Medicaid Asset Transfers and Estate Planning
Testimony Before the Senate Committee on Finance

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Good morning Mr. Grassley, Mr. Baucus, and members of the committee. My name is Julie Stone-Axelrad and I am a health policy analyst at the Congressional Research Service. In an attempt to help set the stage for your policy discussions about Medicaid asset transfers and estate planning, my testimony addresses several topics. First, I review Medicaid's eligibility rules for people needing long-term care. Next, I summarize Medicaid rules regarding asset transfers and estate recovery. At the request of this committee, I then provide examples of how people may divest assets. I also briefly discuss state efforts to limit such transfers. I conclude by offering information about how common such activities may be and their potential cost.

Introduction

Medicaid is a means-tested program and covers about 54 million people across the nation, including children and families, persons with disabilities, pregnant women, and the elderly. Although the program is targeted at low-income individuals, not all of the poor are eligible, and not all of those covered are poor. To qualify, applicants' income and assets must be within specified limits. There are three general ways in which applicants meet these requirements: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus, "spending down"; or (3) they divest their assets to qualify for Medicaid sooner then they otherwise would.

In calendar year 2003, combined federal and state spending on Medicaid was $250 billion. Of this amount, spending on long-term care services totaled $86.3 billion, or about one third of total program spending.[1] Some policymakers are concerned that the aging of the population will lead to increased demand for long-term care services, further shifting scarce federal and state dollars toward the Medicaid program and away from spending for other purposes. States are also concerned about the high cost of long-term care services.

Medicaid estate planning is a means by which elderly people divest their income and assets to qualify for Medicaid's coverage sooner than they would if they first had to spend their income and assets on the cost of their care. It is also a means by which persons may protect their assets from estate recovery. Motivation for this activity is, in part, a result of the high costs of long-term care services (e.g., a MetLife survey of a select group of nursing homes across the country found that for these facilities the average daily rate of a semi private room was $169 daily, or $61,685 per year in 2004) and the fear that these costs could quickly deplete savings.[2] For the purposes of Medicaid estate planning, this issue applies primarily to a subset of the Medicaid population, specifically a group of those persons age 65 and over who need long-term care services (such as nursing home or home and

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[1] CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). This analysis also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers, and data for the Medicaid 1915(c) home and community-based waivers.

[2] MetLife's survey of 790 home health agencies, also found that the average per hour private pay rate of a home health aide was $18. For a person needing 40 hours of care per week, for example, that would equal $37,440 per year. MetLife Market Survey of Nursing Home and Home Care Costs, Metlife Mature Market Institute, Westport, CT, Sept. 2004.

community-based services) and whose income is greater than $579 per month (or 73% of the federal poverty level).

Concern about these practices has resurfaced in recent years as part of the larger policy debate about the financial strains on federal and state budgets in general, and the increasing costs of Medicaid's long-term care coverage in particular. It is also part of a growing interest by policymakers in assessing the extent to which Medicaid plays a role as a safety net program for persons who are poor as well as the extent to which it plays a defacto role as a long-term care insurance program.

Despite Congress' efforts to discourage asset transfers through the establishment of new asset transfer rules in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), current law has not been able to preclude all available means of protecting assets. A variety of methods may still be used to protect assets and enable persons to obtain Medicaid coverage while using personal resources for other purposes, such as for making gifts to children or third parties, maintaining a certain standard of living, making improvements to one's home, or ensuring larger inheritances for heirs, than would otherwise be available.

Some of the methods listed in this testimony appear to be unintended consequences of Medicaid laws that were designed to protect persons who are poor or have high medical expenses and in need of Medicaid's assistance. However, that not all methods of transferring assets are necessarily in conflict with the spirit of Medicaid law. Whereas some persons refer to these provisions in the statute as "loopholes," others suggest that they reflect a lack of consensus among the law's drafters about the extent to which asset transfers should be statutorily prohibited. They also likely reflect the difficulty in writing legislative language to discourage *all* methods for transferring assets while not simultaneously restricting access to Medicaid's safety net services.

Critics of Medicaid estate planning often explain that asset sheltering places a financial strain on the Medicaid program and directs scarce resources away from people who are most needy to pay for care for people who are less needy. Some critics also object to this practice on moral grounds, asserting that people should assume financial responsibility for their own long-term care services before relying on tax dollars to pay for care they could otherwise afford.

Others indicate that people who engage in Medicaid estate planning do so because of the absence of a nationwide social insurance program covering long-term care services for the elderly. In addition, they explain that Medicaid's generally low allowable asset limit (often $2,000 excluding a home and certain other assets listed below) often leave persons with long-term care needs without the resources they need to remain at home and requires them to become virtually destitute before they can receive assistance in paying for their care.

Any changes to Medicaid law designed to discourage asset transfers may impact other groups of eligibles as well, particularly those who may have transferred assets without any intention of ever needing Medicaid's assistance. Consideration of these implications may be a critical component of the evaluation of different policy options.

Medicaid Eligibility for the Aged (Age 65 and Over)

To qualify for Medicaid, an individual must meet both categorical *and* financial eligibility requirements. Categorical eligibility requirements relate to the age or characteristics of an individual. Aged persons (age 65 and over), certain persons with disabilities, children and their parents, and pregnant women are among the categories of individuals who may qualify. Financial requirements limit the amounts of income and assets[3] individuals may have to become eligible for Medicaid (often referred to as standards or thresholds) and provide guidelines for how these amounts are calculated (counting methodologies).

The specific income and asset limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states, and different standards apply to different population groups within a state.

Major Income Pathways

Below is a description of the eligibility criteria for the major income groups. The groups include people who either are receiving cash assistance from the Supplemental Security Income program or have income that does not exceed 100% of the federal poverty level (FPL). Medicaid law also allows states to cover people with higher income if they require the level of care offered in an institution, such as a nursing home, or if they have medical expenses that deplete their income to specified levels.[4] Note that low-income elderly persons without long-term care needs and younger persons with disabilities also qualify for Medicaid through many of these pathways.

Supplemental Security Income (SSI). In general, many Medicaid enrollees who are aged qualify because they meet the financial eligibility requirements of the Supplemental Security Income (SSI) program, which provides cash benefits to disabled, blind, or aged individuals who have income that does not exceed $579 per month in 2005, or about 73% of the federal poverty level (FPL),[5] for an individual, and $869 for a couple. Although most states allow persons who meet SSI's eligibility criteria to qualify for Medicaid, eleven apply more restrictive criteria to either the income, assets or disability tests.[6] These states are often referred to as 209(b) states. As of 2003, these states were Connecticut, Hawaii, Illinois,

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[3] For purposes of Medicaid eligibility, assets are often referred to as resources and the terms may be used interchangeably. Resources include cash and other liquid assets or personal property that individuals (or their spouses) own and could convert to cash. As described later in this testimony, not all resources are counted for purposes of determining Medicaid eligibility.

