By James A. Busse Jr.

Arrangements for uncovered medical costs is an often overlooked aspect of estate planning. Many clients find out, too late, that their medical costs, especially those involving nursing home care, can quickly consume even a sizeable estate. Estate planning attorneys have been able to preserve a significant portion of a client's estate by seizing opportunities within the Medicaid program (Medi-Cal in California) to make the client eligible for state benefits. These benefits have been used in various ways: to pay the $5,000 to $6,000 monthly cost for institutionalized nursing home care, to pay for a client's disability care before he or she becomes eligible for Medicare, or as a supplement to Medicare payments.

The federal government took notice of the success achieved by estate planners in preserving the assets of individuals with large estates whose medical costs are uncovered. Congress enacted the Deficit Reduction Act of 2005,[1] a comprehensive law designed to not only reduce benefits heretofore available but also to increase taxes. The DRA—signed by President George Bush on February 8, 2006—will have a profound impact on Medicaid and Medi-Cal by:

• Implementing stricter requirements for those seeking benefits and claiming to be U.S. citizens.
• Instituting the Income First Rule, which may reduce a stay-at-home spouse's income forever.
• Changing the treatment of annuities.
• Limiting the home equity exclusion amount for eligibility purposes to $500,000 [**CORRECT??**].
• Extending the look back period. Prior law was 30 months from the date of a gift. The DRA designates the period as 60 months from the date the applicant is otherwise qualified.

The DRA will make it more difficult for an individual to qualify for state aid to pay disability or nursing home costs, may disqualify some already receiving benefits, will increase the cost a recipient of state aid will pay (the share-the-cost fraction), and will eliminate many methods currently used to reduce the amount a recipient's estate will have to repay the state for benefits received. Clearly, the enactment of the DRA makes careful and thoughtful estate planning more important than ever. Moreover, any planning strategies for the possibility of a disability—a task that all too often was done, if at all, late in a client's life—will now have to become an early priority in the estate planning process.

The implementation of the DRA in California is complex and piecemeal. Some of the provisions of the DRA are effective nationwide as of the date of the legislation's enactment, which was February 8, 2006; others have later effective dates. The DRA provisions that have an impact on Medi-Cal rules require conforming state legislation and the promulgation of state administrative rules. Current law in California—the rules implemented by the state Department of Health Services (DHS)—is derived from historic Medicaid law that has been slightly modified by the mandates of the Omnibus Budget Reconciliation Act of 1993. These rules include share-the-cost rules, in which the state seeks ways to lower its cost by, for example, requiring an individual receiving Social Security to apply those funds to medical care before Medi-Cal picks up the rest of the bill. Some post-DRA rules have already been promulgated, most notably the DHS's All County Welfare Directors Letter (ACWDL) 06-12, the Administrative Procedure for Increase in Spousal Allowance; and ACWDL 07-12, the Proof of Citizenship Requirement. However, full implementation of the DRA in California is not expected until after January 1, 2009.[2]

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Income First Rule under the DRA

When a married person applies for and receives Medi-Cal benefits for nursing home care, he or she moves into an institution that provides food, clothing, sundries, and most living expenses. The institutionalized spouse is allowed to keep a small amount of his or her own spending money for various items. This amount is currently $30 per month. The spouse who lives at the married couple's home is known as the well spouse or the community spouse. He or she is allowed to keep a Minimum Monthly Maintenance Needs Allowance (MMMNA)—which is currently $2,571 per month—and a Community Spouse Resource Allowance (CSRA) of $101,640 in cash and other nonexempt assets. The CSRA may be increased to generate the allowable MMMNA. This can be accomplished by one of two methods: a "fair hearing" by the DHS or a superior court Probate Code Section 3100 proceeding.

