse mortgage borrowers need to understand and be prepared for that risk.

117 Id.
VII. CONCLUSION

Even if home equity values are slow to recover over the next many years, aging baby boomers will continue to face expenses late in life that lead them to consider reverse mortgages. The reverse mortgage lenders who remain in today’s marketplace have weathered the diminished home values and decreased reverse mortgage loan activity of the past several years. Yet the greatest uncertainty for HECM lenders is that of an uncertain regulatory future. HUD Mortgagee Letters have long clarified the rules for lenders in the HECM program. TILA and HOEPA have long required numerous disclosures of loan costs. Yet lenders might wonder if more scrutiny and more possible regulation via the CFPB or at the level of individual states is really the answer, or if these are simply inevitable consequences of the failure of existing institutions to curb abuses.

No single solution exists to ensure that reverse mortgages are marketed ethically, that consumers who purchase them are informed about the terms of the loan and the risks therein, or that once acquired, the reverse mortgage will be used appropriately. The need for vigilance by and on behalf of aging consumers in reverse mortgages and other financial transactions late in life is ongoing and ever changing. To stop searching for new solutions and pressing for new protections for the elderly would be to fail the generation that has given us so much at the time when they often need us most. Even for those of us who are not yet “old” but who believe that “the best is yet to be,” and aspire to be able to grow old with dignity, autonomy, and some degree of comfort, significant incentive exists to ensure that financial products to meet seniors’ needs are both available and appropriate. If we work hard enough to establish and maintain security for aging Americans, we, too, might enjoy “the last of life, for which the first was made.”

118 As spoken by the protagonist in Robert Browning’s poem, Rabbi Ben Ezra. Published in Dramatis Personae (1864), http://rpo.library.utoronto.ca/poem/295.html (accessed Nov. 18, 2011).
CASE NOTE

DISTRICT COURT FAILS TO RECOGNIZE THE NEED FOR A POST- AHLBORN HEARING TO DETERMINE WHAT PAST MEDICAL EXPENSES A MEDICAID BENEFICIARY RECOVERED FROM A TORTFEASOR

By Ron Landsman, Esq., CAP

The Supreme Court’s unanimous decision in Arkansas Dept. of Health and Human Services v. Ahlborn,1 seemed to portend a new day in dealing with Medicaid agencies’ claims against the personal injury recoveries of Medicaid beneficiaries. It did, but not the one the trial bar or disability law attorneys hoped for or expected. Most courts to address Medicaid agencies’ right of recovery have undercut Ahlborn’s holding and found in it reason to allow states to establish recovery regimes claiming more than plaintiffs recovered for past medicals. Among them is Special Needs Trust for K.C.S. v. Folkemer.2

Ahlborn itself came before the U.S. Supreme Court on a narrow issue. Heidi Ahlborn suffered serious injuries in an automobile collision and qualified for Medicaid as a result. She subsequently settled a personal injury action for $550,000. The Arkansas Medicaid agency asserted that its Medicaid lien statute entitled it to recover its entire outlay of $215,645.30, although it stipulated that “only $35,581.47 of [the] settlement proceeds properly are ... for medical costs.”3 The Supreme Court rejected Arkansas’ claim that its broad lien statute was consistent with or authorized by the recovery activities that Congress required of state Medicaid agencies. The Arkansas statute imposed a lien on the entire settlement but, the Court said, the Medicaid agency was only entitled to recover from the beneficiary what she had recovered from the defendant for her past medical expenses. The agency stood in the plaintiff’s shoes and, because of the anti-lien statute, could not recover from the plaintiff’s other property, including the other elements of the personal injury claim, such as lost wages and pain and suffering. Thus, a lien against the entire settlement or recovery was unauthorized. Given the parties’ stipulation as to what the plaintiff recovered for medical expenses in that case, the Court did not have to resolve those facts, but noted that courts had more than ample means for doing so, without precluding states from developing “rules and procedures for allocating tort settlements.”4

In the recent Maryland case K.C.S., a child who suffered a debilitating birth injury settled a medical malpractice claim for $3 million; the balance after attorneys’ fees of $1 million and expenses of $53,245.07 funded a Special Needs Trust. Maryland’s Medicaid agency claimed its entire expenditure of $298,585.75 from the net settlement under Maryland Health General Code, §§15-109 and 15-120. The latter, at subsection (a), broadly provided for subrogation to the Medicaid agency of any cause of action of a recipient “to the extent of any payments made by the Department on behalf of the program recipient