[4] For more information about Medicaid's eligibility criteria for this population, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone-Axelrad.

[5] In 2005, 100% of the 2005 federal poverty level is $9,570 per year, or $758 per month for an individual and $12,830 for a couple, or $1,069 per month, in the 48 contiguous United States and the District of Columbia. In Alaska, this level is $11,950 per year, or $996 per month, and in Hawaii, it is $11,010, or $918 per month for individuals, see [http://aspe.hhs.gov/poverty/05poverty.shtml].

[6] Each of these states has at least one eligibility standard that is more restrictive than current SSI standards, and some also have standards that are more liberal.

Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.[7]

100% of FPL. States also have an option to cover persons whose income exceeds SSI levels but is *no greater than* 100% of FPL. As of 2003, 20 states and the District of Columbia used this option.[8]

Special Income Rule. Alternatively, states may extend Medicaid to certain individuals with incomes too high to qualify for SSI or the 100% option (if available), and who need the level of care that would be provided in a nursing facility or other institution.[9] Under the special income rule, also referred to as "the 300% rule," such persons may have income that does not exceed a specified level established by the state, but *no greater than* 300% of the maximum SSI payment applicable to a person living at home. For 2005, this limit is $1,737 per month (three times the monthly SSI payment of $579), or about 218% FPL. A number of states also allow persons to place income in excess of the special income level in a trust, called a Miller Trust, and receive Medicaid coverage for their care.[10] Following the individual's death, the state becomes the beneficiary of amounts in this trust.

Spend-Down Groups. Federal law also gives states the option of allowing aged persons with high medical expenses to qualify for Medicaid through so-called "spend-down" groups. Under these groups, people qualify only if their medical expenses (on such things as nursing home care, prescription drugs, etc.) deplete, or spend down, their income and assets to specified Medicaid thresholds.[11] For example, if an individual has monthly income of $1,000 and the state's income standard is $480, then the applicant would be required to incur $520 in out-of-pocket medical expenses before he or she would be eligible for Medicaid. States use a specific time period for calculating a person's medical expenses, generally ranging from one month to six months.[12]

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[7] A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with the Congressional Research Service.

[8] Source: A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with Congressional Research Service. The District of Columbia allowed people to qualify up to 100% of FPL. Other states using this option included: Arkansas (up to 80%), California (100%), Florida (88%), Georgia (100%), Hawaii (100%), Illinois (100%), Maine (100%), Massachusetts (100%), Michigan (100%), Minnesota (95%), Mississippi (100%), Nebraska (100%), New Jersey (100%), North Carolina (100%), Oklahoma (100%), Pennsylvania (100%), Rhode Island (100%), South Carolina (100%), Utah (100%), and Virginia (80%).

[9] Care must be needed for no fewer than 30 consecutive days.

[10] Since 1993 (OBRA 93), states that use only the special income rule for institutional eligibility, and do not use the medically needy option, must allow for income-only trusts.

[11] States may use spend down groups to extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, resources requirements for other eligibility pathways.

[12] The calculation becomes the basis for determining the amount of a person's spend-down requirement. Generally a shorter time period is more beneficial to the applicant. For example, if the state has a one month spend-down calculation period, the individual would be required to incur $520 in medical expenses in a month, after which services would be covered by Medicaid. On the other hand, if the state had a six month calculation period, the individual would have to incur a projected amount of $3,120 ($520 times six) in medical expenses before Medicaid would begin coverage. The length of the spend-down period does not significantly affect total out-of-pocket expenditures for

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The most common spend down group is referred to as "medically needy." Under this option, states may set their medically needy monthly income limits for a family of a given size at any level up to 133 % of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996.[13] The monthly income limits are often lower than the income standard for elderly SSI recipients (i.e., less than $579 monthly in 2005). Once eligible for Medicaid, beneficiaries who qualify under these rules must continue to apply their income above medically needy thresholds toward the cost of their care. As a result, elderly recipients living in the community who must spend down to qualify for Medicaid generally are allowed to retain less money for their living expenses than Medicaid beneficiaries who qualify through SSI. In 2003, 33 states had medically needy programs for persons age 65 and older.[14]

The second spend down group is available in all 209(b) states. Federal law requires those states that apply more restrictive criteria to the SSI population (see above) to allow these individuals to deduct medical expenses from their income when determining eligibility for Medicaid.

Post-Eligibility Treatment of Income. Once eligible for Medicaid, persons are required to apply their income toward the cost of their care. The amounts they may retain vary by setting. For example, Medicaid beneficiaries in a nursing home may retain a personal needs allowance (these amounts ranged from $30 to $70 per month in 2003). Persons receiving services in home and community-based settings may retain a maintenance needs allowance (these amounts ranged from $500 to $2,267 per month in 2003). All income amounts above these levels, including what may be available in a Miller Trust, must be applied toward the cost of their care.

General Rules Regarding Assets

Under the Medicaid program, states also set asset standards, within federal parameters, that applicants must meet to qualify for coverage. These standards specify the amount of countable assets a person may have to qualify. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow SSI rules for computing both countable and non-countable assets.

Under Medicaid and SSI rules, excluded assets include an individual's primary place of residence, one automobile, household goods and personal effects,[15] property essential to

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[12] (...continued)
persons with predictable and recurring medical expenses, such as persons with chronic illnesses or disabling conditions. However, individuals faced with acute nonrecurring problems generally benefit more from a shorter calculation period.

[13] For families of one, the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons.

[14] These include Alaska, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

[15] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March

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income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items. **Appendix 1** provides a more detailed description of SSI's program rules regarding countable and non-countable assets. Under certain conditions (discussed later in this testimony), these non-countable assets may be considered part of a beneficiary's estate and may be available for recovery by the state Medicaid programs after the beneficiary's death.

Additional State Flexibility

The criteria described above provide a *general* description of the income and asset criteria for Medicaid. These criteria, however, vary significantly by state. Under Section 1902(r)(2) of the Social Security Act, states have the authority to use more liberal methods for computing income and assets than are specified in the Social Security Act's eligibility definition for a particular group. States can also use Section 1902(r)(2) to ignore or disregard certain types or amounts of income or assets, thereby extending Medicaid to individuals with income or assets that are above the levels that would otherwise apply to a particular eligibility pathway.

Spousal Impoverishment Rules

Medicaid law also includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added to Medicaid law by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid (community spouse) with little or no income or assets when the other spouse is institutionalized or, at state option, receives Medicaid's home- and community-based services. Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage. These rules created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the other spouse could qualify for coverage. MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules.

Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. Federal law specifies that this limit may not exceed $95,100 and may be no less than $19,020 in total countable assets in 2005.