For example, a retired husband receives a pension of $2,000 per month and will do so for the rest of his life. After his death, his surviving spouse will receive only $750 per month. His wife has not worked outside the home throughout their 45-year marriage and thus has no pension of her own. The couple's investment portfolio contains $400,000, with a return of 5 percent ($1,666 per month). To qualify for Medi-Cal, the husband and wife will have to disperse $298,360 to reach the CSRA so that the husband can qualify for Medi-Cal payments for the nursing home care he needs. This leaves the wife with only $423.50 per month ($101,640 at 5 percent per year).

The wife's income is below the allowable MMMNA of $2,541.50. In order to generate the additional $2,147.50 per month to reach the MMMNA, the husband and wife will have to invest $515,400 at 5 percent. At present, before the DRA is fully implemented, the couple may argue at a fair hearing or in a petition under Probate Code Section 3100 that $515,400 is needed so that the wife will receive the MMMNA. The administrative officer or court will most likely 1) order the husband and wife to keep their $400,000 investment portfolio, 2) reduce their share-the-cost fraction by $905, and 3) waive the look back period.

Under current law, $1,095 of the husband's retirement income is paid to the nursing home as his share-the-cost portion of the $6,000 per month nursing home cost. When the husband dies, his wife is left with the $400,000 in the investment account. That amount is required to generate her monthly income plus the surviving spouse retirement income of $750 per month—that is, the return from the portfolio ($1,666) plus $750 per month, for a total monthly amount of $2,416—and she still has the $400,000.

Under the DRA's new Income First rule, states are required to allocate to the community spouse any available income from the institutionalized spouse before any additional assets are allocated. This means that the husband's entire retirement income of $2,000 per month is first allocated to his wife, leaving her to generate $571 with her investments to reach the MMMNA amount. After a fair hearing, she can only keep $137,040 in investments. Thus, the couple will have to "spend down" $262,960 for the husband to qualify for benefits. When the husband dies, the wife is left with a $750 survivor's benefit and $137,040 in investments that generate $571 per month.

To summarize the differences between current rules and the new Income First rule: Under the current law, after a fair hearing, the husband qualifies immediately for Medi-Cal, the husband and wife can keep $400,000, pay $1,095 per month toward the husband's healthcare, and give the wife $2,541 per month as the MMMNA. When the husband dies, the wife will be left with $400,000 and $2,416 per month ($400,000 invested at 5 percent fixed) income for life.

Under the DRA and the new rule, after a fair hearing, the husband will not qualify for Medi-Cal, and the couple must spend down $262,960, leaving $137,040. They pay nothing toward the husband's healthcare when he does qualify for nursing home care, because his retirement income of $2,000 added to

the investment income of $541 makes up the MMMNA amount. The wife receives the full MMMNA of $2,541 per month during the husband's life, but when he dies, the wife is left with only $137,040 in investments and $1,321 per month in income.

The new Income First rule is designed to deplete the Medi-Cal applicant's cash and to delay acceptance into the program. Once the applicant is in the program, the government cost is increased, because the income that used to go to the share-the-cost fraction (the money used to offset government costs) goes instead to the spouse.

The Income First requirement only has an impact when the applicant appears at a fair hearing by an administrative law judge. It does not modify or change Section 42 USC 1396r-5(d)(5) or (f)(3) pertaining to court-ordered increases in the community spouse monthly allocation or transfers. Therefore, the rule does not apply to a hearing regarding a Probate Code Section 3100 petition.

Other Eligibility Issues

The major DRA changes to eligibility under Medi-Cal involve the look back period, accumulation of gifts, computation of the start date for benefits, and excludable home equity. Also, with few exceptions, the DRA requires proof of citizenship for an individual declaring to be a U.S. citizen to receive Medicaid benefits. ACWDL 07-12—released on June 4, 2007—contains the requirements,[3] including the applicable documentation. In the past, a claimant needed only to affirm his or her U.S. citizenship to collect Medi-Cal benefits. Now claimants must provide proof. Specified categories of applicants are exempt from the proof-of-citizenship requirements.