---

3 Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. at 288.
4 Id. at 288.
that result from the occurrence that gave rise to the cause of action.” The trustee and others eventually filed suit in federal district court 1) seeking a declaratory ruling that the State was required to bring its action against the original defendants, not the plaintiffs, i.e., the “anti-lien” claim, 2) for a determination of what portion of the recovery the State was entitled to and, 3) for declaratory relief finding that the statute violated federal law to the extent it permitted recovery from that portion of the damages paid for future medical expenses.\footnote{5} The district court rejected the plaintiff’s anti-lien claim. The central issue in Ahlborn was how to reconcile the anti-lien provision, which prohibits the states from imposing a lien on any property of a Medicaid beneficiary prior to his or her death except in certain conditions, and the provisions affirmatively requiring the states to pursue recovery against third parties who are liable for the cost of care provided the beneficiary. The Supreme Court held that the federal recovery provision is a narrow and precise exception to the anti-lien rule, allowing Medicaid to recover what the plaintiff recovered for medical care, but not what he or she recovered for lost wages or pain and suffering. Because the Arkansas lien statute as interpreted by the state allowed it to recover from portions of the settlement not for medical care, it was in conflict with the federal statute.

In K.C.S., the district court noted that the Maryland statute “uses language similar to that ... in” the Federal statute, 42 U.S.C. § 1396a(a)(25)(B), which requires that the State “seek reimbursement [f] such assistance to the extent of such legal liability... .” But it then went on to the central confusion that underlies its decision, equating “the extent of [defendant’s] legal liability” for care with “the amount that the Department has expended for medical care,” as though they were the same thing. That confusion will come up again. The court also rejected the argument that the anti-lien provisions meant that state Medicaid agencies were required to proceed against the original tortfeasor, not the plaintiff-beneficiary.\footnote{7}

In rejecting the plaintiff’s third argument, that the Department was not entitled to recover from the portion of the settlement reflecting damages for future medical expenses, the district court at first appeared to agree that the State is limited to recovery for past medical expenses. But the Court failed to see the distinction between what the State paid and what plaintiff received from the tortfeasor defendant as compensation for past medical expenses. Again, it appeared to follow Ahlborn in acknowledging that it “must determine which portion of the settlement represents damages for past medical care expenses,”\footnote{8} but it again interpreted that to be what the State had paid: “This amount is not difficult to determine because the parties have stipulated that the Department spent $298,505.75.” (emphasis added)\footnote{9}
What the district court did not do was conduct the kind of hearing or make the determination that the Supreme Court said was critical — that is, a hearing to ascertain how much of what the plaintiff recovered in the settlement was for medical expenses. On each occasion that the district court discussed the Medicaid agency’s claim, it referred to what the agency had paid, and either assumed that the plaintiff recovered the full amount from the defendant in that element of its claims or failed to appreciate that there might be a difference.

In contrast, an unpublished 2010 decision from the Eastern District of Pennsylvania is a clear example of how a court should approach the abstract but not unsolvable question of how much of a settlement reflects past medical expenses. In McKinney v. Philadelphia Housing Authority, an individual who suffered permanent brain damage as a result of a respiratory incident triggered by damp and mold conditions in a home settled a claim for $11,913,000, unallocated except for fees and expenses. The person had received Medicaid benefits of $1,265,896.16 and the Pennsylvania Medicaid agency claimed that amount.

The Pennsylvania regulation provided for an allocation to Medicaid of one-half of the proceeds, net of fees and expenses “[i]n the absence of a court order … .” The court rejected the claim that the presumption had any role to play when a court was going to decide the allocation. It also rejected both the Medicaid agency’s argument that it could collect from the recovery for future medical expenses and the “ratio theory” urged by plaintiffs that Ahlborn required it to apply the ratio of past medical expenses to total claim and apply that ratio to the settlement.

In rejecting the ratio theory, the court said it would require a full mini-hearing, replete with expert witnesses, to determine the “true value” of the case, “send[ing] judges on a quixotic intellectual journey in search of an illusory number.” But the court then went on to explain a more nuanced approach. It noted correctly that among the problems with the ratio theory is “a logical failing”:

> Why should one assume that simply because Plaintiffs settled for a fraction of the supposed “true value” of their claim, that this fractional reduction applies uniformly across the various heads of damage? For example, a plaintiff’s past medical expenses can more easily be proven to a jury than can a plaintiff’s non-economic damages. Therefore, plaintiffs face less uncertainty regarding recovery of medical expenses and thus will be less willing during settlement talks to reduce their request for past medical expenses than for other, more uncertain heads of damage.