For purposes of determining eligibility, all assets of the couple are combined and counted, regardless of ownership. If the community spouse's assets are less than the state maximum, then the Medicaid beneficiary must transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

Regarding income, federal law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes

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[15] (...continued)
9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

of Medicaid eligibility. For community spouses with more limited income, however, states set the maximum monthly income level that community spouses may retain. Federal law specifies that this limit may be no greater than $2,377.50 per month, and no less than $1,561.25 per month in 2005. Once the applicant is determined eligible for Medicaid, some of his or her income may be used to cover the cost of the monthly allowance of the community spouse. Specifically, the Medicaid recipient may choose to transfer an amount of his or her income equal to the difference between the limit and the community spouse's own income up to the state limit.[16]

States, however, have some flexibility in the way they apply these rules and the rules they have developed have sometimes been the subject of court challenges. With regard to determinations of income and asset allowances for community spouses, for example, some states have added additional standards regarding the way in which income and assets are applied to these allowances.[17]

Asset Transfer Rules

In an attempt to ensure that Medicaid applicants apply their assets toward the cost of their care and do not give them away to gain Medicaid eligibility sooner than they otherwise would, Congress established new asset transfer rules under Omnibus Budget Reconciliation Act of 1993 (OBRA 93). These rules include penalties for the transfer of assets for less than fair market value. Specifically, they require states to delay Medicaid eligibility for certain individuals applying for institutional or certain home- and community-based services if they have disposed of assets[18] for less than fair market value on or after a "look-back date." This date is 36 months prior to application for Medicaid for all income and assets and 60 months in the case of certain trusts treated as assets disposed of by the individual.[19] These rules apply to all persons receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings.

Allowable Transfers

Under the law, not all asset transfers are subject to penalties. For example, asset transfers for fair market value, transfers to spouses of any value, and certain transfers to specified other persons, such as children with disabilities, for less than fair market value, are not

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[16] Centers for Medicare and Medicaid Services, *Spousal Impoverishment*, available at [http://www.cms.hhs.gov/medicaid/eligibility/spousal.pdf]; *2005 SSI FBR, Resource Limits, 300% cap, Break-even Points, Spousal Impoverishment Standards*, available at [http://www.cms.hhs.gov/medicaid/eligibility/ssi0105.asp].

[17] For example, some states use an "income-first" method, others use an "asset-first"method. The "income-first" method was challenged in court, and upheld as a permissible interpretation of federal law by the Supreme Court in *Wisconsin Department of Health and Family Services v. Blumer*, 534 U.S. 473 (2002).

[18] For the purposes of asset transfer rules, the term assets includes all income and resources of the individual and of the individual's spouse. See Section 1917(e)(1) of the Social Security Act.

[19] In the case of a revocable trust, any payments from the trust shall be considered assets disposed of by the individual; in the case of an irrevocable trust, any portion of the trust or income from the corpus, from which no payment could under any circumstances be made to the individual, shall be considered to be assets improperly disposed by the individual. As of the date of the establishment of the trust (or, if later, the date on which payment to the individual was foreclosed).

subject to penalties. Specifically, a home may be transferred, without penalty, from an applicant to a: (1) spouse; (2) child under age 21; (3) child who is blind or permanently or totally disabled (as determined under Title XVI or 1614 of SSA); (4) sibling who has an equity interest in the home and who was residing in the applicant's home for at least one year immediately before the date the individual becomes institutionalized; or (5) son or daughter residing in an individual's home for at least two years immediately prior to the institutionalization of the applicant and who provided care that permitted the individual to reside at home rather than in an institution or facility.[20] These rules were established to ensure that certain family members would not lose their homes or be without shelter so that one member of the family could obtain Medicaid coverage.

In addition, all transfers of any value between spouses are permitted. In part, this is because all assets of the couple, regardless of ownership, are combined and counted for purposes of determining Medicaid eligibility for either one or both spouses. When both spouses apply for Medicaid, the couple's combined non-exempt assets may generally not exceed $3,000. When only one of the spouses applies to Medicaid, spousal impoverishment rules, described earlier, apply to the amount of assets that the community spouse is allowed to protect.

Additional exceptions are made for other types of transfers for less than fair market value. They include certain transfers to a third party by the spouse for the sole benefit of the individual's spouse or transfers to a disabled or blind child for the sole benefit of the disabled or blind child. These transfers may include the establishment of a trust, such as a special needs trust or a pooled trust, for a disabled or blind child.[21,22] These exceptions allow one spouse to retain a source of financial support for another spouse and for parents of disabled children to secure a source of financial support for their disabled children.[23]

Penalties for Improper Transfers

Medicaid law requires states to impose penalties on certain applicants (institutionalized individuals and certain non-institutionalized individuals at the state option) who have made improper transfers. These penalties are defined as months of ineligibility for certain Medicaid long-term care services. The number of months is determined by dividing the total cumulative uncompensated value of all assets transferred on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins with the first month during which the assets were transferred. There is no limit to the length of the penalty period. The starting date of the penalty period has become a topic of policy debate and will be discussed again later in this testimony.

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[20] Section 1917(c)(2) of the Social Security Act.

[21] Section 1917(c)(2)(B) of the Social Security Act.

[22] Allowable transfers also include a transfer for the establishment of a Miller trust, or income-only trust, that is applied to the cost of the beneficiary's Medicaid care and for which the state is the beneficiary.

[23] Section 1917(c) of the Social Security Act.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, and not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations.[24] States may choose to apply this ineligibility period to other state plan long-term care services. In general, states do not extend the penalty to Medicaid's acute care services.

To protect beneficiaries from facing unintended consequences as a result of asset transfer penalties, Medicaid law includes provisions that allow states to waive penalties for persons who, according to criteria established by the Secretary, can show that penalties would impose an undue hardship. The statute also allows waivers of penalties for persons who can demonstrate to the state (also according to the rules established by the Secretary) that they either: (1) intended to dispose of the assets either at fair market value, or for other valuable consideration; (2) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (3) all assets transferred for less than fair market value were returned to the individual.[25]

Criminal Penalties for Transfers of Assets

In an attempt to limit Medicaid estate planning, Congress established provisions in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) that would have imposed criminal penalties on any person who knowingly and wilfully disposed of assets for the purpose of becoming eligible for Medicaid, if disposing of the assets resulted in a period of ineligibility. This law was often referred to as the "Granny Goes to Jail" law, and, largely as a result of public outcry, was repealed shortly after enactment by Section 4734 of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33).

BBA 97 replaced HIPAA's "Granny Goes to Jail" provisions with criminal penalties for persons who assist others in disposing of assets to obtain Medicaid eligibility. Specifically, the law states that whoever, for a fee, knowingly and willfully counsels or assists an individual in disposing of assets (including by any transfer in trust) to qualify for Medicaid, if disposing of the assets results in the imposition of penalty, could be found to have committed a misdemeanor and, upon conviction, be subject to a fine of not more than $10,000 or imprisonment for not more than one year, or both.[26] This became known as the "Granny's Lawyer Goes to Jail" law.