The DRA increases the maximum look back period from 30 months after a disqualifying transfer of assets to 60 months after the applicant is otherwise qualified. Currently, if the applicant gives available resources away within 30 months of the date of application for benefits, that person is disqualified from the date the money was given away for a period calculated by dividing the amount gifted by the Average Private Pay Rate (roughly the average cost per month for nursing homes that accept Medi-Cal). This amount is currently $5,101 per month. For example, under the current rules, if an applicant gave $40,000 away, the applicant is disqualified from receiving Medi-Cal for nursing home care for $40,000 divided by $5,101, or almost 8 months. If the applicant gave away $40,000 in September 2006 and applied for Medi-Cal in February 2007, the period of disqualification would only be 1 to 3 months (depending on what day in each month the triggering event occurred).

When the DRA is fully implemented, the period of disqualification will start from the date the applicant was otherwise eligible for Medi-Cal benefits and run for a period of 7 months and 25 days from that date. The DHS has acknowledged that it does not plan to implement the 60-month look back rule retroactively.[4]

The DRA eliminates the current law's unlimited home equity exclusion.[5] Applicants are disqualified from receiving nursing home and other long-term care assistance when their home equity exceeds $500,000, unless the applicant's spouse, or the applicant's minor child, or a blind or disabled child is residing in the home. Questions remain regarding how home equity will be determined. Also, there is a clear trend for raising the amount of excludible home equity. State Senator Sheila Kuehl has introduced SB 483 to increase the home exclusion cap to $750,000. The bill has cleared the Senate and awaits action in the Assembly.

Currently, to qualify for nursing home care, a single person is allowed to have $2,000 in cash or securities, up to $1,500 cash or securities set aside for burial expenses, a life insurance policy with a face value of $1,500 or less, jewelry valued at less than $100, a home, a car of any value, household goods, personal clothing, and possibly a business if it is the sole method of the individual's support or if there are business partners who will not agree to divest the property or business.

When implemented, the DRA will classify money used to purchase a life estate interest in the home of another individual as a transfer that causes a period of ineligibility unless the purchaser lives in the home for one year after the date of purchase.[6]

Annuities

The impact of the DRA on annuities, particularly regarding eligibility, is substantial and comprehensive. The new annuity rules, which affect annuities purchased after March 2006:

1) Mandate the state to require applicants to disclose any interest they or the community spouse has in any annuity.

2) Require the application or recertification form to include a statement that the state becomes a remainder beneficiary under the annuity. If a regular payment annuity is established for the expected life of the patient and the patient dies early, the state takes possession of the remainder.

3) Treat the purchase of a deferred or balloon payment annuity as a transfer of assets.

4) Exempt work-related pension funds, annuities, and qualified IRAs.

Under the DRA, if the applicant spends $100,000 to establish an annuity that makes regular periodic payments over his or her expected life, the annuity payments are considered income and taken for the share-the-cost reimbursement. Additionally, the applicant will experience a period of ineligibility equal to the amount spent on the annuity divided by the Private Pay Rate. This is converted to months of ineligibility from the date the applicant otherwise qualified for care—unless the state is the remainder beneficiary of the annuity. Under the current rule, the remainder does not revert to the state.

Annuities purchased before March 2006 pose a different set of Medi-Cal eligibility issues.

- For annuities purchased prior to August 11, 1993, the balance is considered unavailable if the applicant is receiving periodic payments—in any amount—of interest and principal.
- Annuities purchased between August 11, 1993, and March 1, 1996, will continue to be treated under the pre-August 11, 1993, rules if the annuities cannot be restructured to meet the post-March 2006 requirements.
- If the annuities were purchased on or after March 1, 1996, the applicant or the applicant's spouse must distribute periodic payments of interest and principal to exhaust the balance of the annuity at or before the end of the annuitant's life expectancy. Annuities purchased by the applicant on or after September 1, 2004, are subject to Medi-Cal recovery when the beneficiary dies.[7]

After the DRA is fully implemented, an effective planning technique will involve purchasing the annuity early in life for care later in life. This approach may increase the share-the-cost fraction, but the state will not have to be the beneficiary, nor will the look back period interfere with eligibility and qualification. An individual could buy a delayed benefit annuity for another that commences payments to a nonrelated beneficiary if the purchaser is ever institutionalized. The third party may be able to use the money to benefit the institutionalized person. The money would be drawn from the institutionalized person's estate and would not be available for the share-the-cost reimbursement. The only requirement is that the payments must be dispersed more than 60 months before the institutionalized person would be otherwise qualified for Medi-Cal.

