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NOMINEE TRUSTS-THIS TIME THEY TAKE THE STAGE

MASS LAWYERS WEEKLY – TRUSTWORTHY ADVISOR
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March 2021

In the constant wrestling between Massachusetts applicants for Medicaid benefits and MassHealth (the agency that oversees the approval of Medicaid benefits), the lowly nominee trust has just won a landmark victory. In the case of *Guilfoil vs. the Secretary of Executive Office of Health and Human Services*, the Massachusetts Supreme Judicial Court held that a retained life estate in a residence held in a nominee trust was not a countable asset. (Mass No. SJC-12992, Feb 9, 2021).

Why is this a landmark victory? Medicaid is not an entitlement but rather a need-based program that pays long term care (nursing home) benefits, when the applicant for benefits cannot pay themselves. Briefly and very generally, a person can only qualify for such benefits if she has no more than $2,000 in assets plus a principal residence. Thus, a person with a modest retirement or savings account would have to "spend down" to $2,000 before Medicaid would pay for care. As for the residence, although generally considered a "non-countable" asset while the applicant is alive, the law allows the state to recover against the residence on the applicant's death from her probate estate. The home proceedscan be used to reimburse MassHealth for its payments for the applicant's care.

To avoid the "estate recovery" result, planners began to recommend holding the residence in a trust to avoid probate and thus avoid estate recovery for Medicaid benefits paid.on behalf of the homeowner.. MassHealth quickly countered with a ruling that a home held in a trust could become a countable asset. The concomitant developing law on the use of trusts created by the applicant to obtain Medicaid benefits was gradually reduced to the question of what is the maximum amount the trust could pay to the applicant or the applicant could reach from the trust. Thus, the simple solution was to create an irrevocable trust which strictly limited payments to the applicant, or in the case of a residence, limited the applicant to the use and occupancy of the residence, typically for life (a "life estate"). In the latter case, since the applicant's interest was limited to her life, there was nothing for the state to collect on her death.

The huge growth in the use of trusts in Medicaid planning caused considerable concern on the Commonwealth's part, causing MassHealth to begin to aggressively pursue any Medicaid application that involved a trust. Unfortunately, the aggressive pursuit often took the form of denying benefits where the denial was based on the most extreme and untenable interpretation of the provisions of the trust, under the "any circumstances" rule, discussed below. For example, when a person creates her own trust, it is not unusual for that person to be concerned over selection of the trustee, who typically has broad authority to manage the trust property, and it is equally common for the trust to provide that the creator of the trust have the power to remove and replace the trustee. In such cases, even though the provisions of the trust would limit or restrict payment of benefits to the creator, MassHealth would deny benefits out of hand, on the basis that the creator (applicant) could remove the trustee, appoint herself as trustee, and distribute all of the trust property to herself. The strategy worked in some aspects, since many applicants didn't have the funds or the sophistication to appeal the case in the first instance to an

administrative hearing examiner, and ultimately to the Superior Court and beyond, and just gave in. But not the family in *Guilfoil.*

The Commonwealth continues on this course and bases most of its arguments on the "any circumstances" rule, which was the basis of a 1996 Supreme Judicial Court decision reflecting the federal regulations stating that if there are any circumstances under which the applicant could receive benefits under the trust, then all of the trust assets to the maximum extent allowed under the trust were considered countable assets available to the applicant. *Cohen v. Division of Medical Assistance*, 423 Mass. 399 (1996). The federal regulation uses an illustrative hypothetical case: Assume a trust would only allow trust benefits to be paid if the applicant/beneficiary needed a heart transplant, but in that instance the trustee could distribute all of the trust's assets for that purpose. Since there was a circumstance where all of the trust could be distributed to the applicant/beneficiary then this provision would make the trust assets fully countable under the "any circumstances" rule. Benefits denied.

In the *Guilfoil* case noted at the outset, Ms. Frank established a nominee trust in 2001, and transferred her home to the trust reserving only a life estate within the terms of the trust. The remainder interest was held in the trust for her five children, jointly. .She entered a nursing home in 2017 (at age 91) and shortly thereafter applied for Medicaid benefits (long after the required 5 years waiting "look back" period after a trust is funded). Benefits were denied based on the value of her home, held in the trust, which was deemed accessible to her by MassHealth. Ms. Frank appealed, and the family took its fight all the way to the Massachusetts Supreme Judicial Court.

The nominee trust in *Guilfoil* was an "agency" trust and not a true trust (see Trustworthy Advisor, November 2020), and as an agency trust it contained the typical language stating that the trustee may only act a directed by the beneficiaries. The trust, unfortunately, also contained language stating that "this trust may be terminated at any time by notice in writing from any (emphasis added) of the beneficiaries". Another section of the trust states that any of the beneficiaries may amend the trust, remove and appoint trustees, and execute documents. Still another section of the trust states that amendments may be made by all of the beneficiaries. MassHealth argued that these powers of amendment, etc. by any beneficiary gave Ms. Frank full access to the trust by amendment.

In observing that the trust "is not a model of clarity, the court did not interpret the two sections of the trust as conflicting, but rather determined that whatever any beneficiary did, they were bound by the fact that Ms. Frank mads a complete gift of the remainder interest to her children, retaining only a life estate for herself. The remainder interests were vested in the children not subject to reacquisition by Ms. Frank. If the trust was terminated, the children would receive the remainder interest and Ms. Frank would receive her life estate (and not the entire property). Importantly, the court went into great detail emphasizing the difference between an agency trust and a "true" trust, subtly suggesting that the same result may not have obtained if the trust were a "true" trust. This could be misleading for Medicaid planners, because a true trust could certainly be drafted to create vested interests and strictly limit the creator's rights and access to trust property – a structure that is used frequently in Medicaid eligibility planning with success.

In any event, there are important lessons to learn from the case, including the importance of careful attention to drafting and review of "standard" provisions, and the guidelines the case

has laid out to create a nominee trust that clearly and irrevocably divides the beneficial interest between a life estate in the beneficiary/applicant and a remainder interest in family members (or whomever). A final lesson may be that the nominee trust with its streamlined efficient structure is not the right trust tool when sophisticated planning is the goal, as it was for Ms. Ford and her family. A more complex trust from the start may have been more costly, but that cost does not begin to compare with what the family must have paid to see the case through to the end.