Shortly after enactment, the U.S. Attorney General, Janet Reno, issued a letter to Members of Congress and U.S. Attorneys stating that, after careful scrutiny, the Justice Department found that the counseling provision in the provision "was unconstitutional under the First Amendment."[27] She also stated that as a result, the Department of Justice would not bring any criminal prosecutions under that provision. Not long after the release of these letters, a federal court in *New York State Bar Association v. Reno*, 999 F. Supp. 710 (D.

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[24] They also apply to home and community care for functionally disabled elderly individuals (under Section 1929). This is an optional coverage group which operates only in Texas.

[25] Section 1917(c)(2)(C) and (D) of the Social Security Act.

[26] Section 1128B(a)(6) of the Social Security Act.

[27] Letter to the Honorable Newt Gingrich, Speaker of the House, U.S. Congress from Janet Reno, Attorney General, Department of Justice, dated March 11, 1998.

N.Y. 1998) also found the statue to be unconstitutional. As a result of these determinations, the "Granny's Lawyer Goes to Jail" provision has never been enforced.

Medicaid Estate Recovery

As discussed above, beneficiaries are allowed to retain certain assets and still qualify for Medicaid. The Medicaid estate recovery program is intended to enable states to recoup these private assets (e.g., countable and non-countable assets held by recipients) upon a beneficiary's death to recover Medicaid's expenditures on behalf of these individuals. Specifically, Medicaid law requires states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care and related services.[28]

General Statutory Requirements

There are two instances in which states are *required* to seek recovery of payments for Medicaid assistance:

- when an individual of any age is an inpatient in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) and is not reasonably expected to be discharged from the institution and return home; and
- when an individual age 55 years and older received Medicaid assistance for nursing facility services, home and community-based services and related hospital and prescription drug services.

In addition, for persons aged 55 and over, states are given the *option* of recovering the amount of funds spent on *any other* items or services covered under the state Medicaid plan.[29]

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state *probate* law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.[30] Thus assets, such as living trusts, life insurance policies, certain annuities, which may pass to heirs outside of probate, would only be subject to Medicaid recovery if a state expanded its definition of "estate."

Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21, or no surviving

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[28] As of February 2005, two states had not yet implemented recovery programs (Georgia's state plan amendment is currently under the Centers for Medicare and Medicaid Services (CMS) review and Michigan has not submitted an amendment). In addition, two states have implemented recovery programs within the last three years (Arkansas and Texas). Source: The Congressional Research Service (CRS) telephone conversation with CMS in February 2005.

[29] Section 1917(b) of the Social Security Act.

[30] Section1917(b)(4) of the Social Security Act.

child who is blind or has a disability.[31] Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.

Exemptions From Recovery

Medicaid law, regulations and guidelines allow states to exempt certain Medicaid long-term care beneficiaries from estate recovery. These beneficiaries are:

- persons for whom the state has determined that recovery would impose an undue hardship (in accordance with standards specified by the Secretary of the Department of Health and Human Services, (DHHS);
- persons for whom the state has determined that recovery would not be cost-effective (subject to a methodology approved by the Secretary and written into the state plan); and
- persons who reside in either New York, Connecticut, California, Indiana, or Iowa and have received benefits under a state-approved long-term care insurance partnership policy.[32]

Collection Amounts for 2003

The amount of funds collected through states' recovery programs has been relatively small. In 2003, for example, the amount recovered from all states was approximately $337.2 million.[33] As a comparison, this amount represents about 0.8% of Medicaid's total nursing home expenditures in that year, totaling about $44.6 billion.[34] Although nursing home expenditures represent the largest service for which recovery is attempted, this comparison does not include expenditures on other eligible long-term care and related services or on eligible services rendered to younger persons with disabilities.

Despite this low recovery ratio overall, significant variation exists across states in terms of the amounts collected. **Table 1** shows the variation among states. With two exceptions, Arizona (9.9%) and Idaho (4.3%), amounts collected fall below 3% of states' nursing home expenditures.

In part these differences reflect variation in the political and economic environments across states. For example, states with more rigorous programs have tended to view estate recovery as a cost-containment strategy. Other states, particularly those with lower recovery ratios, might face barriers as a result of political debate about the appropriateness of recovering an individual's home after a beneficiary's death. In still others, particularly those with relatively low per capita income, a belief that recovery is not cost-effective in that state may contribute to weaker efforts to recover assets than might otherwise exist.

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[31] Section 1917(b)(2) of the Social Security Act.

[32] For more information about the Medicaid long-term care insurance partnership program, see CRS Report RL32610, *Long-Term Care Insurance Partnership Program*, by Julie Stone-Axelrad.

[33] Estate Recovery Amounts: State reported data on Third Party Liability Savings Trend Analysis 2003 at [http://www.cms.hhs.gov/medicaid/tpl/tplpart1.pdf].

[34] CRS analysis of state-reported data on CMS Form 64.

Table 1. Medicaid Estate Recovery Amounts as a Percent of Nursing Facility Expenditures in FY2003

State	Nursing facility expenditures (2003)	Estate recovery (2003)	Amount recovered as a percent of medicaid nursing facility expenditures)
Alabama	$768,429,449	$4,222,784	0.5%
Alaska	99,307,550	0	0
Arizona	22,317,755	2,200,444	9.9
Arkansas	540,164,919	1,730,100	0.3
California	2,931,814,408	44,024,077	1.5
Colorado	415,217,012	4,649,920	1.1
Connecticut	997,830,090	10,884,820	1.1
Delaware	152,539,852	1,108,545	0.7
Washington D.C.	192,937,448	1,658,606	0
Florida	2,126,718,331	11,474,485	0.5
Georgia	900,262,135	0	0
Hawaii	177,179,348	2,255,074	1.3
Idaho	125,414,776	5,357,412	4.3
Illinois	1,431,124,039	16,993,946	1.2
Indiana	762,160,704	7,366,747	1
Iowa	487,480,360	10,977,823	2.3
Kansas	35,1051,074	6,193,161	1.8
Kentucky	619,759,104	2,961,800	0.5
Louisiana	594,880,647	104,755	0
Maine	237,859,692	5,934,701	2.5
Maryland	801,725,424	6,919,915	0.9
Massachusetts	1,511,869,307	28,524,313	1.9
Michigan	999,090,959	0	0
Minnesota	930,440,562	18,300,218	2
Mississippi	503,630,708	168,735	0
Missouri	733,310,219	7,480,548	1
Montana	143,950,197	1,982,288	1.4
Nebraska	345,932,257	12,361,598	3.6
Nevada	111,198,439	not available	not available
New Hampshire	138,368,754	not available	not available
New Jersey	2,092,780,914	not available	not available
New Mexico	165,599,566	0	0
New York	7,121,191,662	27,244,711	0.4
North Carolina	892,644,843	4,053,121	0.5
North Dakota	171,627,898	1,684,666	1
Ohio	2,647,297,226	12,382,674	0.5
Oklahoma	438,007,880	1,873,304	0.4
Oregon	270,751,263	13,996,362	5.2
Pennsylvania	3,732,029,413	23,149,026	0.6
Rhode Island	265,937,326	3,559,076	1.3
South Carolina	418,286,025	5,150,428	1.2
South Dakota	130,053,431	1,293,813	1
Tennessee	918,785,385	4,156,333	0.5
Texas	1,835,713,376	0	0
Utah	104,652,074	459,400	0.4
Vermont	96,293,595	487,029	0.5
Virginia	615,543,238	953,406	0.2