The somewhat predictable path of dementia and Alzheimer's disease allows a party to do some planning. It is important to consider and calculate the time span from the onset of symptoms to the inability of a family to care on their own for the person who is ill. Often this path takes more than five years. So for a person with a family history of these diseases, if there is enough money available, the delayed annuity method might be a good way to reduce the estate, prevent disqualification, and lower the share-the-cost

fraction.

Home Equity Rules

California defines home equity two ways. The California Code of Regulations and the Welfare and Institutions Code define the owner's equity in the property as "the net market value which is determined by subtracting the encumbrances of record from the market value."[8] But another section of the Welfare and Institutions Code states that "[i]f the holdings are in the form of real property, the value shall be the assessed value, determined under the most recent county property tax assessment, less the unpaid amount of any encumbrance of record."[9] It is obvious some reconciliation is required, given the difference between the assessed value of many homes under Proposition 13 and their current market value.

Probably in deference to the banking sector, Congress mentions in the DRA that home equity loans and reverse mortgages may be used to reduce home equity. Care must be taken regarding these vehicles.

The borrower may use the cash from a home equity loan to reduce the value of the home, but the cash disqualifies the borrower for Medi-Cal benefits. If the borrower uses the cash from the loan to improve the home with permitted work or to improve another asset, the borrower's assets and home value are increased, which disqualifies the borrower. Also, it is important to note that when the borrower improves the home with permitted construction, the appraised value is increased. The equity exclusion amount will most likely be based on appraised or assessed value, so a home previously assessed under the lower range scheme of Proposition 13 may find its equity disproportionately increased by an improvement that increases the assessed value of the home. Therefore, the cash generated from a home equity loan should be used to purchase an exempt asset, such as a car, furniture, or burial plot.

Reverse mortgages provide funds to either improve the home or use as regular income. Thus reverse mortgages by nature are counterproductive, because they increase the share-the-cost fraction. They also consume an estate at an alarming rate because the borrower is now paying compound interest on the original amount borrowed. Some reverse mortgages even share the equity buildup but do not share equity loss. The owner is in effect selling the house and paying a compound interest premium to do so. Moreover, most if not all reverse mortgages require the borrower to live in the home. If the borrower does not, the loan is called. The net result may be loss of equity, loss of the home, and loss of Medi-Cal benefits when the home is foreclosed upon and the borrower/Medi-Cal recipient receives a cash settlement from the sale of the home.

Planning Techniques

Traditionally, planning techniques revolve around the applicant's qualifying for benefits; minimizing share-the-cost charges; and delaying, minimizing, or eliminating the state recovery of money dispersed to the Medi-Cal recipient. Under the current rules, a customary approach for Medi-Cal estate planners involves turning nonexempt assets into exempt assets. For example, an applicant may spend money for a home to which he or she intends to return as a residence after the nursing home care is no longer needed. Money may be spent for an addition to the home. The applicant may also purchase a car for transport to and from the nursing home.

Spending money for a house takes advantage of the rule that makes the applicant's home an exempt asset if the applicant states it is his or her desire to return to that home when his or her stay in the nursing home is over. The applicant declares this desire on the Medi-Cal application by checking Item 51. If Item 51 is not checked, the home is not exempt.

If the applicant's home is gifted to another without a writing reserving the right to live in the home for the remainder of the applicant's life, and this occurs before the applicant is accepted into the Medi-Cal system, the home is no longer the applicant's home and is not exempt. One tactic for an applicant is to check Item 51, get accepted into the system, and then gift the home for the love and affection of the person receiving it. That series of steps will prevent recovery.