Thus, the court said if plaintiffs went to a jury and prevailed on the merits, there would be no reason not to award the full amount of past medical expenses because they are so “readily quantified ... there would be no reason for a jury to find Defendants liable

---

12 Id.
but not award Plaintiffs damages to make them whole for past medical expenses.”

On the other hand, in rejecting the Medicaid agency’s claim that it was entitled to the statutory formula or its total expenditures, whichever is less:

[W]here outcomes are uncertain, parties settle to hedge against the risk of an unfavorable outcome. ... Had Plaintiffs taken this case to a jury verdict and been awarded $1.26 million as compensation for past medical expenses, DPW [the Medicaid agency] would undoubtedly be entitled to that money (less attorneys’ fees and costs). DPW would also have it that if Plaintiff traded away some of its recovery prospects for certainty (and cash) via a settlement, DPW would reap the benefits without giving up anything. That is not the way settlement works. When parties settled, everyone sacrifices. DPW’s suggestion that it does not need to sacrifice ... ignores this reality.

If the court meant that, in settling to reduce risk the plaintiffs obtained less as compensation for past medical expenses than their actual amounts, and that the DPW was only entitled to get what the plaintiffs got for past medical expenses, then this is plainly a correct reading of Ahlborn. After reviewing the strengths and weaknesses of each side, the court concluded that the settlement reflected a one-third reduction of what the plaintiff could otherwise hope to recover, including one-third of past medical expenses. The McKinney court, also unlike the court in K.C.S., held that the Medicaid agency’s recovery must be reduced for a pro rata share of the legal fees and that Medicaid’s share of costs was equal to the share that its one-third reduced recovery was to the total recovery.

The McKinney court’s approach stands out as a practical and logical application of Ahlborn, of the very kind that the Supreme Court seems to have contemplated, but which the lower courts seem to have largely rejected. A number of courts have permitted state Medical agencies to establish formulas or presumptions in their favor, citing the Supreme Court’s reference in Ahlborn to the observation in an amicus brief that:

some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers’ rights to recovery are at issue. ... [W]e leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

But the Supreme Court in Ahlborn had no such formulas in mind. The reference was to the Association of Trial Lawyers of America’s amicus brief, which cited two cases approving post-settlement judicial proceedings or mini-hearings to determine the differ-

13 Id.
14 Id.
16 Arkansas Dept. of Health and Human Services v. Ahlborn, 126 S.Ct. at 1765 n. 17.
ent elements of the settlements. In Rimes v. State Farm Mutual Automobile Ins. Co., the question was whether the settlement had made the plaintiff whole; the post-settlement hearing addressed the question of the value of the different elements of plaintiff’s claim. Although not reported in as much detail, Henning v. Wineman also involved a post-settlement evidentiary hearing on which parts of the plaintiff’s claim were subject to subrogation and which not.

The Third Circuit’s recent decision in Tristiani v. Richman also skidded along the surface of Ahlborn on this issue, curiously so after a deep and thorough review of the scope of recovery issue. But it vacated the district court’s holding that a statutory allocation statute was permissible. “[I]n determining what portion of a Medicaid beneficiary’s third-party recovery it may claim in reimbursement for Medicaid expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation.”

Similarly, the K.C.S. court also gave short shrift to the plaintiff’s argument that Medicaid could not recover anything from damages awarded the plaintiff for future medical care. Its confusion was based on its failure to perceive the difference between what the plaintiff recovered in settlement from the defendant for future medical care and what Medicaid paid by way of benefits for past care. Other decisions permitting recovery from the future medical cost recoveries have proceeded on reasoning that is superficial, at best, and never attempt to look at the authorities that guided the Supreme Court in its analysis in Ahlborn. In the leading case on this issue, In re Matey, for example, the court correctly noted that most of the discussion in Ahlborn did not distinguish medical payments made from claims for future medical care. But in reading Ahlborn, it cites the Supreme Court’s discussion without acknowledging the statutory limitation upon which the Court itself relies, 42 U.S.C. § 1396a(a)(25)(A), which supports the mandate in section § 1396a(a)(25)(B), “where such a legal liability is found to exist after medical assistance has been made available …” To be sure, section § 1396k(a) looks toward liability for care to be provided in the future, and no doubt the states have authority to pursue such claims, but these different founts of authority require discrete analysis and treatment.