State	Nursing facility expenditures (2003)	Estate recovery (2003)	Amount recovered as a percent of medicaid nursing facility expenditures)
Washington	623,752,430	5,816,188	0.9
West Virginia	330,832,100	1,183,754	0.4
Wisconsin	1,526,259,152	12,812,864	0.8
Wyoming	56,803,388	1,097,240	1
Total	$44,610,032,180	$337,190,210	0.8%

Sources: Nursing facility expenditures: CRS analysis of state-reported data on CMS Form 64. Estate Recovery Amounts: State reported data on Third Party Liability Savings Trend Analysis 2003, at [http://www.cms.hhs.gov/medicaid/tpl/tplpart1.pdf].

Medicaid Estate Planning

Medicaid's rules regarding eligibility, asset transfers, and estate recovery are designed to restrict access to Medicaid's long-term care services to people who are poor or have very high medical or long-term care expenses and who apply their income and assets toward the cost of their care. Despite Congress' efforts to discourage asset transfers, current law has not been able to preclude all available means for protecting assets. A variety of methods may still be used to protect assets from use toward an applicant's care and to enable applicants to qualify for Medicaid sooner than if they first spent their private resources on the cost of their care.

Asset Divestiture Techniques

The following are some examples of asset transfer and Medicaid estate planning methods that may be used to protect assets from use toward an applicant's care or from estate recovery. This list is not intended to be comprehensive:

- **Minimize the length of the penalty period.** There are a variety of ways in which one might transfer assets with the intention of shortening the penalty period. As explained above, the penalty period of ineligibility begins on the first day of the month in which assets are transferred. One option is to transfer a part of one's assets while using the remainder to pay for one's care until the penalty period expires.

One example of this method might be for a nursing home resident to divest half of his or her assets and retain the other half to pay for his or her care during the penalty period, such that once that remaining assets have been depleted on the cost of care, the penalty period would expire and the individual could obtain Medicaid coverage without delay. This method of transferring half of one's assets is referred to as the "half-a-loaf" strategy.

For example, a hypothetical person has $50,000 in assets and transfers $25,000 to a third party. The penalty period is calculated by dividing the amount of the transferred asset for less than fair market value by the cost of care in a private pay nursing home. If the monthly cost of care is $5,000, then the individual would be subject to five months of ineligibility for certain services ($25,000/$5,000=five months). During the five month period of ineligibility, that individual would apply the remaining $25,000 toward the cost of care. After five months, the individual would run out of funds at about the same time as the penalty period

would expire. The individual could then apply to Medicaid and obtain coverage for his or her long-term care services.

- **Avoid the look-back period altogether**. Any transfers made at least 36 months before an individual applies for Medicaid coverage and 60 months for transfers that are defined as trusts under the law and regulations are not subject to a penalty because the transfer occurred before the beginning of the look-back period;

- **Convert countable assets into non-countable assets.** This is a process in which countable assets (e.g., funds in a savings account) may be converted into non-countable assets. For example, countable assets may be used to purchase an annuity for fair market value.[35] As long as the monthly income from the annuity, combined with all other sources of income, does not raise an individual's income above the eligibility thresholds, the existence of the annuity would not preclude an applicant from obtaining Medicaid coverage. Further, there is no federal requirement that the state be the beneficiary of the annuity. (See section on federal and state action for a more detailed discussion about annuities);

- **Establish irrevocable trusts.** The current look-back period for irrevocable trusts is five years. An applicant could place assets above Medicaid thresholds into an irrevocable trust in which an heir, and not the state, is named as a beneficiary without penalty if done so before the five year look back period. Such a method would protect all assets in the trust from use toward the cost of care and likely protect these assets from being subject to estate recovery;

- **Spend assets on items or services for fair market value.** Under current law, there are no restrictions on how assets above Medicaid thresholds may be used. If an individual who is applying for Medicaid has $8,000 above the asset threshold of $2,000, then that individual may choose to apply those excess funds toward the cost of his or her care or use these funds for home improvements, vehicle maintenance, entertainment, among others;

- **Use promissory notes**. As explained above, all transfers for less than fair market value are subject to penalties, except when made to certain third

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[35] OBRA '93 addressed annuities only tangentially by providing that the term "trust" includes an annuity only to such extent and in such manner as the Secretary of HHS specifies. Transmittal 64, or §3258.9(B) of the State Medicaid Manual, HCFA, No. 45-3, (Nov. 1994), provides the official CMS guidance on annuities. The guidance requires that annuities be actuarially sound, i.e., that the annuity pays back to the annuitant all of the funds used to purchase the annuity within that person's expected lifetime, otherwise the annuity will be considered a transfer of assets for less than fair market value and thus penalized. The CMS guidance attempted to "avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets." However, the CMS guidance does not state whether the payments must be monthly, or equal in size, or whether the remainder of the annuity can be paid to another person if the annuitant dies before the annuity is paid back. In addition, it is not clear under Transmittal 64 whether the purchase of an actuarially sound annuity is, by definition, a valid transfer of assets, regardless of the purchaser's intent.

parties (e.g., spouse or disabled child). To transfer assets for less than fair market value to a non-permissible third party, one could use a promissory note in which the third party agrees to repay the amount of the transfer to the Medicaid applicant. In general, such promissary notes would be part of the person's probate estate, and thus subject to Medicaid estate recovery. However, anecdotal evidence suggests that not all promissory notes are repaid either to the Medicaid beneficiary or the state; or

- **Engage in sequential asset transfers**. As explained above, transfers to certain persons (e.g., a spouse or disabled or blind child) are permissible under the statute. Medicaid law, however, does not prevent these persons from transferring assets to other third parties, such as an adult non-disabled child or other relative, who are not specified in the law. Although states are permitted to take measures to review the financial records of eligible third parties, many do not. As a result, states do not generally monitor the financial records of persons who receive allowable transfers, leaving available the possibility that such persons might transfer those assets to another non-eligible third party.