Transfers for value do not trigger the look back period and can be used to reduce the size of an individual's estate. One example is a contract for care in which the institutionalized spouse contracts with a family member for services. For example, the institutionalized person pays a set amount to the family member for the performance of specified services for the rest of the institutionalized person's life. If the amount paid is equal to the market value of the services to be provided over the institutionalized person's expected life, the transfer will reduce assets without triggering the look back period.

The estate planner often devises approaches in anticipation of the institutionalized spouse's death. Under the current rules, qualifying the institutionalized spouse for Medi-Cal may require all of that spouse's assets to be transferred to the well spouse as his or her separate property. If this occurs, the assets are considered unavailable after the look back period. If the well spouse dies first and his or her will transfers property to the institutionalized spouse, the institutionalized spouse may be disqualified from receiving benefits.

Once Medi-Cal eligibility has been established for the ill person, the well spouse will often want to create a living or revocable trust to hold his or her property. It is essential that this trust not make the ill spouse a beneficiary, since that would terminate the ill spouse's eligibility. Many well spouses understandably want to provide for the ill spouse in the event the well spouse passes away first. One way to accomplish this is to have the well spouse's living trust "pour back" the assets into the well spouse's probate estate if the well spouse dies first, coupled with a will by the well spouse that creates a testamentary trust for the ill spouse. Since current Medi-Cal rules do not cover testamentary trusts, there is no ineligibility risk for the ill spouse.

For institutionalized persons without a spouse, an Intentionally Defective Grantor Trust (IDGT) (sometimes referred to as an Intentionally Defective Irrevocable Trust (IDIT)) may be used. An IDGT is a trust for the benefit of another, in which the settlor pays the income and property tax. An IDGT can remove assets from the institutionalized person's estate so that at death, there is nothing left for the state to collect.

Under the current rules, share-the-cost planning techniques may involve purchasing annuities that do not make fixed payments. The recurring payments are low, but there is a remainder or balloon payment at the end of the annuity that is paid to another person after the patient dies. These payments technically are not allowed, but existing policy is not to recover them due to the high cost and marginal benefit of doing so.

These approaches have allowed families to keep some of their assets when one family member requires placement in a nursing home or becomes disabled. Further, special needs trusts may be used to fund certain comforts for the institutionalized person without the value of the gift being included in the share-the-cost fraction.

When the Medi-Cal recipient dies, the state recovers the money spent on the institutionalized person under Welfare and Institutions Code Section 14006. This section allows the state to seek reimbursement for disability services rendered when the decedent was over age 55 and for nursing home care received at any age. The state can not claim reimbursement during the lifetime of a surviving spouse, when there is a surviving child under the age of 21 or when the surviving child is blind or is permanently and totally disabled within the meaning of the federal Social Security Act.

Under the Welfare and Institutions and Probate Codes, the personal representative, successor trustee, or surviving spouse of a per-

son who may have received Medi-Cal benefits must inform the DHS within 90 days of the date of the recipient's death.[10] The DHS may then place a lien on the decedent's property—and if the property has been given away, the fiduciary is personally liable. Medi-Cal recovery funds are recycled back into the benefits system, so the recovery concept is an important component of the total Medi-Cal program.

Recovery, under current rules, may be minimized or avoided by reducing the assets of the institutionalized person at his or her death. An irrevocable life estate is a method of doing this. Life estates without the right to revoke leave so little in the estate that the DHS has stated that the cost to collect these funds exceeds their value. Therefore, the agency will not pursue collection against an irrevocable life estate.[11] California currently only penalizes transfers to purchase life estates when the transfer is for an item of lesser fair market value—except when the life estate involves the institutionalized person's home, an exempt item.