The authority to pursue recovery for past claims, 42 U.S.C. § 1396a(a)(25)(A) and (B), does not by itself give state Medicaid agencies any authority to claim recovery from what a Medicaid beneficiary as tort plaintiff recovered for future medical care. The anti-lien provision would plainly bar that. The requirement that Medicaid programs as a condition of eligibility require individual beneficiaries “to cooperate with the State in identifying ... any third party who may be liable to pay for care and services available under the [Medicaid state] plan,” 42 U.S.C. § 1396k(a)(1)(C), would appear to stand on a

17 Henning v. Wineman, 306 N.W.2d 550 (Minn. 1981); Rimes v. State Farm Mutual Automobile Ins. Co., 106 Wis.2d at 352, 316 N.W.2d at 268-269.
18 Rimes v. State Farm Mutual Automobile Ins. Co., 106 Wis.2d at 352, 316 N.W.2d at 268-269.
19 Henning v. Wineman, supra at 551.
21 Tristiani v. Richman, supra at 378.
22 In re Matey, 147 Idaho 604, 213 P.3d 389 (2009).
23 See also 42 U.S.C. § 1396a(a)(25)(H) (“that to the extent that payment has been made under the State plan ... where a third party has a legal liability ...” (emphasis added)).
different footing. A related provision recognizes that state Medicaid programs collecting funds under an assignment might collect more than was expended so that after reimbursing itself for payments made, “the remainder of such amount collected shall be paid to such individual.” 42 U.S.C. § 1396k(b). Significantly, the Medicaid agencies themselves disavow any right to obtain compensation for future medical care. That being the case, it is difficult to square that with their claim based on the statute to seize other property — compensation for future medical care — from plaintiffs.

The cases that allow Medicaid agencies to recover compensation for past medical expenses from the recovery for future medical costs, like Matey and K.C.S., generally quote Ahlborn without parsing the specific statutory provisions.\(^\text{24}\) Tristiani is an exception, but it did so for the somewhat different purpose of reviewing the district court’s decision that the assignment provision authorized suits by Medicaid against third parties, not beneficiaries, picking up an issue consciously not resolved in Ahlborn.\(^\text{25}\)

Certainly, the current trend in the cases is to mash together 42 U.S.C. § 1396a(a)(25)(A) and (B), which authorize recovery for past claims, with 42 U.S.C. § 1396k(a)(1)(C) and (b), which looks to some mechanism for securing recovery for future claims, and based on that to allow recovery for past medical care against plaintiff’s recovery for future medical care. Whether that was an issue lurking behind the Court’s unanimous decision in Ahlborn and whether anyone will articulate how and why to keep those provisions separate is problematic yet critical.

The more obvious fall-out from Ahlborn is the one McKinney answered and K.C.S. avoided. The Supreme Court in Ahlborn recognized the problems of the global settlement that is simply silent, or the friendly settlement that recites an allocation established more to limit Medicaid’s recovery than to reflect the realities of the case. It also recognized the reverse problem, of the Medicaid claim that further reduced the limited recovery for the plaintiff. That led to the Court’s point about state’s having judicial procedures available to resolve such claims.\(^\text{26}\)

The solution is obvious, if not simple. The personal injury attorney who settles a medical malpractice or other tort claim has not finished his work when he has collected from the tort defendants. The money collected is owed partly to the client who has retained him and partly to the Medicaid agency that is subrogated to the plaintiff’s claim for medical damages. But it is at least inefficient and in any event puts the original client in a strategically disadvantageous position to settle the claim without laying the proper groundwork for a defense against Medicaid’s claim. The better practice would be to settle claims with defendants and Medicaid agencies at the same time, or at least as part of the same process. No doubt three-way negotiations are vastly more complicated. Among the problems is that attorneys for Medicaid agencies are not under the same pressure to produce results; none would likely be criticized for letting one get away — the plaintiff who lost at trial after declining to settle because the claim post-recovery was too small. But there should be more than one way for defendants and plaintiffs to come to a resolution.

\(^{24}\) See e.g., Perez v. Henneberry, 2011 U.S. Dist. LEXIS 45063 (D. Colo.).

\(^{25}\) Yet another aspect of the issue is the interplay with the payback trust provisions, which like 42 U.S.C. § 1396k(b) contemplates holding funds for later reimbursement.

\(^{26}\) See supra n. 16.
that, by agreement, shifts the burden and rewards them for resolving Medicaid’s claim to their common advantage. And short of that, defendants will have their own independent interest in settling with Medicaid, which means forcing Medicaid to come to the table, however unwillingly. No doubt this reflects a sea change in long-established habits of doing business, but it is what plaintiffs now require.