There are a variety of other techniques that may be used as well, such as divorce in which the Medicaid applicant gives all assets and income to the community spouse; spousal refusal or abandonment in which a community spouse refuses to provide financial support for the institutionalized spouse; the creation of life estates; and giving gifts that fall below the transfer penalty amount (in states with such amounts) to separate individuals to avoid a penalty. The availability of these methods as a means of protecting assets is subject to state law and program rules.

State Action to Address Medicaid Estate Planning

States have attempted to discourage asset transfers within the guidance established by federal law. Using regulatory and program guidance authority, the Secretary has provided direction to states about its flexibility under federal law regarding asset transfers as well as providing additional parameters on the definitions of non-countable assets. For example, CMS has issued opinion letters to individuals requesting information on how federal law applies to particular state Medicaid rules on transfers of assets. In such letters (see, e.g., CMS letter to Michael J. Millonig, April 26, 2004), CMS has stated that states have considerable flexibility in administering their Medicaid programs and may validly make reasonable interpretations of federal law in areas that have not been specifically addressed in federal law, regulation or policy. In addition, CMS has advised states that they may add criteria to the determination of actuarially sound annuities or promissory notes, such as prohibiting balloon payments, or states may interpret gray areas of the law or areas where the law is silent.

States have also taken a number of measures to tighten asset transfer rules, although the design of these measures varies significantly across states. One example of states' efforts has been an attempt to restrict the use of Medicaid annuities. Some states have added criteria which must be met for the annuity to be considered actuarially sound. Examples of additional criteria include requiring that the payments be in equal monthly installments, that the annuity be purchased from a licensed commercial entity, that no one except the individual or his or her spouse benefit from the annuity, or that the annuity name the state as the first

residual beneficiary of the annuity for a value up to the total amount expended by the state for the individual's care.

In addition, with regard to annuities, courts have come to differing conclusions on their treatment of whether, under the CMS guidance, a state may look at not only whether an annuity is "actuarially sound," but also whether the purpose of the annuity is to shelter assets to obtain Medicaid eligibility. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. However, in a recent Ohio case, a state court ruled that it was proper to look at the intent of asset transfers into an annuity, even if the annuity was actuarially sound. *Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. App., 12th, No. CA2003-09-093, Nov. 22, 2004).

States have also attempted to further discourage estate planning by requesting approval to tighten asset transfer rules under Section 1115 waiver authority. Section 1115 of the Social Security Act provides the Secretary with broad authority to waive certain statutory requirements in the Medicaid program allowing states to conduct research and demonstration programs that further the goals of the Medicaid program. Connecticut, Minnesota, Massachusetts, and North Dakota are examples of states that have submitted waivers to the Secretary to do such things as lengthen the look back periods, change the date in which the penalty period begins, tighten rules on exempt assets, such as annuities, and place limitations on transfers to spouses, among others. Waivers for Minnesota, Massachusetts and North Dakota are pending approval. Connecticut recently withdrew its application.

Prevalence of Medicaid Estate Planning and Potential Cost Implications to the Medicaid Program

Although some careful analysis has been conducted to measure the prevalence of asset transfers, for the most part this analysis is based on data and case studies that are not recent or that are narrowly focused.[36] In addition, the prevalence of Medicaid estate planning as well as the types of methods used likely vary by state. None of these studies has been able to capture this variation. As a result, there are insufficient data available to accurately estimate the prevalence of asset transfers today and none that can reasonably predict whether or how much this prevalence might grow in the future.

The following is what we do know. We know that a significant amount of anecdotal evidence exists about persons engaging in Medicaid estate planning. We also know that an industry of elder lawyers specializing in Medicaid has developed across the nation. Court cases at federal and state levels also point toward the prevalence of transfers. In addition, we know that states have expressed a strong interest in curbing Medicaid estate planning and have taken a number of measures to try to do so.

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[36] Examples include E. O'Brien, (2005), *Medicaid's Coverage of Nursing Home Costs: Asset shelter for the wealthy or essential safety net*, Issue Brief: Georgetown University Long-Term Care Financing Project; A. Coates, M. Deily, F. Elig, G. Hoover, et al., (2003) The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies. *American Public Human Services Association, National Association of State Medicaid Directors*; General Accounting Office (GAO): Health Education and Human Services Division, (1997). *Medicaid: Divestiture of Assets to Qualify for Long-Term Care Services B-277354.*

One question for which we do have information is the potential size of the pool of assets that could, but would not necessarily, be protected. A recent study [37] using data from the 2001 Survey of Income and Program Participation (SIPP) attempts to measure the total assets of unmarried elderly persons age 85 and older who are in need of assistance with functional limitations or cognitive impairments. The study looks at assets, excluding the home, (e.g. savings accounts, stocks and bonds, among others) and found that the majority (84%) of this elderly population age 85 and older have assets, excluding home equity, that would *not* enable them to cover one year of nursing home costs (i.e. less than $70,000 per year, with 74% having less than $5,000); 9% have assets that could pay for one to fewer than three years of care; and 7% have assets that could cover three or more years of nursing home costs. In addition, data collected by the U.S. Census Bureau from the 1996 SIPP panel survey show that almost half (49.8%) of the total net worth[38] of persons age 65 and older was in their own home and that this median net worth totaled $108,885 (in constant 2000 dollars).[39]

Within an environment of strained federal and state budgets, the logical next question is how much does Medicaid estate planning cost the Medicaid program. Although data are not available to accurately estimate the quantity of assets that have been protected, it is clear that any protection of assets that results in Medicaid paying for care that would otherwise have been paid with private funds results in increased costs to the Medicaid program. To the extent that legislative changes discourage asset protection and encourage persons to use private funds to pay for their own care, savings to Medicaid would result.

Given what we know, there is no indication that completely prohibiting asset transfers could result in savings that would amount to a large percentage of Medicaid program outlays. Furthermore, it is unlikely that any changes to current law could prohibit *all* of such transfers. Nonetheless, Medicaid spent $86.3 billion on long-term care services in 2003.[40] Even if only a fraction of spending were saved, it could be millions or possibly billions of dollars. In addition, as the population ages and the demand for long-term care grows, the potential financial strain on Medicaid will likely grow as well.[41] A political debate about the appropriate use of public dollars may help policymakers evaluate the various trade-offs that might be made between covering persons with long-term care needs of various wealth levels and using scarce Medicaid resources for other purposes.

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[37] Barbara Lyons, Andy Schneider, and Katherine A. Desmond, "The Distribution of Assets in the Elderly Population Living in the Community," Kaiser Commission on Medicaid and the Uninsured, The Henry Kaiser Family Foundation, June 2005.