A Probate Code Section 3100 petition may be used in Medi-Cal planning. The petitioner uses this method for a court-ordered transaction transmuting the separate and nonexempt community property of the institutionalized spouse to the separate property of the well spouse to satisfy the specific needs of the well spouse. The order increases the CSRA and MMMNA limits. The MMMNA cap may be reasonably increased to meet the recurring needs of the well spouse, including high prescription drug costs, home loan payments, and the like. The CSRA cap may be increased—allowing assets to be transferred without qualification or recovery penalty—to provide the necessary principal for the well spouse.

Remaining Options

Once the DRA is fully implemented, the estate planner must focus on the techniques that will remain available. One involves the transfer of the institutionalized person's residence to his or her spouse or to an IDGT or IDIT to reduce recovery. A transfer will only be valid if it was not made for the purpose of qualifying for Medi-Cal.

A donative transfer of the home does not invoke a period of ineligibility under the Medi-Cal regulations if the donor retains or is given a legal right to return to the home.[12] The homeowner receiving Medi-Cal benefits may decide to give away the house during his or her lifetime so that the house is protected from a Medi-Cal estate recovery claim at the homeowner's death. Placing a home in an IDGT in which the owner retains the right to live in or return home and the owner pays the tax on the property allows the owner to remain in or return to the home and removes the property from the owner's estate upon death, thereby reducing recovery.

The acquisition-of-services-for-value method remains an option. It will still be possible to transfer funds to others by contracting for care over the expected life of the institutionalized person. Planners must ensure that the contract uses cost information that is reasonable for the services provided and the actuarial life expectancy of the institutionalized person. Otherwise, the contract is at risk of being deemed a transfer of assets invoking the look back provisions.

A delayed annuity to a trusted third party or parties will reduce assets and might provide funds to that third party so that he or she can provide some comforts to the institutionalized person. One method to transfer assets would be to gift the annual exclusion amount, now $12,000 per person, earlier in life to another person who is not a spouse. That person then establishes a third party special needs trust for the benefit of the potential Medi-Cal recipient. A third party special needs trust is exempt from recovery and may provide funds for items that improve the quality of life of the institutionalized person. This method thus offers an opportunity to reduce the estate and provide care.

Probate Code Section 3100 petitions are not affected by the DRA. So a court action is still available to protect the well spouse's future and the cash and securities left in the well spouse's estate.

An irrevocable life estate remains a viable alternative to avoid recovery. The caveat for planners is to be sure the transfer is irrevocable and that the applicant has lived in the home for at least one year before applying for Medi-Cal.

Special needs trusts are available but require careful consideration. A special needs trust established by a third person with the third person's funds is not subject to recovery. The most popular form of special needs trust, a D4A trust, is sometimes called a payback trust.[13] It is a trust funded with assets belonging to the beneficiary. The D4A trust is established for a disabled beneficiary under 65 by a court, parent, grandparent, or legal guardian. A D4A trust must pay back the state for all medical assistance received at any time up to the full amount of the principal in the trust on the date of the beneficiary's death. Another form of special needs trust is the first-party trust established under Probate Code Sections 3600 et seq.[14] This type of trust is usually funded with judgment money owed the beneficiary and is subject to review by the DHS before approval by the court. These trusts require the trustee to notify the state upon the death of the beneficiary and pay any claims made by the state. These trusts are subject to the control and reporting requirements enumerated in Rule 7-903 of the California Rules of Court, unless the value of the trust is less than $20,000.[15]

An IDGT may be still be an appropriate choice after the DRA is fully implemented. With an IDGT, the applicant transfers an exempt asset, such as a home, irrevocably to the trust, reserving the right to live in and return to the home and retaining the obligation to pay the property and income taxes on the property in the trust. This transfer is excluded from the look back period and removes the property from the applicant's estate for recovery purposes.