[38] Based on the value of all assets minus all liabilities and excluding equities in pension plans, the cash value of life insurance policies, and the value of home furnishings and jewelry.

[39] Source: Shawna Orzechowski, Peter Sepielli, "Net Worth and Asset Ownership of Households: 1998 and 2000," Current Population Reports, P70-88, Issued May 2003.

[40] CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS).

[41] See William F. Basset, *Medicaid's Nursing Home Coverage and Asset Transfers*, Board of Governors of the Federal Reserve System, Washington, D.C. Sent to CRS by the author in April 2005.

Appendix 1

Asset Rules Under SSI

Supplemental Security Income (SSI) is a federal program that provides monthly cash payments to people with limited income and resources who are age 65 or older, blind, or disabled. To qualify for SSI benefits, an individual (or a couple) must meet categorical criteria by being age 65 or older, blind, or disabled. They must also meet financial criteria by having *countable* resources below the SSI limit ($2,000 for an individual and $3,000 for a couple; these amounts are not indexed for inflation and have been at current levels since 1989) and *countable* income below the SSI benefit rate ($579 for an individual and $869 for a couple in 2005; these amounts are indexed annually for inflation and may be lower for individuals and couples living in someone else's household or in an institution).[42]

Federal regulations specify that for purposes of SSI, resources are cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.[43] Not all resources are counted in determining SSI eligibility. The value of an item may be totally or partially excluded when calculating countable resources. Couples receive the same resource (and income) exclusions as individuals (e.g., one automobile is excluded from countable resources for the couple as a whole, rather than one automobile for each member of the couple).

According to the Social Security Administration's most recent annual report on SSI, principal items that are excluded from countable resources include the following:[44]

- a home serving as the principal place of residence, regardless of value;
- life insurance policies whose total face value is no greater than $1,500;
- burial funds of $1,500 each for an individual and spouse (plus accrued interest);
- all household goods and personal effects;
- one automobile (if used for transportation for the individual, or for a member of the individual's household);[45]
- property essential to self-support (e.g., property used by an individual as an employee for work);
- resources set aside by an individual who has a disability or is blind to fulfill an approved Plan for Achieving Self-Support (PASS); and

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[42] In some cases the income and resources of others are also counted when determining SSI eligibility. This process is called deeming, and it applies when an eligible child lives with an ineligible parent, an eligible individual lives with an ineligible spouse, or an eligible alien has a sponsor.

[43] 20 CFR 416.1201(a).

[44] Social Security Administration, *SSI Annual Statistical Report, 2003*, Sept. 2004, pp. 3-4, available at [http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2003/ssi_asr03.pdf].

[45] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable resources. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. See 70 *Federal Register* 6340, Feb. 7, 2005.

- amounts deposited into an individual development account (including matching funds and interest earned on such amounts) under the Temporary Assistance for Needy Families program or the Assets for Independence Act.

Table 1 provides a more comprehensive accounting of items (including those listed above) that are excluded from countable resources for purposes of determining SSI eligibility.

Table 1. Supplemental Security Income (SSI) Resource Exclusions

Exclusion	Limit on value or length of time?	Description
Home serving as the principal place of residence	No	A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. The home is not included in countable resources, regardless of its value. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.
Funds from the sale of a home if reinvested timely in a replacement home	Yes	The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of receipt of the proceeds.
Nonliquid resources above the SSI resource limit if certain conditions are met	Yes	People with excess nonliquid resources generally cannot receive SSI benefits even if they meet all other eligibility requirements. As a result, they may have little or nothing on which to live while they look for a buyer for excess property. However, SSA has statutory authority to prescribe the period(s) within which and the manner in which to dispose of various kinds of property, and federal SSI regulations describe the conditions under which SSI payments can be made while an individual attempts to dispose of property. Such "conditional benefits" paid during this period are considered overpayments and must be repaid from the proceeds of the sale of excess resources. When the excess resources are in the form of real property which cannot be sold for certain specified reasons (undue hardship or unsuccessful reasonable efforts to sell, exclusions which are described later in this table), the owner can receive regular (not conditional) benefits. An individual (or couple) who meets all nonresource eligibility requirements, but fails to meet the resources requirement due solely to excess nonliquid resources, can receive SSI benefits based on a "conditional" exclusion of the excess nonliquid resources (lasting nine months for real property, and up to six months for personal property) if the individual/couple (or deemor) meets both of the following conditions: Countable liquid resources do not exceed three times the applicable federal SSI benefit rate (e.g., $579/$869 x 3 = $1,737/$2,607 in 2005) for an individual/couple. — The individual/couple agrees in writing to sell excess nonliquid resources at their current market value within a specified period and use the proceeds of sale to refund the conditional benefits (which are considered overpayments) they received.

Exclusion	Limit on value or length of time?	Description
Jointly owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)	No	Excess real property which would otherwise be a resource is not a countable resource when it is jointly owned and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources.
Real property for so long as the owner's reasonable efforts to sell it are unsuccessful	No	Real property that an individual has made reasonable but unsuccessful efforts to sell throughout a nine-month period of conditional benefits (see the"nonliquid resources above the SSI resource limit" exclusion described earlier in this table for an explanation of conditional benefits) will continue to be excluded for as long as: (1) the individual continues to make reasonable efforts to sell it and (2) including the property as a countable resource would result in a determination of excess resources. If the property is later sold, benefits paid during the nine-month conditional benefits period are subject to recovery as overpayments. Benefits paid beyond the nine-month period as a result of this exclusion are not subject to recovery as overpayments.
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his/her tribe, or an agency of the federal government	No	In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest of the individual (or spouse, if any) in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government is excluded.
Life insurance, depending on its face value	Yes	In determining the resources of an individual (and spouse, if any), life insurance owned by the individual (and spouse, if any) will be considered to the extent of its cash surrender value. If, however, the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any). In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance will not be taken into account.

Exclusion	Limit on value or length of time?	Description
Burial funds for an individual and/or his/her spouse	Yes	In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	No	In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.
Household goods and personal effects	No	Household goods are not counted as a resource to an individual (and spouse, if any) if they are: (1) items of personal property, found in or near the home, that are used on a regular basis, or (2) items needed by the householder for maintenance, use and occupancy of the premises as a home. Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes. Personal effects are not counted as resources to an individual (and spouse, if any) if they are: (1) items of personal property ordinarily worn or carried by the individual, or (2) articles otherwise having an intimate relation to the individual. Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. Items of cultural or religious significance and items required because of an individual's impairment also are not counted as resources to an individual. However, items that were acquired or are held for their value or as an investment are counted as resources because they are not considered to be personal effects. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles. Such items will be counted as a resource. (Prior to March 9, 2005, there were restrictions placed on the value of household goods and personal effects that could be excluded from countable resources. See *Federal Register* 70, no. 24, Feb. 7, 2005, pp. 6340-6345.)
One automobile	No	One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be nonliquid resources and are counted as a resource.