Estate planners should consider whether a hardship waiver of the recovery is viable for a client. The state will not be able to deny benefits to a person who has applied for and received a hardship waiver in accordance with DRA Section 1917(c)(2)(D). According to the DRA, an undue hardship exists when the application of a penalty for a transfer of assets would deprive the individual of 1) medical care, without which the individual's health or life would be endangered, or 2) food, clothing, shelter, or other necessities of life. California has not yet codified specific criteria for eligibility for this waiver. A commentator to a draft rule stated that a hardship should not qualify for waiver if the hardship is created by estate planning methods.[16]

Finally, one method that does not save the estate but may bring comfort to a person requiring care would be for that person to borrow on his or her own property to generate funds for in-home care—which is not covered in any way by Medi-Cal. If the person has children, they could provide the house payments as a gift to their parent, knowing that when the parent dies they will receive the property and can repay themselves. All parties would have to strike a balance between the expected duration of in-home care and the amount of money borrowed. This family-funded care would keep the ill person at home, which is usually a far better place to be than even the best nursing home. This approach reduces the estate but is more cost-effective than a reverse mortgage. The result is that the children receive more for their inheritance than they would if the ill parent chose a reverse mortgage, and the ill parent will be able to remain in familiar surroundings.

Among the purposes of the DRA is the reduction or elimination of the estate planning methods that have been widely used to conserve taxpayers' estates for their families. Although the DRA rules in California have not yet been fully devised or promulgated, the estate planner must keep in mind the potential for future changes when working with clients. California rarely implements laws

retroactively, but the DRA's enactment date of February 8, 2006, does trigger some mandatory transfer rules involving real property and transfer of assets to purchase annuities. ■

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[1] Deficit Reduction Act of 2005, Pub. L. No. 109-171 (Feb. 8, 2006) [**CODIFIED YET?? IF SO, WHERE??**].

[2] Estate planners must carefully watch legislation and rule proposals for their effect on individual clients. Numerous advocacy organizations provide updates on proposed changes and platforms for comments. *See*, *e.g*., the California Advocates for Nursing Home Reform (CANHR) Web site, *at* http://www.canhr.org /medical/medical_changes092006.html.

[3] *See* http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs.

[4] *See* CANHR, Legal Network News, vol. 18, no. 2, Summer 2007, *at* http://www.canhr.org.

[5] DRA §6014 adds new subsection (f) to 42 U.S.C. §1396p.

[6] 42 U.S.C. §1396p(c)(1)(J).

[7] WELF. & INST. CODE §§14006.41, 14009.6.

[8] 22 CAL. CODE REGS. §50415; WELF. & INST. CODE §14006.

[9] WELF. & INST. CODE 14006(e)(1).

[10] WELF. & INST. CODE §14009; PROB. CODE §§215, 9202, 19202.

[11] *See* CANHR Web site, *at* http://www.canhr.org/medical/medical_changes092006.html. On June 12, 2006, the state Department of Health Services released the following statement regarding recovery against life estates and enforcement of the May 10, 2006, regulations:

> After the filing of R-32-00 with the Office of Administrative Law, the Department of Health Services (Department) continued to review and analyze the numerous public comments that had been received during the second public comment period for the package. As a result of that analysis, a policy decision was made to amend a portion of R-32-00 through regulations package R-14-04. The amendment will result in the removal of recovery efforts against the value of life estate only interests. The Department has now determined that during the short period of time in which R-32-00 as currently enacted will be in effect, it will not be cost effective for the Department to initiate or pursue recovery against life estate only interests. This decision is based on balancing the anticipated small dollar value associated with recovery for the few months R-32-00 would be in effect prior to the filing of R-14-04, against information obtained from advocates that the legality of life estate only interest recoveries would be challenged in the courts.

[12] DHS, All County Welfare Directors Letter (ACWDL) No. 90-01, Jan. 5, 1990, at 5, Questions and Answers Nos. 7 and 8, *available at* http://www.dhs.ca.gov /mcs/mcpd/MEB/ACLs.

[13] *See* 22 CAL. CODE REGS. §50489.9.

[14] *See* CAL. R. CT. 7-903 for trust requirements.

[15] CAL. R. CT. 7-903(D).

[16] Proposed changes to CAL. CODE REGS. §50961, 11/1/06 Draft Rule R-14-04.