Exclusion	Limit on value or length of time?	Description
		(Prior to March 9, 2005, there were restrictions placed on the value of the automobile that could be excluded from countable resources. See *Federal Register* 70, no. 24, Feb. 7, 2005, pp. 6340-6345.)
Property essential to self-support	Yes	When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property used in a trade or business, nonbusiness income-producing property, and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support. Resources excluded under this provision generally fall into three categories: (1) Property excluded regardless of value or rate of return. This category encompasses: — property used in a trade or business (effective 5/1/90); — property that represents government authority to engage in an income producing activity; — property used by an individual as an employee for work (effective 5/ 1/90); and — property required by an employer for work (before 5/1/90). (2) Property excluded up to $6,000 equity, regardless of rate of return. This category includes nonbusiness property used to produce goods or services essential to daily activities. For example, it covers land used to produce vegetables or livestock solely for consumption by the individual's household. (3) Property excluded up to $6,000 equity if it produces a 6% rate of return. This category encompasses: — property used in a trade or business in the period before 5/1/90; and — nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each.
Resources of a blind or disabled person which are necessary to fulfill an approved Plan for Achieving Self-Support (PASS)	Yes	If the individual is blind or disabled, resources will not be counted that are identified as necessary to fulfill a plan for achieving self-support. A PASS must: (a) be designed especially for the individual; (b) be in writing; (c) be approved by the Social Security Administration (a change of plan must also be approved); (d) be designed for an initial period of not more than 18 months. The period may be extended for up to another 18 months if the individual cannot complete the plan in the first 18-month period. A total of up to 48 months may be allowed to fulfill a plan for a lengthy education or training program designed to make the individual self-supporting; (e) show the individual's specific occupational goal; (f) show what resources the individual

Exclusion	Limit on value or length of time?	Description
		has or will receive for purposes of the plan and how he or she will use them to attain his or her occupational goal; and (g) show how the resources the individual set aside under the plan will be kept identifiable from his or her other funds.
Stock held by native Alaskans in Alaska regional or village corporations	No	Shares of stock held by a native of Alaska (and spouse, if any) in a regional or village corporation were not counted as resources during the period of 20 years in which the stock was inalienable (nontransferable). Effective January 1, 1992, the stock became transferable and is treated as an excluded resource.
Federal disaster assistance received on account of a presidentially declared major disaster, including interest accumulated thereon	No	Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a state or local government, or from a disaster assistance organization, is excluded in determining countable resources. Interest earned on the assistance is excluded from resources.
Retained retroactive SSI or Social Security Disability Insurance (SSDI) benefits	Yes	In determining the resources of an individual (and spouse, if any), the unspent portion of any Title II (SSDI) or Title XVI (SSI) retroactive payment received on or after 3/2/04 is excluded from resources for the nine calendar months following the month in which the individual receives the benefits. The unspent portion of retroactive SSI and SSDI benefits received before 3/2/04 is excluded from resources for the six calendar months following the month in which the individual receives the benefits.
Certain housing assistance	No	The value of any assistance paid with respect to a dwelling under: (1) the United States Housing Act of 1937; (2) the National Housing Act; (3) Section 101 of the Housing and Urban Development Act of 1965; (4) Title V of the Housing Act of 1949; or (5) Section 202(h) of the Housing Act of 1959 is excluded from resources.
Tax refunds related to the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC)	Yes	In determining the resources of an individual (and spouse, if any), any unspent federal tax refund or payment made by an employer related to an EITC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund or payment made by an employer related to an EITC that is received before 3/2/04 is excluded from resources only for the month following the month refund or payment is received. Any unspent federal tax refund from a CTC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund from a CTC that is received before 3/2/04 is excluded from resources only for the month following the month the refund or payment is received. Interest earned on unspent tax refunds related to an EITC or a CTC is not excluded from resources.

Exclusion	Limit on value or length of time?	Description
Victims' compensation payments	Yes	In determining the resources of an individual (and spouse, if any), any amount received from a fund established by a state to aid victims of crime is excluded from resources for a period of nine months beginning with the month following the month of receipt. To receive the exclusion, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.
State or local relocation assistance payments	Yes	Relocation assistance is provided to persons displaced by projects which acquire real property. In determining the resources of an individual (or spouse, if any), relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act is excluded from resources for a period of nine months beginning with the month following the month of receipt. Interest earned on unspent state or local relocation assistance payments is not excluded from resources.
Dedicated financial institution accounts required for past-due benefits paid to disabled children	No	In determining the resources of an individual (or spouse, if any), the funds in a dedicated financial institution account that is established and maintained for the payment of past-due benefits to disabled children will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account (specified in federal SSI regulations) and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.
Grants, scholarships, fellowships, and gifts used to pay for educational expenses	Yes	Effective June 1, 2004, there is a nine-month resource exclusion for grants, scholarships, fellowships, and gifts used to pay for tuition, fees, and other necessary educational expenses at any educational institution, including vocational and technical education.
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	Yes	Cash (including any interest earned on the cash) or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource. This exclusion applies if the cash (and the interest) is used to repair or replace the excluded resource within nine months of the date the individual received the cash. Any of the cash (and interest) that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the nine-month period expires. The initial nine-month time period will be extended for a reasonable period up to an additional nine months if the individual is found to have had good cause for not replacing or repairing the resource.
Certain items excluded from both income and resources under a federal statute other than the Social Security	Varies	In order for applicable payments and benefits received under a federal statute other than Title XVI of the Social Security Act (SSI) to be excluded from resources, the funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

Exclusion	Limit on value or length of time?	Description
Act		Examples of excluded payments include those relating to: Agent Orange; Austrian Social Insurance; Corporation for National and Community Service (CNCS) programs; Individual Development Accounts (IDAs) funded by the Temporary Assistance for Needy Families (TANF) program; demonstration project IDAs; Japanese-American and Aleutian restitution payments; energy assistance for low-income households; victims of Nazi persecution; the Netherlands' WUV program for victims of persecution; a Department of Defense (DOD) program for certain persons captured and interned by North Vietnam; the Radiation Exposure Compensation Trust Fund; the Ricky Ray Hemophilia Relief Fund; and veterans' children with certain birth defects. (For more information on these and other excluded payments and benefits, see 20 CFR 416.1236 and [http://policy.ssa.gov/poms.nsf/lnx/0501130050].)

Source: Congressional Research Service (CRS), based on 20 CFR 416.1201-1266; Social Security Administration (SSA), Program Operations Manual System (POMS), *Excluded Resources*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501110210!opendocument]; SSA, POMS, *Guide to Resources Exclusions*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501130050]; and SSA, *Social Security Handbook*, What are the Resource Exclusions?, available at [http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2156.html].